Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust

Royal Preston Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Royal Preston Hospital is one of two hospitals providing care as part of Lancashire Teaching Hospitals NHS Foundation Trust. It provides a full range of hospital services, including emergency department, critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, paediatrics and midwifery-led maternity care.

Lancashire Teaching Hospitals NHS Foundation Trust as a whole provides services to 390,000 people in Preston and Chorley, and specialist care to 1.5 million people across Lancashire and South Cumbria.

We carried out this inspection as part of our comprehensive inspection programme.

We undertook an announced inspection of the hospital between 9 and 11 July 2014, and an unannounced inspection between 6pm and 8pm on 21 July 2014 at Royal Preston Hospital only. We looked at the management of medical admissions out of hours.

Our key findings were:

Access and flow

- The hospital had a high number of medical emergency admissions that was resulting in high numbers of medical outliers (patients placed in areas not best suited to their needs). There were times when there were more than 35 patient outliers.
- Patients sometimes remained in the Emergency Department overnight.
- There were also occasions when patients were moved from ward to ward many times, sometimes at night.
- The number of medical outliers placed in surgical beds led to unused theatre capacity.
- Issues with bed capacity were also made worse by the number of delayed discharges.
- The management of patient access and flow across the hospital was of immediate concern and remained a significant challenge for managers. The hospital had made arrangements to ensure timely medical review of patients placed in a clinical setting that did not best suit their needs. However, the number of moves across wards and being placed in less appropriate clinical settings was far from ideal and was having a negative effect on patient experience.

Mortality rates

- Mortality rates were within expected limits.

Never events

- There had been five reported potential surgical never events during the period April 2013 to April 2014. However, three had been declassified, and the trust had taken appropriate steps to reduce the risk of further occurrences.

Infection control

- The hospital was clean throughout. Staff adhered to good practice guidance in the prevention and control of infection. There was a good rate of compliance with hygiene audits.

Food and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs were supported by dieticians and the speech and language therapy team.
- There was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. We also saw that a coloured tray system was in place to highlight the patients who needed assistance with eating and drinking.

Summary of findings

Medicines management

- Medicines were provided, stored and administered in a safe and timely way. Some concerns were raised regarding the completeness of prescription charts in outpatients and the timely provision of medicines for patients to take home.

Nurse staffing

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services. However, nurse staffing levels, although improved, remained of concern. The trust was actively recruiting nursing staff using innovative methods of recruitment. These included a number of efforts to improve recruitment and retention through wider access schemes with local universities and dedicated ring-fenced funding to support this. They had also linked into international universities to support this recruitment. However, we found that required staffing levels were not consistently achieved in all core services at the time of the inspection.

Medical staffing

- Medical treatment was delivered by committed medical staff, however:
- Medical staffing was not sufficient to provide appropriate and timely treatment and review of patients at all times within the medical division and to maintain timely clinics in outpatients to meet targets. Many of the middle grade vacancies were due to national shortages of trainees and the full allocation not being sent from the regional training schools. It was noted that the North West had historical difficulty in recruiting and retaining doctors and there had been a number of efforts to improve recruitment and retention through wider access schemes with local universities and dedicated ring-fenced funding to support this.
- Medical staffing was not always appropriate at the location, including medical trainees, long-term locums, middle-grade doctors and consultants.

We saw several areas of good practice, including:

- Data from the College of Emergency Medicine (CEM) consultant sign-off audit showed that 100% of patients at Preston Emergency Department were seen by an emergency department doctor, compared with a national average of 92%. Also 25% of patients were seen by a consultant, which is well above the national average of 13% in 2012/13.
- Ultrasound-guided blocks for patients with neck of femur injuries in the Emergency Department.
- Children's safeguarding review meeting in the Emergency Department.
- Chaplaincy service engagement with patients in the Emergency Department.
- Consistently rapid handover times for patients arriving by ambulance to the Emergency Department.
- Responsive and flexible training using 'simulation man' to deliver trauma training within the Emergency Department at quiet times.
- The trust was committed to becoming a dementia-friendly environment. An older people's programme was developing this work and we saw several excellent examples of how this was being put into practice during our inspection. The proactive elderly care team helped staff to identify and assess the needs of older people. The team worked proactively with intermediate care services to ensure the safe discharge of older people and people living with dementia. Activity boxes had been introduced throughout the division to promote and maintain cognitive and physical function and help reduce the unwanted effects of being in a hospital environment.
- The trust had won the Clinical Innovation category at the North West Excellence in Supply Awards for developing a disposable female urinal.
- The alcohol liaison service had been nominated for a national Nursing Standards award. Staff spoke highly of the service and the positive contributions they had made in supporting patients with alcohol-related conditions.
- Our specialist adviser assessed that speech and language therapy input for neonatal babies was likely to improve the long-term outcomes for these children and considered this to be outstanding practice.
- The end of life team coordinated rapid response for discharge to the preferred place of care. Staff told us there was a multidisciplinary approach to discharge planning, which involved the hospital and the community staff working towards a rapid but safe discharge for patients.

Summary of findings

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

Importantly, the trust must:

Staffing

- Ensure that there are enough suitably qualified, skilled and experienced nurses to meet the needs of medical patients at all times.
- Ensure that there are enough suitably qualified, skilled and experienced midwives to meet the needs of patients at all times.
- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times within the medical division and outpatients.
- Ensure that medical staffing is appropriate at the location, including medical trainees, long-term locums, middle-grade doctors and consultants.

Supporting staff

- Ensure that relevant staff receive advanced paediatric life support and moving and handling training.
- Take steps to enable the trust to confirm the status of mandatory training that staff have completed in the child health directorate, so that staff have received information about the actions required to maintain and promote safety.
- Improve patient flow throughout the hospital to reduce the number of bed moves and length of stay – particularly in the medical division.
- Prevent the cancellation of outpatients clinics at short notice and ensure that clinics run to time, particularly within ophthalmology outpatients.

In addition the trust should:

In the Emergency Department:

- Improve mechanisms to achieve and maintain performance to meet the four-hour target set by the government for emergency departments.
- Address the reasons why patients wait for up to nine hours in the department before being admitted to an inpatient area.
- Address the appropriateness of the environment for the children's treatment area in the Emergency Department with regard to visual or audible separation.
- Address the appropriateness of the environment for the delivery of modern emergency medicine.
- Review how the constraints of the environment would negatively affect plans to increase services within the department.
- Review privacy and dignity for patients being handed over by ambulance crews in the corridor area.
- Address the effectiveness of how services for acute gastrointestinal bleeds are provided out of hours.
- Review mechanisms for supporting and recording clinical supervision within the Emergency Department.

In the medical division

- Improve the management of people with diabetes and stroke in line with national guidance.
- Improve the consistency of access to emergency upper gastrointestinal endoscopy and interventional radiology.

In the surgical division

- Consider reviewing the overnight provision for ophthalmology patients who require unplanned overnight stays.
- Consider reviewing unused theatre capacity within the surgical division.
- Ensure that checklists for daily cleaning jobs within the surgical division are completed and current.

Summary of findings

In critical care

- Ensure that the use of critical care beds is factored into any trust-wide discussions and solutions for improving patient access and flow. This should include continuing to monitor and report on delayed discharges, cancelled elective procedures and the use of theatre recovery at times of peak demand.
- The trust is not currently providing a critical care outreach service 24/7. In the absence of this 24/7 service, the trust should ensure that all staff employed within the hospital at night team are suitably qualified and competent to cover the critical care support role.
- Consider the impact of not having a weekend pharmacy service in the intensive care unit (ICU). Appropriate care of critically ill patients requires frequent review and re-assessment of therapies, including medication.

In maternity services

- Continue to review patient flow with regard to managing induction of labour and transfer of mothers to the delivery suite.

In children's services

- Ensure that all incidents are described in a consistent manner so that details and the action taken can always be easily reviewed.
- Ensure that the information in the audits is accurate so that the trust can be confident that appropriate steps are taken to promote safety.
- Consider the security and safety of how expressed milk is stored, as the kitchen and fridge were accessible to anyone on the unit.
- Be able to provide a comprehensive training record for each member of staff.
- Review the décor and furnishings in the children's day surgery waiting room and pre-operative area.
- Ensure that the Child Health directorate completes a comprehensive audit of the Day Case Unit that includes feedback from all stakeholders to ensure plans incorporate all aspects of the services strengths and weaknesses.
- Ensure that all opportunities are used to alert staff about the risks identified in relation to safety.
- Ensure that staff always report all incidents that are concerned with child safety.
- Ensure that information provided about the safety of children's services is accurate and consistent.
- Take more robust action to prevent parents from taking children to Chorley and South Ribble Hospital Accident and Emergency (A&E) department, as there are no children's A&E services at that site.

Regarding end of life care

- Review the processes in place for the return of syringe drivers from the community to ensure availability.
- Ensure that audits are carried out on pain management and pain relief for end of life care.

In outpatients

- Ensure that the trust receives feedback from patients within the outpatients departments to monitor and measure quality and identify areas for improvement.
- Ensure that appropriate checks are in place to provide assurance that medicines prescriptions are correctly completed.
- Ensure that members of staff have the opportunity to discuss any issues or concerns they may have on a regular basis within clinical supervision.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	The Emergency Department had reliable systems and processes including approaches to infection prevention and control, cleanliness and maintenance of equipment and facilities, and the safe management of medicines. Staffing levels and skill mix were set and reviewed to meet patients' needs at all times of the day and night. Staff were appropriately qualified and received regular relevant training and appraisal. There was a multidisciplinary approach to care and treatment. Effective emergency preparedness plans were in place. Patients received care and treatment based on available national and international evidence-based standards and guidelines. Staff offered care that was kind and compassionate and involved patients and those close to them. Patients' choices and preferences were valued and, where possible, met. The department was responsive to patients' needs. There were specialist support teams for elderly patients and those with alcohol- or substance abuse-related conditions. Communication services were available. The trust's performance in relation to the four-hour waiting time target for emergency departments had been inconsistent. Higher than average bed occupancy rates meant that some patients waited an unacceptably long time for admission to an inpatient area. Leadership, management and governance of the Emergency Department assured the delivery of high-quality person-centred care, supported learning and innovation and promoted an open and fair culture. Governance, risk management and quality measurements were proactively reviewed and updated to take account of models of best practice.
Medical care	Requires improvement 	The medical service was subjected to many emergency admissions that had an impact on in patient bed capacity. This meant that there were times when a significant number of patients were placed in clinical areas not best suited to their needs (outliers).The hospital had an escalation

system in place to ensure medical outliers were reviewed regularly by an appropriate consultant. However, we found that some of the escalation areas were unsuitable for patients to stay in. Patients often experienced multiple moves between wards during their stay and were regularly in hospital for longer than they required. The trust had recognised these were areas for improvement and had implemented processes to try and address these issues. However, we found that discharge processes were slow and fragmented.

Nurse staffing levels, although improved, were still a concern and there was a heavy reliance on staff working extra shifts and on bank and agency staff. Adequate staffing levels were not consistently achieved in all the wards within the medical division.

The outcomes for patients in some areas needed improvement, particularly in the management of patients with diabetes and those who had had a stroke.

However, we found ward environments were clean and well maintained and staff followed infection control procedures. Staff reported that there was clear visibility of the trust's board throughout the service. Medical services were delivered by caring and compassionate staff.

Surgery

Requires improvement

Surgical services were delivered by caring and compassionate staff who treated patients with dignity and respect and planned and delivered care in a way that took into account patients' wishes. There was evidence of dissemination of learning from incidents and complaints. The environment on the surgical wards and theatres was clean and equipment was well maintained and ready for use. There were concerns about the availability of some types of surgical equipment, which was recorded on the risk register and was being addressed by the hospital.

Although safe staffing levels were maintained, we found that this was due to the use of overtime, bank or agency staff. On some wards we saw that vacancy rates were as high as 32%. The medical staff vacancies were covered by locum doctors who met the patients' medical care needs.

Summary of findings

Patient-reported outcome measures were available for varicose veins, hip replacements and knee replacements, with the trust performing better than the national average.
Senior managers were aware of the current issues within surgery services and were considering changes in the way the service was delivered. The trust had addressed issues regarding referral to treatment time and these had improved. The trust had unused capacity within the service as a result of theatre session cancellations.

Critical care

Good

The trust was providing a good critical care service overall. However, in terms of the responsiveness domain, some improvements were required, these related predominantly to patient access and flow.

There was evidence of strong medical and nursing leadership in the ICU that led to positive outcomes for patients. The service submitted regular Intensive Care National Audit and Research Centre data so was able to benchmark its performance and effectiveness alongside other units nationally.
The unit employed two nurses specifically in educational roles that enabled them to support both new staff and those requiring additional support or performance management. There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. On the day of our inspection the unit had four empty beds at the start of the morning shift and was safely staffed with the appropriate number of trained nurses per patient, plus a senior coordinating nurse, matron and consultant nurse who was responsible for the critical care outreach service for the trust.

Maternity and gynaecology

Good

The maternity service had a number of vacant midwifery posts with staffing funded to maintain a midwife to birth ratio of 1:29. However, long-term staff shortages over a six-month period, combined with high sickness absence rates, heavy dependence on community midwives, staff working extra hours and in-house bank staff meant the ratios were 1:34. Despite a recovery action plan, staff-to-patient ratios were of concern.
There were clear systems for reporting incidents and managing risk within the service. The wards

Summary of findings

were clean and infection rates were within expected ranges. Medicines were administered safely. The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment, including neonatal resuscitaires, was available and fit for use by suitably trained staff.
We found that maternity services were delivered by committed and compassionate staff. All staff treated patients with dignity and respect. The majority of people were positive about the care they had received.
The midwifery staff felt well led, and staff felt engaged with the proposed model of maternity services. The service had a learning culture and robust systems were in place for reviewing the quality of care and service delivery.

Services for children and young people

Good

The child health division had systems in place to protect children and young people from avoidable harm and abuse.
However, medical staffing levels meant safety was jeopardised at times because there were delays in treatment. The effectiveness of the service required improvement because the skill mix of staff was not at an appropriate level to provide effective care and support for children accessing the paediatric assessment unit and the neonatal unit.
Children, young people and their guardians were treated with kindness, dignity and respect by staff. The leadership within the child health division was good and plans were in place to develop the service. Plans had been influenced by feedback from children, young people and their guardians. Staff were engaged in future planning and were aware of the progress in bringing about positive change. Staff in the service maintained positive and effective working relationships.

End of life care

Good

Care for patients at the end of life was supported by a consultant-led specialist palliative care team. Staff effectively followed end of life care pathways that were in line with national guidelines. Staff were clearly motivated and committed to meeting patients' different needs at the end of life. Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents.

Summary of findings

The palliative care team were clear about their roles and benefited from good leadership. We observed that care was given by supportive and compassionate staff. People spoke positively about the care and treatment they received and said they were treated with dignity and that their privacy was respected. The nursing staff and doctors spoke positively about the service provided from the specialist team.

Outpatients and diagnostic imaging

Requires improvement

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. Staffing numbers and skills mix met the needs of the patients. There was a clear process for reporting and investigating incidents but staff told us they had not received outcomes of incidents reported. The outpatients departments we visited were clean and well maintained.

We found concerns within the ophthalmology department. Both patients and staff told us that clinics were sometimes cancelled at short notice and we found that clinics frequently ran late. The cancelled clinics were a concern within the department and the quarterly audits showed an increase over the last four quarters. There were also concerns noted with the partial booking queue within ophthalmology for patients needing follow-up appointments. Patients spoke of the anxiety and inconvenience this caused them. They told us that delayed appointments also caused confusion with ambulance transport services.

People said they had difficulty with the car parking arrangements at the hospital. They found car parking difficult because the demand for spaces was high and they often had a long walk to get to the clinic.

There was good local leadership and a positive culture within the outpatients service. Staff worked well as a team and supported each other. The trust had guidelines to meet the needs of the local population, for example an interpreter service.

While we found robust and well-led local service provision, the trust-wide leadership team needed to be more visible and responsive to frontline staff.

Summary of findings

Improvements were required to show that the service reviewed, understood and managed the risk to people using the service and the staff who provided it.
We found the trust needed to make improvements to ensure staff received regular feedback on performance and were involved in the 'lessons learned' process. We noted staff needed to be kept updated with developments within the outpatients department. We observed staff had not received clinical supervision, as required by the hospital's own policy and procedures.

Requires improvement

Royal Preston Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

Contents

Detailed findings

Background to Royal Preston Hospital

Royal Preston Hospital is one of two hospitals providing services as part of Lancashire Teaching Hospitals NHS Foundation Trust. It 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.

Our inspection team

Our inspection team was led by:

Chair: Ian Abbs, Medical Director, Guy's and St Thomas' NHS Foundation Trust

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an Inspection Manager, seven CQC inspectors and a variety of specialists including Operational Manager of Acute Trust Clinical Services; Director of Improvement, Quality and Nursing; Diabetes Consultant; Consultant Radiologist; Consultant Colorectal Surgeon; Emergency Medicine Consultant and Senior Clinical Lecturer in Emergency Medicine; Consultant Obstetrician and Gynaecologist; Critical Care/ Anaesthesia/ECMO; ST6 in Paediatrics; Junior Doctor; FY2 Doctor; Matron in Medical Investigations and Respiratory Care; Theatre Specialist; Divisional Director for Medicine; Lead Paramedic; Midwife; Intensive Care Nurse; Nurse Consultant Paediatrics; 3rd year Paediatric Student Nurse; Student Nurse and two Experts by Experience.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event in Preston on 8 July 2014 when people shared their views and experiences of both Royal Preston Hospital and Chorley and South Ribble Hospital. Some people who were unable to attend the listening event shared their experiences by email or telephone.

The announced inspection of Royal Preston Hospital took place on 9, 10 and 11 July 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients 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 undertook an unannounced inspection between 6pm and 8pm on 21 July 2014 at Royal Preston Hospital only. We looked at the management of medical admissions out of hours.

Detailed findings

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 Preston Royal Hospital.

Detailed findings

Facts and data about Royal Preston Hospital

Royal Preston Hospital is one of two hospitals providing services as part of Lancashire Teaching Hospitals NHS Foundation Trust. There are 877 beds across the two sites and in 2013/14 there were 125,631 admissions and 489,426 outpatients and 123,014 emergency department attendances. There are over 6,500 staff.

The trust serves a local population of 390,000 living in South Ribble, Chorley and Preston boroughs and approximately 1.5 million patients for specialised care.

The health of people in Lancashire as a county varies. Just over half of the health indicators are worse than the England average, including binge drinking adults and life expectancy.

The trust has an annual income of £353 million for clinical activity and £49 million for non-clinical activity.

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

The Emergency Department at Royal Preston Hospital provided consultant-led emergency care and treatment 24 hours a day, seven days a week. A helicopter pad enabled patients to be transported by air ambulance to quickly access medical attention. Since April 2012 the department had been accredited as the major adult trauma centre for Lancashire and South Cumbria. Last year the department saw 74,852 patients.

An Emergency Department clinic operated each morning Monday to Friday. A Primary Care Centre, run by GPs, was located adjacent to the Emergency Department. This service was available between 10.30am and 11pm. Approximately 20% of patients attending the Emergency Department in the previous year had been redirected to this service for assessment and treatment.

During our inspection, we spoke to 14 people using services, seven relatives or carers and 55 staff members. We looked at 18 records of care and treatment. As part of our inspection we used the Short Observational Framework for Inspection, which is a specific way of observing care to help us understand the experience of people who could not speak with us. We also reviewed information from comment cards that were completed in the waiting area.

Summary of findings

Incident recording and reporting was effective and embedded in the service. Incidents had been investigated, learning was communicated and action was taken to improve services. Reliable systems and processes were in place that promoted safe care. This included the approach to infection prevention and control, cleanliness and maintenance of equipment and facilities and the safe management of medicines. Patients were involved in their care and treatment and risks were appropriately assessed, managed and recorded. Staff recognised and responded appropriately to any deterioration in patient health. Staff worked with others to prevent abuse and responded appropriately to any signs or allegations of abuse. Staffing levels and skill mix were set and reviewed to meet patients' needs at all times of the day and night. Effective emergency preparedness plans were in place.

Patients received care and treatment based on best available national and international evidence-based standards and guidelines. Patients' needs were assessed appropriately and care and treatment was planned and delivered in accordance with their needs. Staff were appropriately qualified and received regular relevant training and appraisal. There was a multidisciplinary approach to care and treatment. Staff worked with other health and social care providers to

Urgent and emergency services

assess, coordinate and plan individual patient care and treatment. Effective and consistent levels of care and treatment were available 24 hours a day, seven days a week.

Patients and their relatives were all positive about the care they had received. Staff offered care that was kind and compassionate. Staff involved patients and their relatives in decisions about their care and their choices and preferences were valued and, where possible met.

The department was responsive to patients' needs through effective communication and sensitive, safe handovers of information. There were specialist support teams for elderly patients and those with alcohol- or substance abuse-related conditions. Translation and interpretation services were available as was support for patients with other communication needs. Staff in the department understood the needs of patients and had designed and delivered services to meet those needs. The trust's performance in relation to the four-hour waiting time target for emergency departments had been inconsistent. Higher than average bed occupancy rates meant that some patients waited an unacceptably long time for admission to an inpatient area. Patients were encouraged and supported to provide feedback or make complaints.

Leadership, management and governance of the Emergency Department assured the delivery of high-quality person-centred care, supported learning and innovation and promoted an open and fair culture. Governance, risk management and quality measurements were proactively reviewed and updated to take account of models of best practice. There was strong collaboration and support within the department and with external partners, with a common focus on improving quality of care and patients' experiences. Consultants in the department promoted continuous improvement and we saw a high level of innovation.

Are urgent and emergency services safe?

Good

Incident recording and reporting was effective and embedded in the service. Incidents had been investigated, learning was communicated and action was taken to improve practice and patient experience.

There were reliable systems and processes to promote safe care. These included approaches to infection prevention and control, cleanliness and maintenance of equipment and facilities as well as the safe management of medicines.

Patients were involved in their care and treatment and risks were appropriately assessed, managed and recorded. Staff recognised and responded to any deterioration in a patient's health. Staff worked with others to prevent abuse and responded appropriately to any signs or allegations of abuse.

Staffing levels and skill mix were set and reviewed to meet patients' needs at all times of the day and night.

Effective emergency preparedness plans were in place.

Incidents

- The department reported two Serious Incidents Requiring Investigation (SIRIs) to the Strategic Executive Information System between April 2013 and May 2014. We looked at the serious investigation reports for both of these incidents and saw evidence that learning had been shared with the team and follow-up actions agreed and monitored.
- Staff were aware of the trust's electronic incident reporting procedure and all staff told us that they knew how to report incidents. Staff told us that all incidents were discussed at team meetings and we saw minutes of these meetings that recorded learning and actions.
- We looked at minutes of departmental clinical governance meetings and saw that meetings included reviews of incidents, audits of procedures, review of the risk register as well as mortality and morbidity learning points.

Safety thermometer

- Information relating to patient safety was displayed on noticeboards in a staff area of the department.

Up-to-date information on performance relating to hand hygiene, falls, pressure ulcers and other incidents was available. There were no areas of concern identified.

Cleanliness, infection control and hygiene

- The department was clean and staff were aware of the current infection prevention and control guidelines.
- We saw adequate hand washing facilities and alcohol hand gel was available throughout the department.
- We observed good practices, such as staff following hand hygiene and bare below the elbow guidance while delivering care. We saw staff handling and disposing of clinical waste and sharps safely.

Environment and equipment

- There were ample supplies of suitable equipment. Appropriate life support and associated monitoring equipment, along with resuscitation equipment, was available and accessible within the department. There was a schedule for regular checks of this equipment and the checks were up to date.
- There was a safe and effective system in place for the repair and maintenance of equipment.
- During our inspection we found toys blocking the fire exit in the children's treatment area on two separate occasions. On both occasions staff took immediate action to move the obstruction and on the second occasion organised for a notice to be placed on the door reminding staff and patients that the toys should not obstruct emergency access.
- A member of staff had been injured when pushed by a trolley into the lower shelf of the central desk. This incident had been reported and there was a plan to remove the shelf to avoid further injury.

Medicines

- Policies and procedures were accessible to staff on the trust's intranet and staff were aware of the procedures to follow. Medicines were stored, managed, administered and recorded safely and appropriately.
- Emergency nurse practitioners were working under a patient group direction for the prescription of simple pain relief. Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. Some nurses had recently attended a nurse prescriber course to enable them to prescribe a wider range of medicines for the benefit of patients.

Records

- We looked at 18 patient records and found that they were all completed in accordance with the trust's Clinical Records Policy and Procedure. Appropriate risk assessments had been completed, for example in relation to the risk of pressure ulcers. Fluid intake, regular observations and National Early Warning Scores were completed as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Policies and procedures were available to staff on the trust's intranet. Staff were aware of the procedures to follow. We saw staff discussing care and treatment options with patients and their relatives to enable them to make informed choices. Where patients lacked capacity we saw that appropriate actions were taken to ensure that decisions were made in the patient's best interests and that these actions were recorded.
- We saw during our observations that staff sought consent from patients before undertaking treatments and that patient consent was recorded in the records we reviewed.

Safeguarding

- Policies and procedures for both adult and young people's safeguarding were available to staff on the trust's intranet. Staff were aware of the procedures to follow if they had concerns. We saw from patient records that the section relating to safeguarding had been completed. However, on some occasions there was a line through the section rather than an indication that completion was not applicable.
- The Emergency Department had a multidisciplinary safeguarding children group that had recently won a team working award at the trust annual quality awards. The team was led by a consultant within the department and met monthly to discuss all safeguarding referrals made by the department. They also reviewed records for patients where a referral was appropriate but had not been made. Representatives from other agencies such as Child and Adolescent Mental Health Services, Health Visiting Services and the trust's safeguarding children's lead attended.

- A Health Visitor attended the department daily to follow up on concerns relating to children.
- The department had recently begun a multidisciplinary safeguarding adults group using a similar format to the one for children.

Mandatory training

- Staff received mandatory training that covered a wide range of subjects. This was delivered and updated in two waves over two years. At the time of our inspection 66% of staff had completed mandatory training. We saw that the remaining staff were booked to attend this training. However, staff told us that the requirement to maintain staffing levels within the department sometimes prevented staff from attending planned training sessions.
- The department had a clinical lead who was responsible for supporting staff to access training. We looked at the department's training records up to July 2014. Some completion rates were lower than expected and for some sessions staff were overdue update training. For instance, the performance report summary of 9 July 2014 indicated that only 20% of staff had completed moving and handling training and nine staff were overdue update training. Staff told us that covering shifts to allow staff to attend training was a challenge. However, the departmental clinical lead had taken steps to be responsive and flexible so that training could be delivered within the department during quiet periods. One example of this was a recently acquired 'simulation man' which could be used as a simulation patient for the delivery of trauma training within the department at quiet times.
- There was a training and development noticeboard in the department that gave staff information about future learning opportunities. This information was also available in the departmental newsletter.

Management of deteriorating patients

- Reception staff had all been trained in the recognition of acute life-threatening events. They told us that nurse support was rapidly available to them if they had concerns about a patient in the reception area.
- The department used the recognised National Early Warning Score to show when a patient's condition was serious or deteriorating. For children, the Paediatric Early Warning Score was used. Staff were aware of the tools and how to escalate concerns regarding a patient. The policy and records we looked at were filled out and scored correctly.
- Staff told us and we saw that there was no formal acute gastrointestinal bleed service. Staff reported difficulty in accessing specialists able to provide interventions to halt bleeding from the bowel. The trust reported that an endoscopy rota had recently begun, but at the time of this inspection the arrangements were not yet embedded.

Nursing staffing

- Nurse staffing levels and skill mix were appropriate for the department. There was a full nursing establishment in place.

Medical staffing

- Medical staffing levels and skill mix were appropriate for the department. Medical staff worked across the emergency departments at Chorley and South Ribble and Royal Preston Hospitals. The department was funded for 12 consultant posts and all were staffed at the time of our inspection.
- Consultants were present in the department from 8am to midnight and available on-call outside these times.

Major incident awareness and training

- The department had suitable major incident plans in place. Information and guidance about roles and responsibilities in the event of a major incident was available to staff within the department. Staff told us they had received training and that they took part in simulation exercises. Records showed that 88.75% of staff had completed training in chemical, biological, radiological and nuclear protocols, which are one category of emergency planning.
- The security team was based in the department and staff were available 24 hours a day. Nursing staff told us that security staff responded very quickly to requests for help. In addition porters carried a security bleep and responded to incidents.

Are urgent and emergency services effective?

(for example, treatment is effective)

Urgent and emergency services

Not sufficient evidence to rate

Patients received care and treatment based on best available national and international evidence-based standards and guidelines.

Patients' needs were assessed appropriately and care and treatment was planned in accordance with their needs. CEM consultant sign-off data audit showed that 100% of patients at Preston Emergency Department were seen by an Emergency Department doctor compared with a national average of 92%. Also 25% of patients were seen by a consultant, well above the national average of 13% in 2012/13.

Since the department became the major trauma centre for the North West of England, no additional environmental capacity had been developed. The resuscitation area had retained four bays. Plans to increase services within the department would be negatively affected by the constraints of the environment.

Staff were appropriately qualified and received regular relevant training and appraisal.

There was a multidisciplinary approach to care and treatment. Staff worked with other health and social care providers to assess, coordinate and plan individual patient care and treatment.

Effective and consistent levels of care and treatment were available 24 hours a day, seven days a week.

Evidence-based care and treatment

- the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools.
- Clinical guidelines were developed and referenced with associated NICE guidance and other nationally recognised standards. These were accessible for clinicians and we saw evidence of review and updating.
- The department provided the major adult trauma centre for Lancashire and South Cumbria. There was a major trauma network noticeboard in the department. This displayed training opportunities for staff and other information about evidence-based care and treatment.
- The department had a robust pathway for the care of patients with sepsis. A consultant from the Emergency Department and an intensive care consultant jointly led on sepsis care for the trust.
- Patients with suspected hip fractures were treated in line with best practice.
- Consultants within the department had introduced ultrasound-guided fascia-iliaca blocks in patients presenting with a fractured neck of femur. This is an effective local anaesthetic technique for pain relief in elderly patients without the need for sedation using opiate drugs.
- Care and treatment pathways for stroke patients were consistent with approved guidelines. However, staff told us that because of some internal tensions, out of hours stroke thrombolysis had largely become the responsibility of Emergency Department consultants. They told us that this was a challenging situation, especially when space in the resuscitation department was restricted and departmental capacity limited.
- The Trauma Audit and Research Network data (used to promote improvements in care through national clinical audit and show performance comparisons information on survival rates of major injury for patients who have been admitted to hospital) showed that an additional 0.9 patients survived at Royal Preston Hospital compared with the national expected survival rates.

Pain relief

- Patients were offered pain relief, when required. Staff monitored patients' pain, responded appropriately and recorded the information in patients' records.
- In the ambulance handover area we saw information displayed regarding pain management as a prompt for all staff including ambulance crews.

Nutrition and hydration

- Water jugs were available in the department. We saw that staff offered drinks to patients. Housekeeping staff provided food when it was appropriate for the patient and patient notes confirmed this.

Patient outcomes

- Consultants described to us clear plans to improve patient outcomes, including working with other teams within the trust where appropriate. They told us about an occasion when a specialist from another team came into the department at 2am to see a patient despite not being on-call, because this was considered by the emergency team as essential for the patient.

Urgent and emergency services

- The department participated in College of Emergency Medicine (CEM) audits. We looked at three of these and saw they had been reviewed and priorities for improvement had been identified.
- CEM consultant sign-off data audit showed that 100% of patients at Preston Emergency Department were seen by an Emergency Department doctor compared with a national average of 92%. Also 25% of patients were seen by a consultant, well above the national average of 13% in 2012/13.
- CEM clinical audit for feverish children showed that the department had met all standards at audit.
- During 2013/14 the department had worked with hospital trusts across Lancashire, South Cumbria, the North West and with North West Ambulance Service to develop a regional trauma network.
- Unplanned re-attendance rates to the department within seven days for the previous 12 months were better than the national average but worse than the standard. We saw that re-attendance rates were reviewed as part of the department's clinical governance framework and actions planned to improve performance in this area.

Competent staff

- Medical and nursing staff received appraisals and supervisions. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. We saw records that showed that 87% of staff had received appraisal within the department. However, staff told us, and managers confirmed, that there were no formal records of nursing clinical supervision, although there were for doctors clinical supervision.
- Doctors told us that there were no issues with the revalidation of doctors within the department.

Facilities

- The environment in the Emergency Department was challenging. Space was limited, facilities were old and, because of this, not designed to cope with the number of patients accessing the services. While the waiting area for adults and children was separated according to best practice, treatment areas were not visually or audibly separate.
- Since the department became the major trauma centre for the North West of England no additional environmental capacity had been developed. The resuscitation area had retained four bays. Plans to increase services within the department would be negatively affected by the constraints of the environment.
- During our inspection work was taking place to build a CT scanning facility adjacent to the resuscitation area to improve speedy access and preserve dignity for trauma patients requiring diagnostic screening.

Multidisciplinary working

- Medical and nursing staff worked well together as a team and there were clear lines of accountability and leadership that contributed to the planning and delivery of patient care.
- We saw effective working with ambulance crews. Ambulance crews told us that an Emergency Medicine Consultant was also Assistant Medical Director for North West Ambulance Service. Protocols agreed with North West Ambulance Service for the transportation of seriously ill patients to the appropriate hospital were displayed in the department and available on ambulances. Ambulance staff told us that they were very clear about where to take patients in order to give them the best outcome for their condition or injury. The department used a pre-alert system where a computer screen identified when patients would arrive. Protocols were in place for resuscitation, trauma and sick patients.
- Police officers attending the department following road traffic collisions told us that the staff worked well with them to enable them to do their job while in the department.
- Two physiotherapists were employed within the department to support patients with soft tissue injuries.
- The department had worked in partnership with Lancashire County Council to produce an agreement so that emergency department staff could access crisis care directly from the care provider Housing 21 without the need to involve a social worker. This meant that staff were able to discharge patients ensuring that they were cared for safely and appropriately in their own home for up to 72 hours. This also avoided unnecessary hospital admissions. This service was available 24 hours a day, including weekends.
- The trust had a proactive elderly care team. This team was actively involved with elderly patients as soon as the decision was taken to admit them in order that plans could begin for safe discharge home.

Urgent and emergency services

- A rapid assessment team was available to support patients within the department to access prompt physiotherapy or occupational therapy support as well as equipment to enable them to be safely discharged home.
- The department had agreements in place with Young Addaction and Discover to provide alcohol and substance misuse services to young people under the age of 21 and to adults within the department.
- The Emergency Department had a multidisciplinary safeguarding children group that had recently won a team working award at the trust's annual quality awards. The team was led by a consultant within the department and met monthly to discuss all safeguarding referrals made by the department. They also reviewed records for patients where a referral was appropriate but had not been made. Representatives from other agencies such as Child and Adolescent Mental Health Services, Health Visiting Services and the trust's safeguarding children's lead attended.
- A health visitor attended the department daily to follow up on concerns relating to children.

Seven-day services

- The Emergency Department was consultant-led, offering a service 24 hours a day, 365 days a year.
- Consultant presence in the department was reported from 8am to midnight with on-call cover available between midnight and 8am seven days a week. Staff told us that consultants always returned to the department if they were requested to do so. Consultant sign-off data audit showed that consultant cover out of hours and at weekends was effective in the Emergency Department; 60% of patients arriving in the department on weekend evenings were seen by a consultant compared with the national average of 11%.
- Middle grades, specialist and junior doctors covered rotas 24 hours a day, seven days a week throughout the year.
- Diagnostic radiology services were available in the department. Although the CT scanner was at a distance from the department, there was work ongoing at the time of our inspection to install a CT scanner adjacent to the resuscitation area. Medical staff told us that some CT scanning was externally reported but always available within one hour.

Are urgent and emergency services caring?

Good

Patients and their relatives were all positive about the care they had received. Staff offered care that was kind and compassionate.

Staff involved patients and their relatives in decisions about their care and their choices and preferences were valued and, where possible, acted on.

Compassionate care

- We observed positive interactions between staff, patients and their relatives. Staff consistently demonstrated caring attitudes towards patients throughout the inspection. Junior doctors told us that they saw a high standard of care in the department.
- We spoke with eight patients and four relatives. They all spoke positively about their care and treatment and they told us that they were treated with dignity and respect. A number of them said "I cannot fault the care".
- We saw staff pulling curtains around each patient's bay and closing doors to individual cubicles to maintain patients' privacy and dignity.
- We saw that all staff introduced themselves and ensured that discussions about care and treatment were carried out discreetly and in private.
- During our Short Observational Framework for Inspection observation, staff demonstrated genuine care and concern for patients.

Patient understanding and involvement

- We saw that staff explained treatment options to patients. Patients told us that they were included and involved in making decisions about their care and treatment. Their comments included, "[The doctor] was very thorough, informative and easy to ask questions of".
- During our Short Observational Framework for Inspection observation, we saw medical staff taking extra care to discuss treatment options with a patient with a learning disability and their relatives. This was to enable the patient to participate in a pre-planned activity once discharged. This consideration recognised the patient as an individual and demonstrated genuine concern for their situation.

Urgent and emergency services

Emotional support

- We saw staff talking with patients and their relatives and responding to questions in an appropriate manner. All staff provided appropriate responses, reassurance, comfort and emotional support to patients and relatives who were anxious or worried.

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

Good

Staff were responsive to patients' needs through effective communication and sensitive, safe handovers of information. There were specialist support teams for elderly patients and those with alcohol- or substance abuse-related conditions. Translation and interpretation services were available as was support for patients with other communication difficulties.

Staff in the department understood the needs of patients and had designed and delivered services to meet those needs.

The trust's quarterly performance in relation to the four-hour waiting time target for emergency departments was above the 95% target across the two sites. Higher than average bed occupancy rates meant that some patients waited an unacceptably long time for admission to an inpatient area and some had remained in the department overnight, although reasonable adjustments had been made.

Patients were encouraged and supported to provide feedback or make complaints.

In terms of emergency care for children and young people, the specialist paediatric service was available 24/7 and from 9pm to 8am there was a consultant paediatrician on call .There was a dedicated treatment area and resuscitation bay for children. However, the treatment area was not separated visually or audibly from the adult area. There was a risk that children could see or hear ill and distressed adults. Children had to walk past the adult bays in order to access the children's area.

Service planning and delivery to meet the needs of local people

- Communication between staff was effective. We observed a shift handover involving medical and nursing staff where detailed information was provided on the risks, treatment and care for each patient. The team also discussed patient flow through the department.
- Handovers between ambulance and nursing staff were conducted sensitively, safely and efficiently without delay. However, the trust may wish to note that handovers took place in a corridor where privacy was difficult at times.
- The department was supported to discharge patients safely by three teams: the proactive elderly care team, Housing 21 and a rapid assessment team who carried out physiotherapy and occupation therapy assessments and provided mobility equipment to support patients going home.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. Over the previous 12 months the department's performance against this target had been inconsistent.
- The trust told us that they had concerns regarding the flow of patients through the hospital. Bed occupancy rates for the trust averaged 94% for the year 2013/14 compared with the England average of 86%. It is generally accepted that the quality of patient care and how well hospitals perform being to be affected when bed occupancy rates rise above 85%. At the time of our inspection five patients were bedded down overnight in the department because beds were not available for them in the main hospital. Six patients had been waiting up to nine hours for a bed on a medical ward. Staff told us that this was necessary on average twice a week and a senior manager confirmed this. Overall, 18% of patients in the last year waited over four hours from arrival at the ED to admission. Of these, almost 3% waited between nine and 12 hours and 1% over 12 hours. The trust had no 12-hour waits from decision to admit to admission. Although this situation was not in line with best practice and did not promote good outcomes for patients, we found that patients were safe. We spoke with two of these patients and reviewed their records. We saw that they had received all the

appropriate care, treatment and clinical intervention required to meet their needs, despite the lack of appropriate environment. Staff had ensured that they had beds to sleep on rather than trolleys, that they were located in the quietest area of the department and that they had received food and drinks as appropriate.

- Ambulance crews told us that handovers were very swift, "the best in the area"; 100% of ambulance patients had been transferred to the care of the department in under five minutes during the previous 12 months. This was significantly better than the 15-minute standard set by the government.

Meeting people's individual needs

- We reviewed 18 patient records during the inspection and saw the patients' care and treatment was carried out in accordance with their needs.
- The department had a room available for relatives to use. There were information leaflets in this room and facilities to make drinks. The trust may wish to note that the environment was dark and small. When a number of families were using the room, as was the case during our inspection, there was a lack of space and privacy. In addition, it was not possible to gain wheelchair access to the room because of the narrow entrance.
- In addition to the relatives' room, staff showed us a room available for bereaved families where they could have privacy and space to sit with their loved one after death.
- The hospital had a 24-hour chaplaincy service with three chaplains and volunteers participating in a rota for cover. Staff told us that chaplains were available to support patients whatever their faith or beliefs. We particularly heard about how staff would request chaplaincy support for patients who did not have relatives locally. We were told that chaplains would sit with patients and escort them to wards. We saw an example of this during our inspection when a chaplain waited with a patient and assisted them to move around the hospital site in a wheelchair.
- The department had access to translation and interpretation services. Contact details were displayed and staff knew how to access the services. Staff told us how they pre-booked interpretation services for follow-up appointments in outpatients clinics at the point of discharge. Staff told us that they had a multilingual phrasebook available on the intranet and we were able to access this.
- Information leaflets were readily available in the department. We saw that staff gave them to patients where appropriate and one patient told us that they had been given good advice. However, we observed that information leaflets were not available in any other language or in accessible formats. Signs in the department were not translated into languages other than English.
- The department had a learning disability link nurse and the trust had a 'patient passport' scheme for patients with a learning disability. This helped staff to meet the individual care, treatment and communication needs of these patients. We saw an occasion where the patient passport was used by staff to support their treatment of a patient. There was a communication book containing pictures that staff could use to support them when communicating with patients. We saw a copy of this handbook.
- There was a separate waiting area for children attending the department. This was open 24/7. There was a dedicated treatment area and resuscitation bay for children. However, the treatment area was not separated visually or audibly from the adult area. There was a risk that children could see or hear ill and distressed adults. Children had to walk past the adult bays in order to access the children's area. During our inspection the agitation and distress of an adult patient in the department was audible to all other patients including children. We also saw that an elderly adult patient was being treated in a cubicle in the children's area while young children were waiting in the department. This was because all of the adult cubicles were occupied.
- A mental health liaison team was available on site 24 hours a day.

Learning from complaints and concerns

- Systems and processes were in place to advise patients and relatives on how to make a complaint. Information about how to make a complaint or offer a compliment was displayed in the department. Staff were aware of how to manage complaints and how to support patients who wished to complain.
- The department monitored and tracked complaints and identified themes which they responded to with action plans. We saw evidence that action had been taken as a result of learning from complaints and concerns, for example staff had received additional training or

practices had been amended. Learning from complaints was discussed at departmental and division meetings and shared more widely with staff including on noticeboards within the department.

Are urgent and emergency services well-led?

Good

Leadership, management and governance of the Emergency Department assured the delivery of high-quality person-centred care, supported learning and innovation and promoted an open and fair culture.

Governance, risk management and quality measurements were proactively reviewed and updated to take account of models of best practice.

There was strong collaboration and support within the department and with external partners, with a common focus on improving quality of care and patients' experiences.

Consultants in the department promoted continuous improvement and we saw a high level of innovation.

Vision and strategy for this service

- The clinical director had a clear vision for the Emergency Department along with a recognition and understanding of existing constraints.
- Plans for the future included a rebuild of the department in 2016.
- Staff we spoke with were aware of the vision and strategy and shared a common focus on high-quality care.

Governance, risk management and quality measurement

- The leadership team within the department maintained a comprehensive risk register. We saw this register was up to date and regularly reviewed.
- Departmental clinical governance meetings were held monthly, led by a consultant, supported by administration staff and attended by medical staff, nursing staff and General Manager for Emergency Medicine. The agenda covered a range of governance issues including operational and clinical risks, quality of services, review of audits and learning from incidents. We saw the minutes for these meetings with action logs, which were shared with all staff and discussed at division meetings. Minutes showed that there was a comprehensive programme of governance activities and learning from complaints and incidents was an embedded part of the culture within the department.
- Clinical governance was a standing item on the agenda for all division and staff team meetings as well as nursing handovers. We saw an up-to-date noticeboard in the staff area of the department, which gave information about clinical governance.

Leadership of service

- The department was led by a Clinical Director, Matron and Manager. Staff we spoke with told us that they were highly visible and responsive.
- Without exception staff we spoke with told us that this was a good department with an excellent ethos and excellent consultant support.

Culture within the service

- Medical and nursing staff were committed and enthusiastic about their work and worked hard to ensure that patients were given the best care and treatment possible.
- There was a positive culture within the service; staff shared their views about the service openly and constructively. They were caring and passionate about the hospital and about the care they provided to patients. Staff worked well together as a team.
- Senior doctors told us, "I work here because of my medical and nursing colleagues", "The whole team ethos is to go the extra mile."
- Junior doctors told us they received a good level of support from the team within the department.

Public and staff engagement

- Patient feedback forms were available in reception and staff told us that they were collected every couple of days for review.
- The department produced a newsletter designed to keep staff up to date with events, news and also to give useful clinical tips. We saw a copy of the June 2014 edition, which included information on possible summer injuries and future learning opportunities. All staff had the opportunity to contribute articles and ideas to this newsletter. The trust also produced a staff magazine, which was widely distributed and available on the intranet.

Urgent and emergency services

Innovation, improvement and sustainability

- Consultants within the department had introduced ultrasound scanning to facilitate fascia-iliaca blocks in patients presenting with a fractured neck of femur. This is an effective technique for pain relief in elderly patients without the need for sedation. One of the consultants within the department had taken a lead for training all consultants and middle-grade doctors in the use of ultrasound to support diagnosis and treatments being initiated within the department.
- The Trauma Audit and Research Network Data Coordinator in the department acted as scribe for trauma patients in the resuscitation department. This allowed a member of staff who would normally be entirely office-based to contribute directly to patient care and understand the context and significance of the audit. Staff involved in trauma audit were enthusiastic and committed to the whole process of quality improvement.
- A consultant within the department led a multidisciplinary children's safeguarding team, which met monthly to review all safeguarding referrals made by the department. Three other trusts had visited the department to learn about this model so that they could introduce it in their services.

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

The medical division at Royal Preston Hospital provides a range of general and specialty medical services including: stroke, elderly, respiratory, gastroenterology, diabetes, cardiology and integrated nutrition and communication services (INCs). Lancashire Teaching Hospitals NHS Foundation Trust as a whole provides services to 370,000 people in Preston and Chorley, and specialist care to 1.5 million people across Lancashire and South Cumbria.

As part of our inspection we visited the following wards: ward 18 (diabetes and cardiology), ward 20 (general medicine), ward 21 (stroke unit), ward 23 (respiratory), ward 24 (gastroenterology), Medical Assessment Unit (MAU), Barton and Bleasdale (transitional unit wards), and the coronary care unit. We also visited Ribblesdale (which is oncology and is part of specialist services). As part of our unannounced inspection we returned to the MAU, ward 21 (stroke unit) and ward 24 (gastroenterology).

We spoke with 26 patients and seven relatives, received information from our listening events and from people who contacted us to tell us about their experiences. We spoke with 42 members of staff at all levels including nurses, matrons, allied health professionals, consultants, junior doctors, sisters and ward managers. In addition we also held focus groups for nurses, matrons, allied health professionals, healthcare assistants and medical staff. We observed how care and treatment was provided and reviewed 13 patients' records. Before our inspection, we reviewed performance information about the trust and information from the trust.

Summary of findings

Escalation beds were in use on wards across the medical division and into the surgical division, patients were also transferred to Chorley and South Ribble Hospital to cope with the numbers of inpatients. The hospital had an escalation system in place to ensure medical outliers (patients not placed in an area most suited to their needs) were reviewed regularly by a consultant. However, we found that some of the escalation areas were unsuitable and did not always promote patients privacy and dignity. Patients often experienced multiple moves between wards during their stay and patients were regularly in hospital for longer than they required. The trust had recognised these were areas for improvement and had implemented processes to try and address the issues. However, we found that discharge processes were slow and fragmented.

Nurse staffing levels, although improved, were still a concern and there was a heavy reliance on substantive staff working extra shifts and on bank and agency staff. Adequate staffing levels were not consistently achieved in all the wards within the medical division. The outcomes for patients in some areas needed improvement, particularly in the management of patients with diabetes and those who had had a stroke. However, we found ward environments were clean and well maintained and staff followed infection control procedures. Staff reported that there was clear visibility

Medical care (including older people's care)

of the trust's board throughout the service. Medical services were delivered by caring and compassionate staff. During our visit we observed staff treating patients in a kind and sensitive manner.

Are medical care services safe?

Requires improvement

Nurse staffing levels, although improved, were still a concern and there was a heavy reliance on staff working extra shifts and on bank and agency staff. Adequate staffing levels were not consistently achieved in all the wards within the medical division.

We found ward environments were clean and well maintained and staff followed infection control procedures. Staff told us they were confident in reporting incidents and there was evidence that learning from incidents took place.

- There were systems for reporting actual and near-miss incidents across the medical division. Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so. The CQC intelligent monitoring report March 2014 showed that there was no evidence of potential under reporting. Learning from incidents was discussed during team meetings and there were examples of learning from incidents being applied and evaluated.
- The 2013/14 data showed there had been five serious incidents reported by the trust in relation to the medical division. These had been investigated and action taken to prevent reoccurrence.
- Corporate mortality and morbidity meetings were held weekly and were attended by consultants, ward managers and senior nurses. These meetings discussed any deaths that had occurred within the medical division and any learning points. Ward managers and nurses then took learning and any actions back to their individual teams for implementation.

Safety thermometer

- For the majority of time from May 2013 to May 2014 the trust-wide performance rates for pressure ulcers and urinary tract infections (catheter related) were in line with or slightly better than the England average.
- However, trust-wide performance for falls was worse than the England average for five months in the same 12-month period. As a result the trust had developed and implemented a falls action plan. Actions taken to reduce falls included 'intentional rounding', a system by

which nurses checked patients regularly to see if they were comfortable, had drinks and were able to move safely. Nursing records and our observations confirmed this practice.
- Results of the safety thermometer were displayed on performance boards on every ward we visited. The data displayed on the wards reflected the trust-wide performance data, with falls being the most prevalent cases. Performance boards also included a 'Patient safety focus for the month' section, which included improvement actions for areas such as falls prevention.

Cleanliness, infection control and hygiene

- From May 2013 to May 2014 the trust reported four cases of MRSA, 53 cases of Clostridium difficile and 29 cases of MSSA. This meant that MRSA rates were in line with the England average but C. difficile and MSSA rates were slightly worse than the England average. Monthly infection rates were displayed on ward performance boards.
- The wards we inspected were clean and well-maintained. Staff were aware of current infection prevention and control guidelines.
- There was a sufficient number of hand washing sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- We observed staff following hand hygiene practice and bare below the elbow guidance.
- Side rooms were used when possible as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.

Environment and equipment

- We checked the resuscitation equipment on all of the wards we visited and found in most cases they had been checked regularly by a designated nurse. However we still found that in two instances there were items missing or that had expired. We also found that most of the trolleys we looked at were dusty. We alert the staff to make safe the trolleys and action was taken while we were there.
- Where identified as required, pressure-relieving mattresses were used in the prevention and management of pressure ulcers. Additional equipment such as falls alarms had also recently been purchased by the trust to assist in the prevention and management of falls.
- The wards we visited were clean and generally well maintained, though we did notice that some areas were cluttered with equipment. This occurred when there were no dedicated storage areas.

Medicines

- The trust's performance dashboard showed the medical division had achieved 97.6% compliance for medicines administration and prescribing in 2014 to date. We spoke with ward managers who confirmed that medicine management and the reduction of errors was an ongoing key area of focus.
- All ward-based staff reported a good service from the pharmacy team. Wards received support from a clinical pharmacy team who would attend wards to ensure medication was available and had been prescribed correctly.
- Staff reported some delays in discharge were due to long waits for prescriptions. Before our inspection we also received feedback from the Carers UK Pilot from a patient who said: "The slow discharge process, mainly having to wait for prescriptions, means discharges happen after 5pm." We found examples where patients were discharged quite late in the evening as a result of waiting for medicines and transport.
- Most ward fridge temperatures were checked regularly and adjusted if found to be outside the accepted range. Most controlled drugs were checked daily in line with requirements. One pharmacy check was found not to have been completed

Records

- Documentation in all the records we reviewed was legible, signed and dated, and easy to follow.
- Patient records included a range of risk assessments and care plans for VTEs (venous thromboembolism/ blood clot in a vein), falls, nutrition and hydration, pressure ulcers and personal care, which were completed on admission and were updated throughout a patient's stay. However, we found these documents were not completed consistently.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- When a patient lacked the capacity to make a decision for themselves, staff consulted with appropriate professionals and others so that a decision could be made in the person's best interests.
- Staff demonstrated good awareness and understanding of the Deprivation of Liberty Safeguards process and could explain how the recent changes to the law had affected practice.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- The wards also had access to a safeguarding lead. Any concerns regarding safeguarding could be escalated to the lead for advice and support.

Mandatory training

- The trust provided core mandatory training to all permanent staff. The medical division's performance dashboard showed 61% of the trust's medicine division staff and 65% for the emergency department staff, which is part of the medical division, had completed mandatory training so far for 2014/15 (as of 30 June 2014). However, interviews with ward managers suggested that compliance with mandatory training was higher than 61%. This was because some ward managers had not updated the training information on the electronic system.

Management of deteriorating patients

- The National Early Warning Score System was used throughout the trust to alert staff if a patient's condition was deteriorating. As part of the observation chart, the expected escalation process was displayed.
- From the records we reviewed, each patient had an early warning score and pain score assessment completed daily and at regular intervals throughout the day if required.
- We found that, where indicated, patients were referred to a consultant for a review, in line with escalation protocols.

Nursing staffing

- Nurse staffing levels, although improved, were still a concern and there was a heavy reliance on staff working extra shifts and on bank and agency staff.
- The trust undertook a staffing analysis twice a year using a recognised acuity tool. Ward managers welcomed these reviews and told us they had been a useful way to plan staffing levels in order to address the increase in capacity and needs of patients. However, managers on all the wards we inspected reported vacancies for trained nurses and healthcare support staff and many reported long-term sickness absence, which meant that none of the wards we inspected had a full complement of staff.
- The planned and actual staffing numbers for nursing and support staff were displayed on every ward. We saw that the trust had a system in place for escalating staffing shortages. However, we found that the trust was not adhering to recognised best practice in terms of nursing staff levels. We viewed copies of duty rotas that confirmed there were occasions when the wards were short staffed. We also found that when escalation beds were in use on the wards, nurse staffing levels were not automatically increased to support the care of additional patients.
- The hospital had been actively recruiting nursing staff, including looking to employ nurses from abroad.
- We observed several nursing and multidisciplinary team handovers during our inspection. Communication between staff was effective, with staff handover meetings taking place during daily shift changes. Staff handover discussions included information regarding risks and concerns relating to each patient. Discharge plans were also discussed as well as any issues that required follow-up.

Medical staffing

- Consultant cover was available seven days a week from 8am to 9pm onsite. Out-of-hours cover was provided by junior medical staff and a registrar on duty with on-call consultant support if required.
- The majority of junior doctors we spoke with told us they felt supported by the consultants, though we found there were some issues regarding availability of consultants and middle-grade doctors on the coronary care unit and cardiology ward.
- According to trust figures there were four medical staffing vacancies within the medicine division (excluding consultants); all four were being covered by

locums. There was a 20% consultant vacancy rate in MAU and a 23% consultant vacancy rate in neurosciences. The trust had a recruitment action plan in place to address these deficiencies.
- A standardised morning medical handover process took place on MAU between the on-call consultant and medical team to prioritise patient reviews and identify a plan of action for that shift.
- We found that there was no mechanism for a consultant-to-consultant handover of patients who left MAU to go to general medical wards. However, plans were in place to expand the online medical handover system to include these patients.

Major incident awareness and training
- The trust's major incident policy was available for all staff on the trust's intranet. Ward managers and nursing staff knew where to find the policy.
- The trust told us that because of increased capacity and complexity of patients, the traditional busy period over the winter months now continued throughout the year. This meant there were escalation beds in use on wards across the division and into the surgical division to cope with the increase in patient numbers. The hospital had an escalation system in place to ensure medical outliers were reviewed regularly by a consultant.

Are medical care services effective?

Requires improvement

Patients were treated in accordance with national guidance. The medical wards used clinical pathways for a range of medical conditions based on current legislation and guidance. Nevertheless, outcomes for patients in some areas needed improvement. Analysis of data demonstrated that particular improvements were needed in the management of patients with diabetes, especially with regard to foot risk assessments and patients who had had a stroke.

Evidence-based care and treatment
- Patients were treated in accordance with national guidance. The medical wards used clinical pathways for a range of medical conditions based on current legislation and guidance.

Pain relief
- Pain relief was managed on an individual basis and was regularly monitored for efficacy.

Nutrition and hydration
- Where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. We also saw that a coloured tray system was in place to highlight which patients needed assistance with eating and drinking.
- A range of suitable menus were available to meet different nutritional and cultural needs, such as Halal, gluten-free, vegetarian and modified-texture diets.
- The majority of patients we spoke with told us they were happy with the standard and choice of food available.

Patient outcomes
- Stroke National Audit Programme (SSNAP) placed the hospital in the bottom 36% of trusts in England for the effective management of stroke patients. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards.
- We discussed results of the audit with the manager for the service and the specialist stroke nurse and were told that the biggest challenge was ensuring patients were identified in MAU and by GPs in a timely manner. If patients were not identified promptly then most other targets on the pathway would be missed.
- The 2012/13 heart failure audit showed the hospital performed better than average on most key indicators but was slightly worse than average for the percentage of patients who received input from a consultant cardiologist.
- An analysis of the Myocardial Ischaemia National Audit Project data showed that the hospital was performing worse than the England average for care of inpatients with non-ST segment elevation myocardial infarction. The hospital performed better than England average for the number of patients who were referred for, or had, an angiography after discharge (93.1% compared with England average of 76%).
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital performed worse than the England average against the majority of the

indicators. Of particular concern, data showing that only 2.3% of diabetic inpatients had received a foot risk assessment within 24 hours of admission, compared with an England average of 36.3%.

- The trust participated in the National Cancer Patient Survey 2012/13. Generally the trust was rated about the national averages by respondents for the areas covered by the survey. Items where the trust was rated in the top 20% nationally included: 'Staff explained how operation had gone in an understandable way', 'Patient had confidence and trust in all ward nurses' and 'Staff told patient who to contact if worried post discharge'. The trust was in the bottom 20% nationally for two areas: 'Possible side effects explained in an understandable way' and 'Got understandable answers from nurses in hospital to important questions all/most of the time'.
- HES data from December 2012 to November 2013 showed that the average length of stay for elective admissions for all specialties and general medicine was better than the England average. The average length of stay for non-elective admissions for all specialties was slightly better than England average, but was worse than the England average for general medicine.
- The trust's readmission rate and the standardised risk readmission rate for elective gastroenterology was worse than the England average. We discussed this with one of the matrons for gastroenterology, but they were not aware of this statistic or any possible reasons. We were therefore unable to ascertain why the readmission rate for elective gastroenterology would be worse than average.
- The trust's readmission rate and standardised risk readmission rate was better than England average for all non-elective areas.
- All wards participated in the trust-level audit programme, which included monthly audits of medicines management, tissue viability, falls prevention, nutritional management, pain management and appropriate completion of the National Early Warning Score system. The trust's safety and quality dashboard for June showed the medical division was performing better than the trust target in all areas. Where audits had identified shortfalls, action plans had been developed to address the issues highlighted.

Competent staff

- Staff told us they received an annual supervision. According to trust figures, as of 29 June 2014, 72% of staff in the medical division had received an appraisal within the last 12 months.
- However, an analysis of the 2013 staff survey results showed that 21% of the staff who responded felt that clear work objectives were not agreed during appraisal (trust average 25%) and 25% felt that training, learning or development needs had not been identified (trust average 27%).

Multidisciplinary working

- Multidisciplinary team working was well established on the medical wards. We saw that teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. Multidisciplinary team decisions were recorded and care and treatment plans amended to include changes.
- The trust acknowledged that there was a lack of intermediate care services in the area and were working with social services and commissioners to try and address this.
- A mental health liaison team was based at Royal Preston Hospital. There were good links and working relationships with this team across the division.
- The trust had a transient ischaemic attack (TIA) clinic service based at the hospital that provided seven-day consultant cover with good access to Doppler scans. A TIA is a set of symptoms that lasts a short time and occurs because of a temporary lack of blood to part of the brain. It is sometimes called a mini-stroke.
- The trust had an oncology telephone line that provided advice and advocacy to patients. The service was nurse-led and was available 24 hours a day, seven days a week.
- Consultant cover on general medical wards was available from 8am to 9pm onsite. Out-of-hours cover was provided by junior medical staff with on-call consultant support if required.
- There were daily ward rounds, in conjunction with 'board rounds' where the multidisciplinary team discussed patients around a white board including an overview of patient's history, concerns, risks and actions required.
- There was consultant presence and ward rounds seven days a week on MAU and the stroke unit.

Medical care (including older people's care)

- Staff told us that they would sometimes struggle to access a doctor at weekends. They reported that in some cases this led to doctors prescribing medicines such as insulin or IV fluids without seeing the patients (test results could be viewed on the electronic system). Staff confirmed they did have access to the critical care outreach team in case of emergency or a critically unwell patient.
- The trust had made a commitment to improve seven-day services and had completed an assessment, as an early adopter, to identify which services need to be offered seven days a week, and at what level, and were in the process of reviewing the results, identifying gaps and priorities moving forward.
- Gastroenterology had a seven-day partial provision, without on-call facilities.

Are medical care services caring?

Good

Medical services were delivered by caring and compassionate staff. During our visit we observed staff treating patients in a kind and sensitive manner. This was corroborated by the majority of patients we spoke with when we visited the wards. People told us they were happy with the level of care they had received and that staff had treated them with dignity and respect.

A review of the friends and family data displayed at ward level indicated that in the main responses were positive, with the majority of patients rating the likelihood of them recommending wards as 'likely' or 'extremely likely'.

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. All the people we spoke with were positive about their care and treatment.
- The trust's safety and quality dashboard for June 2014 showed the medicine division response rates for the Friends and Family Test was better than the trust target at 39.2%. The Friends and Family Test asks patients how likely they are to recommend a hospital after treatment. A review of the data displayed at ward level indicated that in the main responses were positive, with the majority of patients rating the likelihood of them recommending wards as 'likely' or 'extremely likely'.
- The trust performed about the same as all other trusts in all areas of the 2013 CQC inpatient survey.
- The trust completed an electronic inpatient questionnaire that focused on five key areas: overall experience of care, respect and dignity, communication, involvement in care and responsive, prompt care. The medicine division performed in line with trust targets in four of the areas. However, it performed worse than the trust target for communication. Before our inspection we received feedback from patients and staff that communication between departments could be improved. During our inspection the majority of people we spoke with felt that communication both with them and between the departments had generally been good.

Patient understanding and involvement

- Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care. Patients we spoke with told us they felt involved in their care and treatment and staff explained benefits and risks to patients about care and treatment. Patients also told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.
- On MAU, a bedside handover had been implemented that aimed to improve patient experience and encouraged staff to have conversations with patients, enabling them to be fully aware of and understand their treatment plans.

Emotional support

- The trust had access to a chaplaincy service with a team of chaplains from a range of denominations and faith communities.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that 89.5% of patients reported that they had received enough emotional support from staff to manage their diabetes, which was better than the England average of 84%.

Are medical care services responsive?

Medical care (including older people's care)

Requires improvement

Bed occupancy for the trust was consistently higher than the England average. Escalation beds were in use on wards across the division, into the surgical division, and patients were also transferred to Chorley and South Ribble Hospital, in line with the stroke pathway, to cope with the increase in patient numbers. The hospital had an escalation system in place to ensure medical outliers were reviewed regularly by a consultant. However, we found that some of the escalation areas were unsuitable, in particular we found two beds on one ward that did not provide patients with privacy, dignity and the required facilities such as access to the call bell system and bathrooms/toilets. Patients often experienced multiple moves between wards during their stay and patients were regularly in hospital for longer than they required. The trust had recognised these were areas for improvement and had implemented processes to try and address the issues. However, we found that discharge processes were still slow and fragmented.

The trust was committed to becoming a dementia-friendly environment. An older people's programme was developing this work and we saw several excellent examples of how this was being put into practice during our inspection.

Service planning and delivery to meet the needs of local people

- We found that because of increased demand and complexity of patients there were escalation beds in use on wards across the division and into the surgical division. Patients were also transferred to Chorley and South Ribble Hospital to cope with the increase in patient numbers.
- The senior management team described the options under consideration to manage pressures on the medical services across the trust in the longer term. This demonstrated that service planning had taken place regarding the best way to utilise resources at all the trust's locations. However, in the short to medium term the hospital was struggling to manage patient flow throughout the medical division.
- Consultants told us that "immense" work had been undertaken in restructuring and implementing a consultant-led seven-day upper and lower gastrointestinal service and that patients had benefited greatly as a result. However, they also felt that the lack of a gastrointestinal bleeds rota was a significant issue. We were told that access to upper gastrointestinal endoscopy in emergency was unreliable and the cover was inconsistent because of the lack of designated rota. Similar concerns were raised about lack of access to interventional radiology on a 24/7 basis.
- The hospital inpatient diabetes nurse specialists worked on rotation from the community to the Royal Preston Hospital. There were two diabetes consultants, but we were told that cover at weekends and out of hours was reliant on locum or middle-grade cover although this was supported through the on call medical consultants. The trust had recognised these issues and were recruiting for a band 6 diabetes specialist nurse at the time of our inspection and planned to recruit for a third substantive diabetes consultant. In addition, the trust was in the process of developing a diabetes 'hot foot line' pathway in conjunction with another local trust.

Access and flow

- Bed occupancy for the trust was consistently above 90%, which is worse than the England average. It is generally accepted that the quality of patient care and how well hospitals perform begin to be affected when occupancy rates rise above 85%.
- We found that some of the escalation areas were not suitable. In particular we found two beds on one ward that did not provide patients with privacy, dignity and the required facilities, such as access to the call bell system and bathrooms/toilets. We were assured that only mobile patients who were able to provide informed consent would be placed in these beds. However, during our inspection we found one example of an elderly patient with COPD having to walk longer distances to the toilet because there were no en-suite or nearby facilities from this room.
- During our unannounced inspection we found MAU was extremely busy and people were waiting to be transferred to an appropriate ward.
- The hospital had an escalation system in place to ensure medical outliers were reviewed regularly by a consultant. We were told that only patients who were ready for discharge or low risk would be moved to outlier beds. The Trust recognised that further work was required to reduce the amount of outliers. However, the Trust had not exceeded the 5% outlier target contained within the national Sitrep report during this current year.

The Trust had taken numerous steps to ensure support and review was given to the medical outliers. There was an outlier review team in place which consists of a consultant and junior medical staff, this ensured daily review and every day an outlier list was produced and shared with the consultant and their teams within medicine. This was co-ordinated on a daily basis by the Associate General Manager.

- However, nurses reported they often had to chase consultants to review outlier patients on the transitional ward. The junior doctors confirmed there was a lack of clarity whether these patients needed to be reviewed, how often and by whom. The management informed us the transitional ward was utilised to step down patients who were in the discharge process. These patients do not require a daily medical review but there was a junior doctor present to respond to any issues on a daily basis and should any patient require a senior review, there was an escalation plan in place.
- Before our inspection we received information of concern from people who used the service regarding the high number of bed moves for patients. The trust had identified this as an area that required improvement. The trust produced a weekly report to review those patients who had experienced more than five bed moves during their inpatient stay. These patients were then discussed as part of a weekly guardianship review to understand the element of moves that were made for non-clinical reasons and to ensure lessons were learned. The report was reviewed at the Safety and Quality Sub-Committee and while the Trust still recognised there were improvements to be made, there was an improvement in the position since April 2013. The interim divisional director for medicine, A&E and outpatients told us that since the implementation of this report there had been a dramatic reduction in the number of patients experiencing five or more bed moves.
- The management of patient access and flow within the division was of immediate concern and remained a significant challenge for managers. The number of medical outliers required a short to medium term solution until the longer term plans for the service could be implemented. The trust told us they were continuing to work with partners across the health economy as part of a "whole system" urgent care review. The review was commissioned to ensure the right capacity was provided across the system in recognition that there were patients currently within the acute trust who did not require this level of setting. This had been confirmed by a number of external utilisation management reviews demonstrating that 45% of patients did not require an acute hospital bed.
- Patients were regularly at hospital for longer than they required. Delayed transfer of care figures from April 2013 to April 2014 showed the main reason for delayed discharge was 'patient or family choice'. In recognition of the delays due to patient choice, the Trust engaged the support of a company called Care Home Selection in 2012. At that point, the number of days delayed due to patient choice was an average of 16 days (once medically fit), since the inception of the care home selection service, the average of days delayed has reduced to 5 days. So whilst the number of patients has not reduced, the days associated with that delay have reduced significantly. The trust reported that 52% of delays to discharge were for this reason compared with the national average of 14%.
- Patient's discharges from hospital were often delayed as a result of internal systems such as timely provision of take home medication and transport issues. The trust told us they were addressing the delays in the writing of discharge prescriptions by implementing pharmacy prescribers. Turnaround of prescriptions once received within pharmacy was subject to regular monitoring and, on average, was available within 2 hours. In some cases discharges were delayed due to the lack of intermediate care facilities or the timely provision of suitable community based care packages.
- The trust produced a weekly report detailing any patients who had been in hospital for longer than 21 days. This was shared with the Heads of Nursing and Matrons. Each area co-ordinated a review of these patients. Within medicine, a weekly MDT review was undertaken of each of these patients. However, we found that discharge processes were slow and fragmented.
- The hospital was aware that delayed discharges were having a negative impact on patient experience and bed capacity. The management team was working with strategic partners to resolve this important issue. Nevertheless, delayed discharges over all admissions was 7.7%. This is worse than the England average.
- Weekend consultant discharge ward rounds had been implemented. These were undertaken by a consultant and junior doctor. However, we were told that discharge

letters were not written until Monday morning. This raised a potential risk of patients being discharged without the appropriate medications and one case had been reported on the incident reporting system.

- For six months between April 2013 and March 2014, the trust performed worse than the England average for 18-week referral to treatment times. However, data showed there had been significant improvements meaning the trust had performed better than the national average from December 2013 to March 2014. An independent review commissioned as part of an investigation by Monitor found that the trust was taking appropriate action to address the delays in referral to treatment times.

Meeting people's individual needs

- Nursing staff used standard risk assessment tools to identify patient needs. Patients were assessed for the risk of falls, pressure ulcers and malnutrition. Staff carried out 'intentional rounding' every two to four hours on most patients. This included documenting the patient's condition, for example, whether they were in pain or discomfort, and their fluid intake.
- A telephone translation service and interpreters were available to support patients whose first language was not English. Staff confirmed that they did use these services.
- Staff worked with relatives and carers to complete 'patient passports' for people with learning disabilities. Patient passports provide information about the person's preferences, medical history, routines, communication and support needs. They are designed to help staff to understand the person's needs. We saw good examples of how this information was being used to provide person-centred care on one of the wards we visited. However this was not consistent throughout the hospital.
- Some wards had dementia-friendly signage, décor and colour schemes chosen in accordance with advice from the King's Fund Enhancing the Healing Environment Scheme.
- The 'Forget me not' scheme had been implemented throughout the division. The scheme helps staff recognise when someone is experiencing memory problems or confusion. This allows staff to take more time when communicating with patients who have difficulty understanding information and offer additional help, or support with tasks where needed.
- The trust had introduced the proactive elderly care team to assist staff in the identification and assessment of the needs of older people. They also worked proactively with intermediate care services to ensure the safe discharge of older people and people living with dementia. Staff spoke highly of the input the proactive elderly care team provided.
- We saw activity boxes in use throughout the division. These helped to promote and maintain cognitive and physical function and reduce unwanted effects of being in a hospital environment for people living with dementia.

Learning from complaints and concerns

- Of the 582 complaints the trust received in 2013/14, 131 related to the medicine division and nine to professional services support.
- The trust's annual complaints report showed learning had taken place and actions had been taken to reduce complaints. For example, the trust had implemented a standardised morning medical handover process on MAU between the on-call consultant and medical team to prioritise patient reviews and identify a plan of action for that shift.
- Local learning from complaints was discussed and cascaded by team meetings.
- 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 wanted to do so. 'Relative's clinics' were held on some wards by the ward manager or senior nurse to allow patients or relatives to discuss any issues or concerns in a timely manner.

Are medical care services well-led?

Requires improvement 

The hospital had clear values that aimed to define how staff behaved towards people who used services and these were displayed on large posters throughout the hospital. The vision for the medicine division was less clear. However, the senior management team described the options under consideration to manage pressures on the medical services and to develop services across the trust in the longer term.

Staff reported that there was clear visibility of the trust's board throughout the service. All nursing staff spoke highly

of the ward managers and matrons as leaders and told us they received good support. Junior doctors told us they felt well supported by consultants and senior medical staff, with the exception of cardiology where they did not always receive the support they required because of limited availability of consultant and middle-grade staff.

The alcohol liaison service had been nominated for a national Nursing Standards award. Staff spoke highly of the service and the positive contributions they had made in supporting patients with alcohol-related conditions and their families. The trust had won the Clinical Innovation category at the North West Excellence in Supply Awards for developing a disposable female urinal.

Vision and strategy for this service

- The trust's vision was summarised as 'Excellent care with compassion' and the trust had clear values that aimed to define how staff behaved towards people who used services: Caring and compassionate, Recognising individuality, Seeking to involve, Building team spirit and Taking personal responsibility. These values were displayed on large posters throughout the hospital.
- The vision for the medicine division was less clear. However, the senior management team described the options under consideration to manage pressures on the medical services and to develop services across the trust in the longer term.

Governance, risk management and quality measurement

- Information about core objectives and performance targets were displayed in all of the areas we visited. Posters were displayed relating to key safety performance areas such as pressure area care and falls along with the improvement actions that were required.
- There were structured monthly divisional clinical governance meetings. The division had a quality dashboard, that showed performances against quality and performance targets and these were presented monthly at the clinical governance meetings. Discussions and actions from the monthly governance meetings were cascaded to staff using the monthly matron's meetings, ward manager's meetings and staff team meetings. Actions were planned and implemented to address any identified performance shortfalls.
- The trust's risk register highlighted risks across all the trust's medical departments, and actions in place to address concerns: for example, nurse staffing.
- However, there were some long standing issues within the division in particular the management of patient flow that remained unresolved.
- Quality performance boards on each ward included a 'Patient safety focus for the month' section that included improvement actions for areas such as medicines management and falls prevention.

Leadership of service

- Staff reported that there was clear visibility of the trust's board throughout the service. Comments included: "I think [the chief executive] is doing a good job; making an effort to engage, consciously trying to get involved with as many teams as she can" and "It is very easy to get in contact with the medical director and management team."
- All nursing staff spoke highly of the ward managers and matron as leaders and told us they received good support.
- Ward managers were supported to undertake a leadership training programme.

Culture within the service

- The trust had a better response rate than the national average for the NHS staff survey. The percentage of staff reportedly working extra hours was better than the national average as was the percentage of staff receiving job-relevant training, learning or development in the last 12 months.
- The General Medical Council National Training Scheme Survey 2013 showed the trust was performing within expectations in all areas surveyed. Junior doctors told us they felt well supported by consultants and senior medical staff, with the exception of cardiology. Staff told us they did not always receive the support they required on the cardiology ward and coronary care unit because of limited availability of consultant and middle-grade staff.

Public and staff engagement

- The trust had held a series of dementia consultation events with people who use services to identify how they could improve ward environments and the care provided to people living with dementia. The results were then incorporated into the trust's older people programme.
- People in the local area could become 'members' of the trust, which provided people with the opportunity to influence how services were provided.

Medical care (including older people's care)

- A breakdown of the 2013 staff survey results showed that 45% of staff in the medicine division who responded felt senior managers did not try to involve staff in important decisions. However, during our inspection, staff at all levels throughout the division, including consultants, nurses and allied health professionals, told us they were aware of the trust's 'big plan' (vision and strategy for the service) and that they had been given the opportunity to feed into its development.

Innovation, improvement and sustainability

- An analysis of the 2013 staff survey results showed that 9% of staff in the medical division who responded felt they were not able to make suggestions to improve the work of their team/department. This was better than the trust average of 11%.
- Specialties within the division were committed to participating in local and national research. For example, the stroke service was involved in eight national trials at the time of our inspection.
- The alcohol liaison service had been nominated for a national Nursing Standards award. Staff spoke highly of the service and the positive contributions they had made in supporting patients with alcohol-related conditions and their families.
- The trust had won the Clinical Innovation category at the North West Excellence in Supply Awards for developing a disposable female urinal.

Surgery

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

Information about the service

Surgical services provided at Royal Preston Hospital included complex major surgery and emergency surgery (including trauma). Royal Preston operated as a major trauma centre for Lancashire and South Cumbria. The surgical division operated a day of surgery admission area through which the majority of all patients undergoing planned surgery were admitted.

Inpatient care was provided. All emergency surgery admissions were assessed on the surgical assessment unit by a dedicated emergency team. Patients requiring admission were then transferred to an appropriate specialty bed. Subsequent patient management was carried out on the surgical wards by dedicated subspecialty teams.

Summary of findings

Surgical services were delivered by caring and compassionate staff who treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients. There was evidence of dissemination of learning from incidents and complaints. The environment on the surgical wards and theatres was clean and equipment was well maintained and ready for use. There were some concerns regarding the availability of some types of surgical equipment that was recorded on the risk register and was being addressed by the hospital.

Although safe staffing levels were maintained, we found that this was because of the use of overtime, bank or agency staff. On some wards we saw that vacancy rates were as high as 32%. The medical staff vacancies were covered by locum doctors.

Patient reported outcome measures were available for varicose veins, hip replacements and knee replacements, with the trust performing better than average.

Senior managers were aware of the current issues within surgery services and were considering changes in the way the service was delivered. The trust had addressed issues regarding referral to treatment time. The trust had unused capacity most months because of theatre session cancellations.

Surgery

Are surgery services safe?

Requires improvement

There had been two surgical Never Events during the period April 2013 to April 2014, but the trust had taken appropriate steps to reduce the risk of further occurrences.

There were both nursing and medical staff vacancies. Nursing vacancies were covered by substantive staff working additional hours and the use of bank and agency staff. Medical vacancies were covered by locum doctors.

Surgical beds were often used to accommodate patients from other specialties, this was a particular issue in medicine.

The division was heavily involved in the corporate recruitment programme, which included international recruitment of nurses.

There was evidence of dissemination of learning from incidents and complaints. The environment on the surgical wards and theatres we visited was clean and well maintained.

However, we noted that the trust had escalated three entries on the division risk register to the trust risk register related to equipment in the surgical division; these were regarding: a shortage of laparoscopic/endoscopic instrumentation and camera stacking systems; shortage of equipment if emergency cases admitted; shortage of harmonic generators and hand-pieces and shortage of table attachments. All of these risks the trust had identified could potentially affect the delivery of safe surgery. The Trust had taken some mitigating actions via a business case to secure additional equipment and make equipment loan arrangements. However, it was not clear from the risk register how the wider risks were mitigated. Some risks had been on the register since 2005.

We also noted the trust's corporate performance report for February 2014 showed that the surgical division's 12-month rolling percentage of staff who completed mandatory training (61%) was significantly below the trust target of 80% as well as all other divisions in the trust. Specialist services division's 12-month rolling rate was 73%.

Incidents

- There have been two surgical Never Events in the surgical division during the period April 2013 to March 2014. The management team had taken robust root cause analysis and appropriate remedial steps to reduce the risk of further occurrences.
- There was a clear process for investigating Never Events and patient safety incidents, including Serious Incidents Requiring Investigation.
- In the 2013 staff survey, the percentage of staff witnessing potentially harmful errors, near misses or incidents (34%) was similar to the national average (33%). The percentage of staff who reported errors, near misses or incidents (88%) was slightly lower than the national average (90%). However, we found no evidence of under reporting.
- Staff in the wards and theatres stated that they were familiar with, and encouraged to use, the electronic incident reporting system to record incidents and near misses. During our inspection we observed staff appropriately using the electronic incident reporting system.
- The trust reported nine Serious Incidents Requiring Investigation (SIRIs) within surgical specialties in 2013/14. We found that the trust investigated serious incidents. For example, in August 2013, the trust investigated an increasing trend of damaged wrappings for theatre trays. This had resulted in a small number of patients experiencing last-minute cancellations. The investigation could not determine whether all damage was accidental. Therefore, the trust increased security and significantly reduced the number of people who had access to the theatre trays. This resulted in a reduction of damaged trays over several months. In December 2013, the trust lifted the security measures and the number of damaged trays has not increased.
- We saw mortality data for expected deaths, which illustrated that the trust performed slightly better (4.1%) than was expected (4.3%).

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Safety thermometer information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new VTE, catheter use with

urinary tract infections and new pressure ulcers. This information was updated regularly and was used to inform staff of current performance and highlight areas for improvement.

- For pressure ulcers in 2013/14, the trust's dashboard for general surgery showed that the Essential Care Audit Programme (ECAP) found 98.49% of patients had an assessment and care plan for tissue viability. This surpassed the trust target of 90%. The trust reported 36 cases of avoidable pressure ulcers (grade II and above), which was lower than expected (49).
- In 2013/14, the dashboard for general surgery showed that the ECAP found 92.79% of patients had an assessment for VTE on admission. Although the trust showed a small improvement from quarter one to four, the percentage of patients continued to fall below the trust's own target of 95%.
- For falls with harm in 2013/14, the dashboard for general surgery showed that the ECAP found 97.98% of patients had assessments and care plans for the prevention of falls. This was higher than the trust's target of 90%. The trust reported 281 incidents because of falls, 64 of which had resulted in harm. These figures were above the trust's expected number of cases (258 and 46, respectively). However the actual rate of falls and associated harm had reduced during the course of the year.
- Within the records we viewed, we noted that risk assessments for the above groups were being completed appropriately on admission.
- The hospital continued to explore its options to avoid inpatient harm, and provide timely assessment and intervention through its governance and risk management systems.

Cleanliness, infection control and hygiene

- In 2013/14, the dashboard for general surgery reported 17 cases of C. difficile infections, six of which were in quarter four.
- In 2013/14, the dashboard for general surgery reported that screening for MRSA in elective (90.87%) and non-elective (94.03%) patients was above their internal standard of 90%. The number of MRSA infections reported was two, which was higher than the trust's target of zero MRSA infections.
- Ward areas were clean and we observed staff regularly washing their hands and using hand gel between attending to patients. We also noted in the wards we visited that the bare below the elbow policy was adhered to. Staff were aware of current infection prevention and control guidelines.
- Staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. In theatres we saw 'no-go areas' unless staff were in theatre clothing and noted a clear policy that staff adhered to.
- The theatres we inspected were clean and well maintained. Daily and weekly cleaning checklists were displayed in each area and these were complete and up to date. Gowning procedures were adhered to in the theatre areas.
- In theatres there was good compliance with the '5 Steps to Safer Surgery' checklist, which was regularly monitored and reviewed.

Environment and equipment

- The environment and equipment on the surgical wards we visited was safe, appropriately checked, cleaned regularly and we found that there was adequate equipment on the wards to support safe care.
- The general environment within theatres was clean.
- All the equipment we saw had service stickers displayed and these were within date.
- Staff told us equipment was serviced by the trust maintenance team under a planned preventive maintenance schedule and they could explain the process for equipment needing replacement or repair.
- All items of equipment needed for surgery were readily available and any faulty equipment could be replaced from the hospital's equipment store. Staff in each team were responsible for checking equipment on a daily basis and any equipment failures or issues were logged as incidents on the electronic system.
- Staff raised requests with the maintenance team by phone and told us they received good support from the maintenance team.
- Resuscitation equipment, emergency drug packs and the defibrillator were checked on a daily basis by staff in the two theatre areas we inspected.
- We noted that the trust had escalated three entries on the division risk register to the trust risk register which related to equipment in the surgical division. These

were: trust risk register entry 270: shortage of laparoscopic/endoscopic instrumentation and camera stacking systems. Shortage of equipment if emergency cases admitted. Shortage of Harmonic generators and hand-pieces. Shortage of table attachments. Shortage of powers assisted; trust risk register entry 549: details and depth of focus inferior with standard stack system; and trust risk register entry 550: two stacking systems available for potentially four areas. All of these risks the trust identified could affect the delivery of surgery. The Trust had taken some mitigating actions via a business case to secure additional equipment and make equipment loan arrangements. However, it was not clear from the risk register how the wider risks were mitigated. Some risks had been on the register since 2005.

- Within ophthalmology we found that the ward was closed, overnight which meant that patients were transferred out to Ward 3 in the majority of cases unless children or other clinical complications and returned the following day.

Medicines

- In 2013/14, the dashboard for general surgery reported that the ECAP found 96.23% of patients had been prescribed and administered medications appropriately. This surpassed the trust target of 90%. The trust reported overall harm rate for medicines was 7% of which 67% were low harm and 33% were moderate harm.
- We noted that the trust also had an entry on its risk register regarding medication: trust risk register entry 190: patients are delayed in receiving discharge medication due to the lack of on-call pharmacy support.
- On the wards and in theatres medicines were stored correctly, including in locked cupboards or fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- However we noted a fridge on ward 14 that contained blood bottles past their expiration date and the fridge temperature sheet had not been checked for the previous six days. These findings were brought to the attention of staff and the blood bottles were subsequently removed.

Records

- In the 10 April 2014 executive team meeting minutes, the trust noted that the mortality and morbidity reviews had identified a common theme of the poor condition of patient records, particularly large, bulky notes. However, this was not surgery-specific and the hospital was moving towards an electronic patient record system.
- Within theatres we looked at patients' records and found that they were completed and up to date. We noted that these were thorough and included a detailed handover from the ward.
- On wards we saw that care plans were completed with appropriate questions on VTE, diet, falls and risk. We noted that the VTE risk assessments were held on the trust's electronic system, which enabled an audit trail together with mechanisms to ensure completeness. However, we reviewed one patient's records and found them to be incomplete, with entries relating to medication either not signed or dated, reviews regarding the person's patient passport and the patient's valuables not completed.
- We saw on one ward that as a result of the use of bank and agency staff, a systematic approach to documentation was being piloted. They had produced a document which was used as a memory aid to help staff provide standardised care and ensure that accurate records were maintained. We spoke to staff on the ward who confirmed that the use of this systematic approach to documentation had been of benefit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the patient records we reviewed we found that patients were consented appropriately and correctly, the Mental Capacity Act 2005 was adhered to appropriately and deprivation of liberty safeguards was appropriately applied.
- Patients' consent was appropriately sought and typed directly into the patient records. This practice enabled both the patient and staff to have a clear record of the conversation that had taken place.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- All of the staff we spoke with about safeguarding had undertaken safeguarding training. We looked at safeguarding reports, which indicated that staff were reporting safeguarding incidents appropriately.

Surgery

Mandatory training

- We looked at staff mandatory training records for the surgical division and found that it had completed 65% of mandatory training as at 30 June 2014, which the hospital had rated as red; however, the data we viewed demonstrated that the completion rate was increasing month by month.
- Previously the trust reported that, as of 30 April 2014, only 63% of staff in surgical division and 73% of staff in the specialist services (which includes neurosurgery and plastic surgery) had completed their mandatory training. This fell below the trust target of 80%. This was particularly low for medical and dental staff across the trust, of whom 52% had completed their mandatory training. The percentage of nurses and midwives who had completed their mandatory training was slightly higher at 66%.
- We also noted the trust's corporate performance report for February 2014 showed that the surgical division's 12-month rolling percentage of staff who completed mandatory training (61%) was significantly below the trust target of 80% as well as all other divisions in the trust. Specialist services division's 12-month rolling rate was 73%.

Assessing and responding to patient risk

- In 2013/14, the trust dashboard for general surgery reported that the ECAP found that 97.62% of patients had appropriate nursing observations. This was higher than the trust target of 90%.
- As part of their learning from the two Never Events, the hospital set an objective to achieve full compliance with the WHO checklist'. The action plan included empowering staff, developing a process for escalation, providing theatre practitioners with human factors and resilience training, and undertaking a safety climate survey. Actions to ensure staff followed correct procedures for listing and preparing patients for surgery were also implemented and included: obtaining consent in a clinic setting, ensuring all relevant patient records are available before a decision is made to list a patient for surgery, and ensuring staff follow standardised protocols for site marking or other pre-operative checks.
- We spoke to the staff and reviewed evidence relating to World Health Organization (WHO) audits. We saw that the trust's audit process had developed from a monthly 'snapshot' audit to a weekly audit and at time of inspection the trust was auditing the WHO checklist on a daily basis as a result to promote full compliance with the WHO checklist.
- The surgical wards used a recognised early warning tool, the National Early Warning Score, standardising the assessment of acute-illness severity. We found clear directions for escalation and staff were aware of the appropriate action to be taken when a patient's condition deteriorated. We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within necessary time frames.
- We observed theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the 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. Compliance rates were consistently good.
- During our visit of ophthalmology we noted that patients who may be required to remain overnight in hospital could not be accommodated and therefore were moved to another ward within the hospital and then returned the following day. We saw one patient who required eye drops every 30 minutes following surgery; we noted that this patient had received these eye drops three times during the night.

Nursing staffing

- Nursing staff numbers were assessed using a recognised staffing tool. We found required and actual staffing numbers were displayed on wards we visited.
- Staffing rotas on the day of our inspection confirmed staff numbers and skill mix were appropriate to meet the needs of patients. Evidence was provided for staff numbers on the surgical wards for January 2014 and June 2014; these documents demonstrated appropriate staffing levels for the surgical wards.
- Although staffing levels were maintained, we found that this occurred because of the use of overtime, bank or agency staff.
- On some wards vacancy rates were as high as 32% following recent skill mix reviews. We were told by the trust that arrangements were in place to address the gaps in rosters. Staff we spoke to told us that there can be issues getting patients to the toilet in a timely way and helping patients to eat and drink could sometimes be challenging.

Surgery

- Most staff we spoke with stated that staffing pressures on wards was a key concern and that "some days could be very tough" and "it's a struggle, we have a good team but it can feel it's fraying".
- We observed several nursing and medical staff handovers during our inspection. Communication between staff was effective, with staff handover meetings taking place during daily shift changes. We also noted that staff used a proforma team briefing sheet to ensure consistency of handover.
- The division held daily staffing meetings to ensure appropriate deployment of staff. The difficulty in recruiting nursing staff was an ongoing challenge for the hospital. The division was heavily involved in the corporate recruitment programme, which included international recruitment of nurses.

Medical staffing

- Within theatres, there were sufficient staff with an appropriate skills mix to ensure procedures could be carried out safely.
- The teams included the surgeon, theatre nurses, operating department practitioner, and anaesthetist and healthcare assistants.
- The trust's proportions of staff at different skill levels were similar to the national average.
- The Health Education England June 2013 visit noted good handovers and induction. We spoke with staff who also confirmed this.
- The vacancy rates for consultants in neurosciences was 30.7% in April 2014, which has remained at this level since the trust increased its neurosciences establishment numbers from 25.26 in May 2013 to 31.66 in June 2013. The vacancy rate for general surgery consultants was 10.32% in April 2014, which had reduced from their peak of 19.08% in September 2013.
- The trust's corporate performance report for February 2014 showed that the trust's expenditure on locum staff increased as a result of the trust increasing capacity to address backlogs in surgical waiting lists.

Major incident awareness and training

- We noted that the trust has a major incident plan in place and saw that 'Exercise Jagger', a mass casualty exercise, took place on 3 October 2013.

Are surgery services effective?

Good

Surgery is managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery. Audit data for general surgical, orthopaedic and ophthalmology at a trust-wide level was provided and we found evidence that this information was available in the areas we visited. Patient reported outcome measures were available for varicose veins, hip replacements and knee replacements, with the trust performing better than the national average.

Evidence-based care and treatment

- Emergency surgery is managed in accordance with the NCEPOD recommendations and the Royal College of Surgeons standards for emergency surgery.
- At the monthly departmental meetings changes to guidance and its impact on practice were discussed.
- Enhanced recovery programmes were used in specialties and we saw that needs assessments were of a good standard.
- Audit data for general surgical, orthopaedic and ophthalmology at a trust-wide level was provided and we found evidence that this information was available in the areas we visited.
- We saw evidence of local audit activity that was discussed during audit mornings within theatres and on the wards we visited. On one ward we followed a ward audit on the electronic ward dashboard which had highlighted nutrition as being an issue. We visited the ward and found that nutrition plans had been implemented together with changes in practice and recording of information.

Pain relief

- Patients were assessed before their operation for their preferred post-operative pain relief.
- There was a dedicated pain team, with pain nurses seeing patients daily.
- Pain relief was monitored regularly for efficacy.

Nutrition and hydration

- Patients we spoke with were complimentary about the meals served. People were provided with a choice of suitable food and drink and we observed hot and cold drinks available throughout the day.

Surgery

- We saw that wards had protected mealtimes in place when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assistance was given to those patients who needed help. We also saw that a blue tray system was in place to highlight patients that needed assistance with eating and drinking.
- Patient records demonstrated that nutritional assessments were regularly undertaken and recorded.
- In the 3 April 2014 executive team meeting, the trust reviewed guidance from the Royal College of Anaesthetists and planned to review patient fasting as part of the intentional rounding process.
- Multidisciplinary clinics for patients with a head and neck cancer diagnosis pre and post treatment had been implemented, with proven benefits to patient outcomes and experience.
- The team has achieved a significant reduction in the length of time that patients require PEG feeding post-surgery, allowing patients to return to a normal diet much sooner.

Patient outcomes

- In 2012, the trust performed the same as or better than the England average for all indicators measured as part of the national lung cancer audit.
- In 2013, the trust performed the same as or better than the England average on all indicators measured as part of the national hip fracture audit. The mean total length of stay was 13 days, compared with the national average of 19.2 days.
- From December 2012 to November 2013, with exception of neurosurgery (29%), breast surgery (37%) and ears nose and throat (ENT) (67%), day case rates for the trust ranged from 77% (plastic surgery) to 99% (restorative dentistry).
- The NHS Better Care, Better Value Indicators for quarter three (2013/14) showed that the trust performed slightly better than the national average for increasing day surgery rates, because 83% of their surgeries were day case compared with 79% nationally.
- The NHS Better Care, Better Value Indicators for quarter three (2013/14) showed that the trust performed similar to the national average for pre-procedure bed days for both elective procedures.
- From December 2012 to November 2013, the average length of stay was higher than the national average for both elective (five days) and non-elective (six days) general surgery patients (three days and four days, respectively). Other specialties were also higher than the national average for non-elective patients, such as trauma and orthopaedics (10 days compared with eight days nationally). The length of stay for elective patients was similar to national averages.
- The actual number of readmissions was similar to expected for the trust, although the standard relative risk readmission ratios for both elective trauma and orthopaedics (75) and elective urology (75) were lower
- 2013/14 dashboard for general surgery showed that in quarters one, two and three, 5% of patients were readmitted within 28 days. This was within the trust's internal target.
- Patient reported outcome measures were available and we noted that varicose veins (Aberdeen Varicose Vein Questionnaire), hip replacements (Oxford Hip Score) and knee replacements (Oxford Knee score) were all better than the national average.

Competent staff

- Appraisals of both medical and nursing staff were being undertaken and staff spoke positively about the process. Appraisal data was also listed on noticeboards within each ward so that it was clear what the current rate of appraisal was. Within the surgical division, 64% of staff had recent appraisals in January and February 2014. This percentage was slightly higher in the specialist services division, which included neurosurgery and plastic surgery (68%). Both figures were below the trust target of 80%.
- As part of their learning from the two Never Events, the trust produced an action plan, which stated that they would roll out a quality improvement programme across all theatres that included swab count competency assessments for all theatre practitioners.

Multidisciplinary working

- The trust recently moved the surgical waiting list teams to the divisional teams and reported in the March 2014 board meeting that this had been beneficial to reducing the surgical waiting lists.
- There was evidence of good multidisciplinary working for complex pelvic malignancy, including colorectal, gynaecology and urology teams.
- The trust operated nurse-led follow-up clinics for upper gastrointestinal and colorectal cancer patients.
- The trust had developed a nurse-led ophthalmology A&E service that allowed patients to be seen by a

specialist nurse for urgent eye care needs. This had increased the number of patients seen by the trust on any given day and promoted timely access to appropriate care.
- The trust expanded their nurse-led aural care service to improve access to specialist nurses for patients across both hospital sites, following referral from the medical team.

Seven-day services
- Orthopaedic and trauma services were provided between 8am and 8pm each day including weekends, while emergency surgery was provided 24 hours a day, seven days a week.
- There were four general surgeons available for the surgery division between 8am and 10pm, with a consultant on-call out of hours.

Are surgery services caring?

Good

Surgical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

Compassionate care
- Patients were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner. Patients we spoke with were complimentary about the staff, the level of care they received, staff attitude and engagement. Comments received included: “staff are very good, they have had a lot of patience”; “I felt well informed to make a decision” and “they have been good overall, all the staff are lovely”. The comments received from patients demonstrated that staff cared about meeting patients’ individual needs.
- We saw that patients’ bed curtains were drawn and staff spoke with patients in private. Patients we spoke with told us the staff respected their privacy and dignity.
- We saw that staff respected patient dignity while transferring patients between the wards and operating theatres. We observed staff assisting patients throughout the duration of our visit and noted that patients were not rushed and staff regularly checked with them to see if they required assistance. We watched a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient privacy and dignity.
- Between April 2013 and April 2014, the Friends and Family Test response rate for surgery wards ranged from 16.27% to 39.9%.
- The trust 2013/14 dashboard for general surgery reported that 23.13% of patients responded to the Friends and Family Test, which was higher than the trust’s internal target of 15%.

Patient understanding and involvement
- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment. We looked at records that showed that both verbal and written consent had been obtained from patients and that planned care was delivered with their agreement. We also found that they were completed sensitively and noted that discussions with patients were recorded.
- Staff respected patients’ right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. We observed staff speaking with patients in a way they could understand.
- We found that each patient had a named nurse.
- Patients felt well informed on what to expect on admission.
- One patient who was an emergency admission told us that although they were delayed going to theatre they were kept informed about the reasons for the delays.

Emotional support
- Patients we spoke with confirmed that they had access to emotional support if required, and on each ward we found there was appropriate information available about counselling services and services providing assistance with anxiety and depression.
- We also noted how staff had accommodated large numbers of friends and relatives visiting a patient during the period of Ramadan.

Surgery

Are surgery services responsive?

Requires improvement

Senior managers were aware of the current issues within surgical services and were considering changes in the way the service was delivered. The trust had addressed previous performances issues regarding referral to treatment time. The trust's percentage of patients whose referral to treatment time was within the 18-week standard fell from 85% to 75% between May and September 2013 and had remained around 75% up to March 2014. This was below the national standard of 90%.

However, in March 2014 none of the surgical specialties reached the national standard for referral to treatment, although trauma and orthopaedics and ENT came close. Some specialties fell below the trust average, namely, neurosurgery (although the trust was not currently commissioned to achieve 18 weeks in neurosurgery) and general surgery. The trust had implemented an action plan in May 2014 and as a result the trust was now meeting the entire 18-week standard for referral to treatment.

The 26 February 2014 executive team meeting minutes noted that the breast service two-week wait target was at risk. The trust was recruiting to an additional consultant post to address this matter and promote timely referral.

In the 10 April 2014 executive team meeting minutes, the trust reviewed their compliance with regulation 20 (Records) and agreed several actions, such as developing new trust standards, new arrangements for record access, and an investigation into the management of large, bulky notes. However, we saw during our inspection that there was continued use of large bulky notes within the division.

The trust had unused service capacity each month, mainly as a result of theatre session cancellations.

Systems were in place that enabled staff to learn from complaints, concerns and incidents. Weekly team meeting minutes showed that the discussion of complaints was a regular agenda item.

Service planning and delivery to meet the needs of local people

- In the February 2014 corporate performance report, the report showed that the surgical division continued to underperform on elective activity as a result of capacity issues, although the number of day case patients had increased. A number of initiatives had been implemented to improve performance including;
- The implementation of the 6:4:2 system (theatre session utilisation) to support maximum utilisation of theatre capacity.
- One-stop haematuria clinics to improve patient experience and efficiency;
- One-stop breast service in a new dedicated breast unit at the Chorley site; the introduction of new high observation bay on surgical ward to support level 1 care and "step-down" from critical care and the introduction of the day of surgery unit to reduce pre-operative length of stay and improve patient experience.
- The hospital was also working on increasing emergency theatre capacity. The envisaged outcome was the further enhancement of best practice standards for care of patients with a fractured neck of femur.
- The spinal service had been expanded over the last five years and continued to see increased demand. The trust was investigating and implementing new ways of working to ensure that current capacity was utilised effectively.
- The Major Trauma Centre accreditation for the trust had increased the non-elective activity for the surgical division, and although patient numbers were low, the acuity and complexity was high. These patients often needed a lengthy rehabilitation plan and this was often delivered in the acute ward environment. Consequently there were plans in place to provide a high observation area for these patients to ensure that the nursing care reflected dependency. This will be combined with senior trauma nurses to support the patients and their families throughout their whole journey following a major trauma incident.
- The hospital introduced a new transnasal flexible laryngo-oesophagoscopy service that enabled eligible patients to have endoscopic investigations during their outpatients visit, thereby reducing the need for an additional visit to theatre.

Access and flow

- The trust's percentage of patients whose referral to treatment time was within the 18-week standard fell from 85% to 75% between May and September 2013 and has remained around 75% up to March 2014. This was below the national standard of 90%.

Surgery

- In March 2014, none of the surgical specialties met the national standard for referral to treatment, although trauma and orthopaedics (92%) and ENT (86%) came close. Some specialties fell below the trust average. Only 56% of neurosurgery patients, 71% of general surgery patients and 65% of oral surgery patients were within the 18-week standard for referral to treatment.
- The trust had implemented an action plan in January 2014 and as a result the hospital was now meeting the 18-week standard for referral to treatment.
- Data showed that cancer targets had been breached in quarter four 2012/13 and quarter three 2013/14. As a result of this the trust developed and implemented timed pathways and was working with partners to address patient flows between organisations for tertiary referrals.
- The 26 February 2014 executive team meeting minutes noted that the breast two-week wait target was at risk. Following a meeting with the breast team, the trust triggered a review to develop a recovery action plan. The trust had authorised the appointment of a third consultant surgeon for breast "some time ago", but had not yet made an appointment.
- In the May 2014 executive team meeting, the trust noted that patient choice was having an adverse impact on the cancer two-week wait target. The executive team commissioned an exception report for the next board of directors' meeting to understand and address this issue. The outcome was not known at the time of our inspection.
- In the May 2014 executive team meeting, the trust discussed the 31-day cancer target, which was 95% and was approaching the 96% target. The executive team agreed that the 62 day cancer position would be reported as a separate metric in the future. The trust expected to become compliant with the cancer targets in June 2014.
- During our visit to theatres we saw that the trust displayed performance data on noticeboards. This data highlighted that during 2014 theatres had on average 330 hours of unused capacity each month. We discussed this situation with the associate general manager, who explained that this was because of last-minute theatre list cancellations. To address this, the trust has introduced a Theatre Session Utilisation Scheme as a proposed method to tackle the issue of cancelled operating sessions. This scheme included checkpoints at six, four and two weeks to provide early warnings of cancellations and allow for a more systematic approach to determining medical and theatre requirements.
- We spoke with the Divisional Director for specialist surgery, who confirmed that the issue of unused capacity had been a problem. However, we were provided with documents that indicated measures had been implemented to begin to address unused capacity.
- Between April 2013 and March 2014 the trust cancelled 675 operations and 94 of these patients did not go on to receive their treatment within 28 days of the cancellation. This was significantly worse than the national average, for example, between July and September 2013 the trust had 20% of patients whose operation had been cancelled and had not received treatment within 28 days compared to the national average of 3.7%.
- However, since April 2014 and June 2014, 152 operations had been cancelled and only four patients (2.6%) had not received treatment within 28 days, better than the national average of 5.1%. This is a good improvement however, it only relates to the first quarter of the year and this improvement must be sustained to support patients receiving care and treatment in a timely way.

Meeting people's individual needs

- Support was available for patients living with dementia and learning disabilities and we noted that the trust identified patients living with dementia or memory impairment to enable them to take this into consideration when providing surgical care.
- We found there were multiple information leaflets available on the entrance to wards for many different minor complaints, but these were only available in English. We discussed this with staff, who informed us that leaflets in other languages were available on the trust's intranet and would be printed off if necessary.
- For patients whose first language was not English, staff could access a language interpreter if needed. We saw the services of an interpreter being used on one of the surgical wards during our inspection. British Sign Language interpreters were available for deaf people.

Learning from complaints and concerns

- As part of their learning from the two Never Events, the trust produced an action plan that stated that professionals involved in the Never Events would

participate in a debriefing regarding the investigation findings. The information would then be cascaded across the organisation. There was evidence that this had taken place within the division.

- We had received whistleblowing concerns regarding the ophthalmology service. The trust responded to these concerns by reviewing 30 patient cases and producing a report in May 2014. At the May 2014 board meeting, the trust agreed that the original draft of the report was not adequate, which triggered a review of the investigation process by the divisional director of surgery. The review of the opthamology service was in progress at the time of our inspection.
- Learning from complaints, concerns and incidents was disseminated among staff in a number of ways. This included the daily team brief and passing to trust executives directly. We were informed that during a Chief Executives "walk round" of neurosurgery, staff had requested an area to have confidential conversations with friends and relatives. Following the "walk round" we were informed an area was made available for private conversations.
- We saw on one ward that the sister had implemented a complaints file; this file held all complaints relevant to the ward and other general complaints. Staff were asked to read and sign the file regularly to ensure they were updated. This system promoted learning from complaints on the ward.

Are surgery services well-led?

Requires improvement

The trust had a vision and strategy for the organisation with clear aims and objectives. These had been cascaded across the surgical wards and departments and some staff had a clear understanding of what these involved. We saw evidence of monthly governance meetings for the surgical business unit, orthopaedic departmental meetings, theatres monthly governance report, the anaesthetics department cross-site departmental meeting and Datix incidents. It could be seen from these documents that incidents and risk were discussed. Staff felt well led at ward level, but considered that there was a disconnect between the theatre managers and managers of surgical specialties.

There were good governance arrangements within the division and performance information was cascaded and shared appropriately to maintain and secure improved performance.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust vision, values and objectives had been cascaded across the surgical wards and most staff had a clear understanding of what these involved. Ward managers in each of the areas we visited reinforced the organisation's vision and values regularly during their meetings and interactions with their teams.
- Staff in the surgical team were engaged and committed to the organisational values and felt able to participate in future plans for the service at a local level.

Governance, risk management and quality measurement

- There were monthly governance meetings for the surgical business unit, orthopaedic departmental meetings, a theatres monthly governance report, the anaesthetics department cross-site departmental meeting and Datix incidents. Records of the meetings demonstrated that incidents and risk were discussed and mitigating actions agreed.
- The surgical division provided a surgical dashboard that contained performance data; this information was disseminated to the Clinical Directors for each specialty to be discussed in their specialty governance meetings.
- As part of the learning from the two Never Events, the trust produced an action plan that stated that they would roll out a quality improvement programme across all theatres, which included a peer review of the theatres, a re-launch of the WHO checklist and a productive theatre work programme. Plans were being implemented at the time of our inspection.
- The corporate performance report at the March 2014 board showed the trust's performance, as of 28 February 2014, included Red-Amber-Green colour-coded headline indicators for safety, effectiveness, access, emergency department, and workforce. This meant that the board could quickly identify areas for improvement.
- The hospital had implemented action plans to increase the number of staff who had recent appraisals (64% in January and February 2014). The trust planned to achieve compliance by the end of quarter four.

Surgery

Leadership of service

- Staff we spoke with were positive about the service they provided for patients and about their immediate line manager.
- We noted that there was a disconnect between theatre managers and managers of surgical specialties, but the Divisional Director was aware of this situation was implementing regular meetings to improve communication and understanding.
- The under-utilisation of the theatre suite and the number of cancelled operations remained a matter of concern and a challenge for the service. A theatre key performance dashboard had been devised and was used to monitor the number of unfilled theatre sessions on a weekly basis. Actions to support a reduction in the number of vacant sessions were being taken.

Culture within the service

- Staff were positive about the service they provided for patients.
- The corporate performance report presented at the March 2014 board stated that the overall sickness rate for the surgical division was 5.60% in February 2014, which was an increase from the previous month. The anaesthetics (6%), plastic surgery (6%) and orthopaedics (6%) divisions had sickness rates above the trust average, whereas general surgery (3%) had sickness rates below the trust average. The internal target was 3%. The hospital was working to address this issue.
- In February 2014, the trust's corporate performance report stated that the highest absence rate for the trust was the surgical management team, at 24%.
- The trust also reported a number of absences due to ill health in the ophthalmology medical workforce. In response, the medical director had agreed a support plan and the service was reviewing progress against that plan.

Public and staff engagement

- In 2013, the trust's response rate for the staff survey (62%) was significantly better than the national average (49%).
- The trust reported good clinical engagement with working flexibly to increase capacity, as part of the trust improvement plan to reduce the backlog of patients awaiting surgery.

Critical care

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

Information about the service

For the purpose of management and governance, the ICU at Royal Preston Hospital is in the surgery, critical care, anaesthesia, theatres and outpatients division. Critical care was provided in a 24-bedded unit, which was set up to provide 14 beds at level 3 and 10 at level 2. The ICU accepts more than 1,200 admissions per year.

We visited the ICU on the announced inspection and were unable to talk directly with any patients because of their dependency, although we were able to speak with some relatives and more than 10 staff. These included junior and senior nursing staff, junior and senior doctors and managers, at both unit and division level. We observed care and treatment and looked at several care records in detail. Before and during the inspection we reviewed performance data from, and about, the critical care service. We also visited three 'high dependency or high observation' areas used within specific specialty wards. These were on ward 2a – neurosurgery (two four-bedded bays), ward 11 – gastroenterology (one five-bedded area) and ward 23 – respiratory support (one four-bedded bay).

Summary of findings

The hospital provided a good critical care service overall. However, in terms of the responsiveness domain, some improvements were required, relating predominantly to access and flow. There was evidence of strong medical and nursing leadership in the ICU that led to positive outcomes for people. The service submitted regular Intensive Care National Audit and Research Centre data so was able to benchmark its performance and effectiveness alongside other units nationally.

The unit employed two nurses in educational roles, which enabled them to support both new staff and those requiring additional support or performance management. There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. On the day of our inspection the unit had four empty beds at the start of the morning shift and was safely staffed with the appropriate number of trained nurses per patient plus a senior coordinating nurse, matron and consultant nurse, who was responsible for the critical care outreach service for the trust.

Critical care

Are critical care services safe?

Good

There were robust systems embedded for reporting and learning from incidents. There was an awareness of the need to provide a safe and clean environment for patients and performance against safety thermometer indicators was effectively monitored.

There were sufficient numbers of suitably trained nursing and medical staff in accordance with national guidance for intensive care units.

Incidents

- All the staff we spoke with knew how to report incidents and 'near misses' on the trust-wide electronic reporting system and regularly did so.
- Designated band 7 nurses were assigned lead responsibilities for the investigation of specific areas when incidents were reported. For example, all tissue viability, staffing or blood sampling related incidents would be investigated by that designated band 7. A root cause analysis was undertaken for all tissue viability related incidents.
- Incident reporting trends were mapped and lessons learned with subsequent actions fed back to staff by a number of different routes. For example, at safety huddles before the start of a shift or through the use of 'communication points' in which wider trust incident lessons were disseminated. We also saw minutes of unit and band 6+7 meetings, where incidents were discussed along with the consequential actions.
- A report looking at incident reporting on ICU for the period January 2012 to June 2013 showed that pressure ulcers represented the highest category of incidents, followed by blood transfusion and medication incidents.
- There was a thorough approach to mortality and morbidity directed by clear trust policy. For the year from October 2012 to September 2013, all Intensive Care National Audit and Research Centre standardised mortality ratios for critical care patients were similar to the England average or slightly better.
- Since April 2014 to date there have been 171 reported incidents. In terms of patient harm, these have been classified as 46 low harm, 14 moderate harm and the reminder no harm. In terms of classification, the highest number of incidents related to medical devices (19) and anaesthesia (19).

Safety thermometer

- There were clear Safety Thermometer performance boards displayed in the ICU corridor that showed current performance (July 2014). These provided a quick and simple method for surveying patient safety and analysing results in order to measure and monitor improvement.
- The performance boards showed the current results in respect of falls, pressure ulcers, urinary infections for patients with indwelling urinary catheters and VTE.
- The unit reported a significant improvement in the incidence of pressure ulcers. There was an identified tissue viability lead on the unit and they had instigated a number of measures to reduce the incidence of pressure ulcers. For example, any incidence of a pressure ulcer was reported as an incident using the trust-wide reporting system and was subject to root cause analysis.

Cleanliness, infection control and hygiene

- We saw that the environment was clean and that staff adhered to good practice guidance for the control and prevention of infection. Staff followed bare below the elbow policy in clinical areas. We saw that wall-mounted antiseptic gel dispensers were appropriately sited around the unit and used. Staff washed their hands appropriately and used personal protective equipment such as gloves and aprons.
- All equipment trolleys carried a label that stated when they had last been checked and cleaned.
- The ICU reported on healthcare-acquired infections quarterly for all staff. The report included the quarterly and year to date results and trajectories for healthcare-acquired infections such as MRSA and ventilator-associated pneumonias along with analysis, evaluation and lessons learned.
- The ICU reported zero cases of MRSA for the period from April 2013 to April 2014 and two cases where C. difficile had been detected, one in April 2014 and one in June 2014.
- There were appropriate arrangements in place for the safe disposal of sharps and contaminated items

Critical care

Environment and equipment

- All the equipment was appropriately checked, cleaned and regularly maintained; this included the resuscitation equipment. Safety checklists were completed daily.
- The ICU employed its own technical staff who maintained the unit's equipment.
- Care and treatment was provided in four distinctly separate areas within the unit which included the provision of isolation facilities.
- Storage was an issue of concern on the unit, particularly the risks associated with floor storage.

Medicines

- Medicines were being stored correctly in locked cupboards and fridges where necessary. Fridge temperatures were being checked and recorded.
- Staff conducted a balance check of all controlled drugs each day.
- We attended a medicines safety group meeting during the inspection at which medicines incidents were discussed along with innovations and developments in medicines management.
- There was a documented pharmacy strategy that included a defined audit programme aimed at reducing the frequency and harm of prescription and administration errors. All administration errors were reported as incidents.
- Posters were produced and displayed of the top eight critical care drug prescription errors to support staff learning and error avoidance.

Records

- We looked at three sets of patients' notes, all of which contained daily entries from the multidisciplinary team.
- There were some instances where not every sheet in the paper patient notes recorded the patient's name.
- We were told that the unit was moving towards a paper-lite system, which would represent a shift from paper-based records to an electronic record system, but this was some way off.
- Nursing documentation included appropriate risk assessments and the implementation of specific care bundles, for example, for ventilator-associated pneumonia.
- Detailed paper observation and National Early Warning Scores were kept for each patient within their bed area and were completed appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a sound knowledge of the Mental Capacity Act 2005. They assessed their patient's mental capacity to make a decision about their care. If the patient was judged as lacking capacity, they sought the advice of appropriate professionals to ensure that decisions were always made in the patient's best interest.

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could describe what constituted abuse. Safeguarding formed part of the mandatory training programme for all staff.

Mandatory training

- Electronic records were kept to monitor compliance with mandatory training. The figure on the day of inspection showed an overall rate of 78% having completed their mandatory training.
- Mandatory training included an annual update on fire safety, moving and handling theory, information governance, equality and diversity, and counter fraud and bribery training.
- In addition staff needed to complete two further waves of training, which included safeguarding (adults and children), infection control (including hand hygiene), health and safety, record keeping and the hazards associated with transfusions.
- The ICU had two designated nursing staff (one band 6 and one band 7) who were employed in educational roles. This enabled them both to deliver training and also work clinically to support nursing staff in caring for people in ICU.

Management of deteriorating patients

- There were tools in place for the early detection and escalation of changes in a patient's condition (National Early Warning Scores).
- The National Early Warning Scores documentation included an A, B, C, D, E assessment and management matrix to assist staff, alongside an escalation plan that linked clinical responses to the scores applied to physiological parameters.
- The critical care outreach team were collecting data on the completion of National Early Warning Scores and the frequency of escalation as well as the numbers of arrest calls.

Critical care

Nursing staffing

- On the day of our inspection the ICU was staffed safely and appropriately. The unit was able to provide nurse staffing levels that met the needs of their patients. All level 3 patients were nursed on a 1:1 ratio and all level 2 patients were nursed on a 1:2 ratio. In addition to these numbers there were senior nurses in coordinating and educational roles.
- The Intensive Care Society 'Levels of Intensive Care' document was used to determine the acuity of the patients in the unit. This document sets out the criteria for patients being assessed at level 0 (patients whose needs can be met through routine care) through to level 3 (patients requiring advanced respiratory and organ support).
- There was a mix of senior and junior band 5 nurses on duty supported by a band 6 nurse per patient area. The shift coordinator was a band 7 nurse. There was also a band 8 matron on duty.
- We were told that there were currently no issues with recruiting new staff. A programme of recruitment was due to start in preparation for the proposed expansion of the critical care service. This was being overseen by a project lead. Two further band 6 nurses were being employed to help staff the four level 2 beds that were occasionally used in the theatre recovery area.
- Any shortfalls in nursing numbers as a consequence of sickness were usually met by staff from the existing establishment working additional shifts or those shifts were filled using the unit's bank staff.
- During the inspection we also looked at a number of 'high dependency or high observation' areas. These included ward 2a, where we had some concerns about the numbers of level 2 patients being cared for in relation to the nurse to patient ratios. We raised these concerns immediately with the trust, which responded comprehensively, giving evidence in mitigation. The trust demonstrated that in February 2014 the ward had undertaken a patient dependency and acuity review using the Association of UK University Hospitals adult acuity dependency tool. The results showed that the number of level 2 patients on the ward was less than two for most of the assessment period and occasionally rose to four. The trust also produced figures to show that over more recent months there had been no occasions when any more than three patients at level 2 (as defined by the Critical Care Minimum Data Set) had been admitted at any one time. We also received confirmation that in response to the recent workforce review the nursing establishment for ward 2a had been increased to 36.5 whole time equivalents. This was more than the numbers considered necessary by the February 2014 dependency and acuity results.

Medical staffing

- The unit had a designated associate clinical director. In addition the clinical director for the anaesthetics and critical care division was an ICU consultant.
- During the day there were two consultant intensivists on duty on the unit for up to 24 patients. This level of cover was also available over the course of the weekend, although the ratio went down to one consultant on an overnight weekday.
- The ICU consultants worked a 1:7.5 on-call rota
- Ward rounds took place twice daily at approximately 11am and 9pm, including weekends and bank holidays.
- The unit had typically five junior doctors also on a shift during a weekday, with two on the unit out of hours. At the weekends there were usually three junior doctors on duty in ICU during the day and two at night.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place. Major incident stations were clearly visible on the ICU and contained the appropriate tabards and action cards for key staff to follow.
- For the current year, 136 out of 174 ICU staff had undertaken major incident training. It was included on both waves of the trust's annual mandatory training plan.

Are critical care services effective?

Good

There was good multidisciplinary team working and a commitment to clinical audit and evaluation. The ICU contributed to the collection of data for the Intensive Care National Audit and Research Centre and continually evaluated its performance against other units.

The trust was also part of the Lancashire and South Cumbria Critical Care Network and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Critical care

Evidence-based care and treatment

- A range of local policies and procedures were in place. These had been developed using NICE guidance and the Core Standards for Intensive Care Units. For example, in accordance with NICE clinical guideline 83, each patient had an assessment of their rehabilitation needs within 24 hours of admission.
- Care pathways and care bundles were used to ensure appropriate and timely care. For example, there was a bundle for the prevention of ventilator-associated pneumonia.
- There was an extensive local audit programme with leadership for specific areas delegated to senior nursing staff. The programme included auditing all high impact interventions. High impact interventions are an evidence-based approach that relate to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately. They included central and peripheral line insertion and management, ventilator-associated pneumonia, urinary catheter insertion and ongoing management, pressure ulcers and enteral feeding. Each high impact intervention was audited monthly in a rolling programme and then the results were collated and reported on quarterly, with the reports disseminated to all ICU staff. The reports included an analysis plus lessons learned for any areas on non-compliance against the high impact intervention audits.

Pain relief

- As part of their individual care plan all patients in ICU were assessed for their pain management. 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 saw that epidurals and patient-controlled analgesia systems were used in accordance with trust guidelines.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission, to ensure adequate nutrition and hydration.
- Nutritional risk scores were updated and recorded appropriately.
- The unit had access to dietetic advice.
- Patients who had swallowing difficulties were referred to a speech and language therapist.

Patient outcomes

- All Intensive Care National Audit and Research Centre standardised mortality outliers for critical care patients are similar to the England average or slightly better.
- Patients discharged between 7am and 9.59pm and readmissions within 48 hours are similar to the England average.
- Critical care admissions from another unit for non-clinical reasons and the rate of unit-acquired infections in blood are much better than the England average.

Competent staff

- Nursing staff received an annual appraisal. Senior nurses undertook the appraisals for their junior colleagues. At the time of inspection 82% of nursing staff had received their appraisal within the past 12 months.
- The unit had two nurses in band 6 clinical educator roles. They were able to provide practical support for nursing staff identified as having any performance issues.
- All new trained nurses to the unit completed an induction pack that had been produced jointly by the unit's clinical educators. New staff were assigned a mentor and during their induction period were introduced to the competencies required to work in a critical care environment.
- Having completed 12 months of critical care experience, nursing staff were able to access additional modules and project-based study opportunities.

Multidisciplinary working

- There was a daily multidisciplinary ward round that had input from nursing, physiotherapy and others, as appropriate.
- The ICU at Royal Preston Hospital was responsible for staffing the four-bedded level 2 high dependency unit at Chorley and South Ribble Hospital (see separate report for critical care provision at the Chorley site).
- The Royal Preston Hospital critical care outreach team also provided a limited outreach service at Chorley and South Ribble Hospital (see separate report for critical care provision at the Chorley site).

Seven-day services

- At least one consultant intensivist was available on the unit 24 hours a day seven days a week, supported by junior grade doctors.

Critical care

- Out-of-hours physiotherapy and imaging services were available during the daytime at weekends and then on-call.
- Only on-call pharmacy was cover provided at the weekends.

Are critical care services caring?

Good

We saw people and their relatives being treated with understanding, compassion, dignity and respect. The evidence demonstrated that the unit was good at involving patients, family and friends in all aspects of their care and treatment.

Compassionate care

- During the inspection we saw that critical care services were delivered by a caring and professional staff group.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.
- Staff sensitively managed the dignity and privacy of patients being cared for on the unit.

Patient understanding and involvement

- Wherever possible, patient's views and preferences were taken into account when planning and delivering care and treatment.
- Patients were allocated a named nurse for a span of duty on either a 1:1 or 1:2 basis, depending on their acuity. This helped to ensure continuity of care.

Emotional support

- We received very positive feedback from patients' families, especially with regard to being kept informed by the unit's nurses and doctors.
- Where necessary, additional face-to-face meetings were organised to ensure family members were kept informed and had the opportunity to have their questions answered.
- Staff described some of the psychological aspects patient care in ICU, where sensory and sleep deprivation is commonplace. These included the use of wall clocks to orientate people to time and the dimming of lights at night time. We saw one patient being relocated to a position where they were able to see out of the window.

Are critical care services responsive?

Requires improvement

It was not uncommon for elective surgery cases to be cancelled when there was no critical care bed available for a patient post-operatively. Between April 2013 and April 2014 this had occurred on 79 occasions. In times of bed pressures, the theatre recovery area was used as a place to care for both level 2 and level 3 patients, temporarily. The unit had employed some additional nursing staff to assist in staffing this area when it had to be used for ICU patients. Patients were managed safely however, it is not an ideal environment for ICU patients to be cared for over a length of time. At such times there was an impact on the patient flow and efficiency of theatres and recovery.

Bed occupancy was generally over 90%, with the unit having the second highest numbers of delayed discharges across the Lancashire and South Cumbria critical care network.

The critical care outreach team was unable to provide a 24/7 service and there was only on-call pharmacy service at weekends.

Service planning and delivery to meet the needs of local people

- The unit had a dedicated relatives and visitors waiting room, but this was quite small considering the number of ICU beds (24).
- Lancashire Teaching Hospitals NHS Foundation Trust serves a local population of 390,000 living in South Ribble, Chorley and Preston boroughs, and an additional 1.5 million patients for specialised care.
- The trust had undertaken a review of capacity and demand for critical care beds and this demonstrated that demand at times exceeded provision. There were plans to expand the number of beds to 35 and this had been discussed and agreed with the local clinical commissioning groups. Decisions were still to be finalised about how this expansion of the service would be facilitated in terms of infrastructure.

Access and flow

- A review of capacity and demand for critical care beds had been undertaken and this demonstrated that at times demand exceeded provision.

Critical care

- The risk assessed escalation policy for critical care provided additional capacity within the recovery area of the adjacent theatres at times of peak demand. This has affected patient flow and the efficiency of theatres and recovery. We noted that the records showed that recovery had been used for critical care patients 34 times between 20 May 2014 and 7 July 2014. This was often because level 2 or level 3 ICU beds were not available. The length of stay in recovery varied from an hour and a half up to 20 hours.
- Bed occupancy was closely monitored both within the trust and by the Lancashire and South Cumbria critical care network. The April 2014 patient flow report from the network indicated that bed occupancy stood at 90%.
- While the report showed that there had been a reduction of delayed discharges in April 2014, with an average of 1:58% beds lost per day, the unit was the second highest unit in terms of delayed discharges across the network. A total of 1,143 hours of beds were occupied by patients awaiting discharge during April 2014.
- In the period January 2014 to April 2014 the unit reported between five and eight patients per month who were discharged out of hours (10pm to 6.59am). Discharges overnight have historically been associated with an excess mortality (Priestap FA, Martin CM, Crit Care Med. 2006, 34(12):2496-51).
- It was not uncommon for elective surgery to be cancelled because of non-availability of a critical care bed. For the period April 2013 to April 2014 it was reported that 79 elective operations were cancelled for this reason (no data for January 2014).
- A review of capacity and demand for critical care beds had recently been carried out and this demonstrated that demand at times exceeded provision. A plan to expand the critical care service at the Royal Preston Hospital had been discussed with commissioners and agreed by the trust. A decision still had to be made on how this expansion would be managed in terms of environment.

Meeting people's individual needs

- Patients were being reviewed in person by a consultant intensivist within 12 hours of their admission.
- The trust's critical care outreach team was based on the ICU at Royal Preston Hospital. This service has run since 2000 and provided a 12-hour-a-day, seven days a week outreach service. At 8pm the outreach function was handed over to the 'hospital at night' team. The hospital at night team was involved in the management of the sickest ward-based patients. While they had the full range of competencies to meet the immediate needs of patients, they did not have critical care experience.
- Data collected by the critical care network showed that between 96% and 100% of patients were followed up within 30 hours of their discharge from ICU.
- Staff from the unit had introduced a follow-up clinic for former ICU patients. The clinic was run weekly and patients who had stayed at least four days in ICU were invited to attend three months after their discharge. The clinics were run by a multidisciplinary team that included a psychologist. This was proving a rich source of information about what people remembered of their stay in ICU and it was hoped that lessons could be learned for the future. It was still 'early days' so far as the clinic was concerned, so no formal evaluation of its findings were yet available.
- Staff had access to a translation and interpreting service, if this was required.

Learning from complaints and concerns

- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with that trust policy.
- The ICU kept their own data base of complaints received, which tracked the progress of investigation and responses against the timescales required in the policy. It also contained details of involvement with the Patient Advice and Liaison Service.
- The records kept by ICU indicated that the unit received approximately one complaint a month and that almost all were from relatives of deceased patients and usually involved aspects of care before and/or after any stay in ICU.
- Analysis of complaints showed that they often related to end of life issues and communication.
- We saw evidence that staff took learning from complaints to inform and improve their practice when dealing with patients and their relatives. For example, taking the time to explain why things are being done, especially for the families of patients who were unlikely to survive.

Organ donation

- The trust had an organ donation team who were based on ICU and were clinically led by an ICU consultant. ICU

nursing staff also contributed to the team along with representatives from the emergency department, theatres, end of life facilitators and specialist nurses in organ donation. The organ donation team developed the trust's annual plan for organ donation and then reported on its activity annually to the trust board. Results for 2012/13 published by NHS Blood and Transplant showed that the trust achieved the national average in seven out of the nine indicators from the potential donor audit with six of these being nationally in the top 25% of trusts. For example, the trust scored 100% in the potential donor audit relating to referrals of patients where neurological death was suspected.

Are critical care services well-led?

Good

There had been a review of capacity and demand for critical care beds in the hospital and this had demonstrated that at times demand exceeded provision. A plan to expand the critical care service at Royal Preston Hospital had been discussed with commissioners and, we understood, approved by the trust board. A project lead and workforce group had been established to develop the plans required around this service expansion.

There was clear clinical leadership at unit level for both doctors and nursing staff.

Vision and strategy for this service

- There was a vision and strategy for developing the critical care service at the Royal Preston Hospital. The expansion plans included a further 11 ICU beds (seven at level 3 and four at level 2). Some key questions remained unanswered relating to the infrastructure of the expanded service. For example, will the extra beds be added on to the existing ICU footprint or will the total 35 beds be relocated to another area within the trust, possibly even into a new build?
- From our observations and discussions with staff of all grades there was an agreed understanding that the service needed to change and develop in accordance with the wider trust initiatives. For example, the development of the trust as a major trauma centre and the expansion of the vascular service.

Governance, risk management and quality measurement

- We saw that monthly governance meetings were held for the anaesthetic division. The meeting minutes reported progress against key priorities, such as effective care, patient safety and experience, giving them a red, amber, green rating along with related comments and actions. The reports also included examples of 'open incidents' and what actions had so far been taken, alongside what actions were still required.
- The risks inherent with the delivery of safe care were understood and identified on the unit's risk register, which was up to date.
- A summary of critical incidents was shared with all unit staff.

Leadership of service

- Senior medical and nurse leaders were committed to providing a safe service for their patients.
- The ICU had a designated consultant clinical lead and the nurse managers or matrons post was job shared.

Culture within the service

- Staff spoke enthusiastically about their work. Staff reported a positive and open culture on the unit and that managers listened to them, for example in the monthly minuted critical care department meetings.
- Staff were encouraged to report incidents and raise concerns openly.
- Patient care in ICU benefited from a multidisciplinary approach. It was clear from our observations that there was respect between the various professional groups of staff.
- The employment of nurses in dedicated educational roles helped to support a culture of learning and development among the nursing team.

Public and staff engagement

- We found no overt patient or family involvement in developing the service at present. However, the weekly support group meetings being held for former ICU patients may provide a source for future public engagement and involvement.

Innovation, improvement and sustainability

- The ICU was an active member of the Lancashire and South Cumbria critical care network. Membership of the network enabled the unit, through collaborative working with commissioners, providers and users of

critical care, to focus on making improvements where they are required. For example, the introduction and evaluation of care bundles and high impact interventions.

- We noted a thriving and comprehensive research culture with participation in many ICU-related research projects. The unit's participation was usually led by one of the consultants supported by ICU nurses. Examples of some of the research activities include:
- NAC: A prospective blinded observational cohort study examining the effect of neo-adjuvant chemotherapy on exercise capacity and outcome in patients undergoing surgery for upper gastrointestinal cancer.
- PROMISE: A multi-centre randomised controlled trial of the clinical- and cost-effectiveness of early goal-directed protocolised resuscitation for early emerging septic shock.
- LEOPARDS: Levosimendan for the prevention of acute organ dysfunction in sepsis. Double-blind randomised control trial. Does levosimendan reduce the incidence and severity of organ dysfunction in patients who have developed septic shock?

Maternity and gynaecology

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

Information about the service

The maternity service provided care and treatment for maternity and family planning for the population of Preston, Chorley and South Ribble. The inpatient units included a range of maternity services at the Sharoe Green Unit on the Royal Preston Hospital site. Services included delivery suite, antenatal care (outpatients/inpatient), postnatal (outpatients/inpatient), ultrasound and termination of pregnancy.

The service also included community midwifery services providing antenatal care, home birth and postnatal care.

During our visit we spoke with 16 staff and ten patients and relatives. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for eight of the patients. We gathered further information from data that we had requested and received from the hospital. We also reviewed information regarding the hospitals internal quality assurance and compared their performance against national data.

The service was managed through the Lancashire Teaching Hospitals NHS Foundation Trust specialist services division and was led by a divisional manager, clinical director with an acting Head of Midwifery in post.

The service averaged 4,500 births a year.

Family planning services were not provided by Lancashire Teaching Hospitals NHS Foundation Trust but by the local community provider.

Summary of findings

The maternity service had a number of vacant midwifery posts, with staffing funded to maintain a midwife to birth ratio of 1:29. But there had been long-term shortages over a six-month period, and when combined with high sickness absence rates, there was heavy dependence on community midwives, extra hours and in-house bank staff on an ongoing basis.

Although this ratio is not used as a day-to-day indicator, based on information from January to June 2014, a six-month period of actual clinical whole time equivalent midwives in post and number of births in that period, the midwife to birth ratio equated to1:34. Additional midwifery staffing was provided by specialist midwives contributing more clinical hours than their normal 50% and midwives working over and above their normal working hours. All midwifery staffing, including community, is part of one team and flexed to meet the needs of the service user. This meant that, despite a recovery action plan, safe care and treatment could not always be assured.

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

Maternity and gynaecology

We found that maternity services were delivered by committed and compassionate staff. All staff treated patients with dignity and respect. The majority of people were positive about the care they had received.

The midwifery staff felt well led, and staff felt engaged with the proposed model of maternity services. The service had a learning culture and robust systems were in place for reviewing the quality of care and service delivery.

Are maternity and gynaecology services safe?

Requires improvement

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

The maternity service had a number of vacant midwifery posts with staffing funded to maintain a midwife to birth ratio of 1:29. But there had been long-term shortages over a six-month period, and when combined with high sickness absence rates, heavy dependence on community midwives, extra hours and in-house bank staff on an ongoing basis, the ratios were 1:34. This meant that, despite a recovery action plan, safe care and treatment could not always be assured.

Records showed that the service had not achieved the 75% compliance in medical device training. We were also told that the attendance figures were below the 50% expected at this point in the year, but plans were in place to restart the training as soon as staffing levels improved. The lack of access to appropriate training and support could affect the ability of the service to provide high-quality care.

Incidents

- There were systems for reporting actual and near-miss incidents across the maternity services. Staff reported incidents and were confident and competent in doing so. We asked staff directly if they reported incidents. 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.
- The maternity service monitored all its risks and had a local risk register. We reviewed the risks identified by the service. The Women's Health Service had identified its own top-three risks in July 2014. These were midwifery staffing, inappropriate management of obstetric emergencies and the lack of a second dedicated obstetric theatre. All the risks had clear action plans in place to mitigate the risks and inform staff of the

management actions to improve patient care. 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.

- During the inspection we observed the weekly risk meeting and found that two incidents relating to the lack of staff had been reported that week. These had been escalated to the service managers.

Safety thermometer

- Information from the NHS safety thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, catheter and urinary infections) indicated that the service was performing within expected ranges for these measures. This information was displayed on the unit and was freely available for patients and staff.
- We reviewed the maternity dashboard as part of the inspection and found low puerperal sepsis rates compared with nationally expected figures. The service outcomes were within expected limits for most of the indicators. The number of emergency caesarean sections and third/fourth degree perineal tears were slightly above the national average.

Cleanliness, infection control and hygiene

- The unit was clean and tidy and each room was stocked with appropriate personal protective equipment.
- During our inspection we observed good personal protective equipment practice, whereby all staff were witnessed to be wearing gloves or washing their hands between patients. Staff observed bare below the elbow guidance. There was an ample supply of hand washing facilities and hand gel.
- We were provided with the last hand hygiene and uniform audit that had taken place in the department, which was in June. Overall the unit scored 100%, which indicated that staff had complied with best practice.
- MRSA and C. difficile rates for the service were within an acceptable range.

Environment and equipment

- Equipment required in case of a cardiac arrest and the resuscitation of a newborn was stored on suitable trolleys that were able to contain the equipment safely if it was moved.
- We found evidence of regular checking and recording of equipment. We checked the resuscitation equipment throughout the unit and found it had been checked regularly by a designated midwife.
- Equipment was clean and regularly checked. All the equipment we saw had service stickers displayed and these were within date.
- Equipment was serviced by the trust's biomedical engineering team under a planned preventive maintenance schedule.

Medicines

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow. Medicines were stored, managed, administered and recorded safely and appropriately.
- Staff records showed that midwives had received appropriate training in line with professional standards for the management of medicines. Staff we spoke with were clear about the drugs they used and confirmed that they had received the relevant training.

Records

- The service carried out regular documentation audits and results were fed back through statutory supervision, newsletters and professional development days. The latest results showed a 92% compliance rate, indicating that record keeping was to an acceptable standard. All the records were complete along with appropriate clinical risk assessments and the lead professional identified.
- During our inspection we looked at five 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.
- 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow regarding the Mental Capacity Act 2005.

- Staff were seen discussing care and treatment options with the patient and/or their relatives to enable them to make informed choices. Where patients lacked capacity to make their own choices, staff consulted with the patient, appropriate professionals and others so that decisions were made in the best interests of the patient.
- The service had clear policies and procedures for the management of the acute mental health needs of a patient. Staff we spoke with were able to outline the processes in place to support mothers with maternal mental health needs. Records confirmed that staff had received training in maternal mental health and if required had access to appropriate clinical support for acute peri-maternal health issues.
- Patients' consent was sought appropriately. Patients we spoke with confirmed that staff sought their permission before carrying out any procedures. Records we looked at confirmed that the appropriate documentation had been completed with informed consent recorded in the documentation.

Safeguarding

- Women and their babies were protected from abuse and staff were trained to deal with suspicions of abuse and neglect. Staff we spoke with were aware of the signs of abuse and the appropriate actions and systems for escalating safeguarding concerns.
- Clear systems were in place to identify and carry out risk assessments on vulnerable women. We saw evidence at the morning safety huddle to share appropriate information.
- All the staff we spoke with were very positive about the support and advice from the Vulnerable Women's team and they felt well supported to manage safeguarding concerns.
- There was good evidence of multi-agency liaison and communication for women deemed high risk. Safeguarding training was available at level 1 and 2 for all the midwives across the service.

Mandatory training

- The service had developed a robust training needs analysis, to ensure that maternity services provide training in accordance with the national recommendations for all professionals working in maternity services. Staff we spoke with confirmed that they had access to professional development days. Staff told us they were encouraged to complete their mandatory training as normal practice on the unit.
- We saw comprehensive records for each individual staff member, including the date of training/competency assessment, name of trainer and a breakdown of training by individual pieces of equipment.
- Staff told us that some plans to postpone training may have an impact on the ability of the service to maintain compliance with mandatory training. A lead manager told us about the decision to postpone all professional midwifery study days until September 2014 because of the escalation of staffing issues. The service has retained the essential clinical study days, such as life support training. Records showed that the service had not achieved the 75% compliance in medical device training. We were also told that the attendance figures were at the 50% expected at this point in the year, but plans were in place to restart training as soon as staffing levels improved. The lack of access to appropriate training and support could affect the ability of the service to provide high-quality care.

Management of deteriorating patients

- The service had processes in place to ensure the recognition of severely ill women during their pregnancy, delivery and postnatal period. It had introduced a modified early obstetric warning scoring system to help improve the detection of life-threatening illnesses. There were clear directions for escalation printed on the reverse of the observation charts. Staff we spoke with told us that they were aware of the actions to follow.
- 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 relating to patient care and treatment.

Midwifery staffing

- We found midwifery staffing levels were calculated using a recognised dependency tool. The maternity service had a number of vacant midwifery posts, with staffing funded to maintain a midwife to birth ratio of 1:29. Managers on the wards we inspected reported vacancies for trained midwives that had not been filled and long-term sickness absence with rates of 9% sickness across the maternity services, which meant that the area we inspected had an actual birth to midwife ratio of 1:34. We met with senior managers who confirmed that despite robust action plans in place, the situation had improved since January 2014 and was not going to be resolved until December 2014.

- One staff member told us "It is very tight for staffing". We saw examples on the day of our visit of community staff re-arranging appointments in order to cover the delivery unit. Staff told us that they had managed to maintain 1:1 supervision for women in labour, but that it had been very challenging.
- We viewed copies of duty rotas that confirmed the shortages of staff. We found that for the four-week period in May 2014, 57% of 'early' 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 or specialist midwives used in line with the women's health escalation policy.
- We noted that staff had reported several incidents when staffing had not been adequate on the unit. They told us that they knew how to access more staff if required, and they were aware of the escalation policy for short-term management of staff shortages/capacity issues. We were shown the trust system for escalating staffing shortages. However, staff told us that they were "exhausted from covering all the extra shifts".
- We observed staff handovers during our inspection. Communication between staff was effective, with staff handover meetings taking place during daily shift changes. Shift handovers promoted clear communication and continuity of care.

Medical staffing

- The medical staff carried out regular handovers during the day and in the evening on the labour ward to ensure clear communication and handover of care for patients.
- We were told that the service was in the process of increasing obstetric consultant cover in line with recommended staffing levels from the Royal College of Obstetricians and Gynaecologists' 'Safer Childbirth'. Recruitment had been successful and an increase in hours had been achieved from 60 hours to 80 hours, with phased recruitment ongoing to achieve up to 98 hours of cover.
- 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 were told that the service had also had agreement for 10 sessions of consultant anaesthetic cover for the labour ward, which meant that staffing levels would now be in line with the recommendations of 'Safer Childbirth'.

Major incident awareness and training

- The training records confirmed that the majority of staff had up-to-date fire safety training.
- We saw evidence of the trust major incident policy, which the managers told us they used.

Are maternity and gynaecology services effective?

Good

The delivery of care for maternity services was based on guidance issued by professional and expert bodies such as NICE. Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs.

Mothers were offered access to various sources of pain relief, such as Entonox and pethidine.

Data showed that the service had a rate of third/fourth degree perineal tears slightly above the national average. The service carries out regular audits on the number of third/fouth degree perineal tears. All the patients attend a pelvic floor clinic after sustaining these tears with appropriate follow-up in place. We found that the service was very proactive in reviewing cases and had clear systems and audits in place to review the incidence of third/fourth degree perineal tears.

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. As supervisors, they provide support, advice and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the Nursing and Midwifery Council. All midwives had an annual review by their allocated supervisor.

Evidence-based care and treatment

- The delivery of care for maternity services was based on guidance issued by professional and expert bodies such as NICE. Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. These included pathways such NICE intrapartum guidelines and maternal and fetal monitoring.

- The service had over 200 policies and procedures based on either NICE/Royal College guidelines, with robust guidelines for staff such as prompt cards for the management of an obstetric emergency and the management of a post-partum haemorrhage.
- There was a variety of information based on research and NICE guidance that was available to inform mothers, such as on emergency caesarean section.

Pain relief

- Mothers were offered access to various sources of pain relief, such as Entonox and pethidine. The service provided an epidural service 24 hours a day; seven days a week to those mothers who wanted to have this method of pain relief. We saw a number of leaflets providing information on the various methods of pain management available during labour and delivery, including a birth pool.
- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet individual need.

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. We met one patient accessing the kitchen area on the unit to make a drink, which was available whenever she wanted.

Patient outcomes

- The service also completed a maternity dashboard to monitor key maternity indicators. We reviewed the data provided as part of our inspection. The trust's data and the maternity dashboard showed that overall the service was performing in line with national standards.
- Data showed that across the maternity service they had a rate of third/fourth degree perineal tears slightly above the national average. The service carries out regular audits on the number of third/fourth degree perineal tears. All the women attend a pelvic floor clinic if they have sustained a third/fourth degree perineal tear with appropriate follow-up in place. We found that the service was very proactive in reviewing cases and had clear systems and audits in place to review the incidence of third/fourth degree perineal tears.
- We saw a number of regular audits that had taken place to review best practice. This included a review of all the elective caesareans sections in a three-month period to understand the rationale for the surgery and to ensure that best practice was followed to reduce the number of people having surgery with its associated risks.
- The service had a safety and quality audit plan in place to ensure that audits were carried out to measure the service performance in line with the maternity dashboard indicators such as post-partum haemorrhage and unplanned admissions to the ICU.
- Pregnant women were assessed in the community as part of their antenatal care and information about patients who were at risk was shared appropriately.

Competent staff

- We found that the service had a range of training opportunities to ensure that training needs were met. In addition ad hoc training was available for specific clinical interventions such as interpretation of monitoring equipment and any individually identified training requirements.
- Medical and midwifery staff received appraisals and supervision. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Staff spoke positively about the process.
- 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. As supervisors, they provide support, advice and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the Nursing and Midwifery Council. All midwives had an annual review by their allocated supervisor.
- The service had several specialist midwife roles to lead specific areas of practice, such as safeguarding, governance and a consultant midwife specialising in 'normality'.
- We saw that individual competencies had been developed for individual roles and specific procedures required across the service such as the 'transport of the neonate'.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations

and discussions with members of the multidisciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.

- We saw records of how the midwives had worked with the physiotherapy service to ensure that patients with third/fourth degree perineal tears had been referred for therapy in a timely manner and ensured effective communication between the professions. We saw evidence of clear multidisciplinary working across all professional groups, such as the critical care outreach team and the paediatric services.
- 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.
- We found clear link working with the ambulance service regarding transfers from the birth centre at Chorley. We saw that there was regular contact with paramedics to share skills and practice.
- 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 meetings taking place during daily shift changes.

Seven-day services

- Services were available seven days a week.
- Postnatal services were provided in the community (women were transferred home to the care of the community midwives until at least the 10th and up to the 28th day following delivery).

Are maternity and gynaecology services caring?

Good

We found that maternity services were delivered by committed and caring staff. We observed that all staff treated patients with dignity and respect. The majority of patients we spoke with were positive about the care they had received. Some people told us that they would have welcomed greater information on what was happening and less medical intervention.

We found that clear systems were in place to offer emotional support to people if required and was carried out with sensitivity and compassion.

Compassionate care

- We found that maternity services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect.
- We spoke with nine patients and the majority we spoke were positive about the care they had received. Some comments made were: “Staff are very helpful but very busy” and the staff are “Very helpful and reliable”. Two people told us that they felt that the staff had not kept them fully informed of what was happening and were unsure of the plans for either discharge home or if any further clinical intervention was required. One person told us “I feel that they do not always respect my opinion and lack empathy”. The lack of clear communication with patients may impact on the care and treatment provided by the service.
- We saw examples of ways in which people were encouraged to share their impression of the services, such as encouraging people to text their views. The trust had below national average response rates for the maternity Friends and Family Test, which asks patients about their overall care at different stages of pregnancy. We noted that the overall results for the service for specific questions such as “were you treated with kindness and understanding?” were comparable with the England average.

Patient understanding and involvement

- Staff planned and delivered care in a way that took account of the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care.
- Women were informed and involved in decisions about their care. The majority of patients told us that they had been involved in their care and felt very involved in decision making. One person we spoke with told us that the service was “very medical” and that they would have preferred to have more of a conversation with staff about their care.

- The use of records held by mothers encouraged them to be aware of their birth plans and provided further information on any specific tests or investigations that may be needed throughout a pregnancy.

Emotional support

- Arrangements were in place to provide emotional support to patients and their families in a sensitive manner. Clear systems were in place to maintain privacy and dignity such as the use of discreet imagery/signage on doors for parents who were bereaved.
- We observed and staff told us that advice and support for antenatal complications and termination of pregnancy was managed sensitively.
- Staff we spoke with understood the need to provide emotional support for mothers, and carried out assessments for anxiety and depression. Women 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 could 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 'Afterthought service' was provided in leaflets available on the maternity ward.
- The service had a maternity bereavement midwife service to support women and their partners following the loss of their baby.

Are maternity and gynaecology services responsive?

Good

The senior managers outlined the plans for the proposed model of midwifery care to members of the inspection team.

The service ran joint clinics with specialist midwives for specific conditions such as diabetes, obesity or mental health.

Policies were in place to escalate staffing issues on the unit and staff were aware of how to access extra support if required. We were told that there had been no closures of the maternity unit in the last two years.

We were told that women were able to self-refer to the service and were able to choose where they wanted to give birth in discussion with the midwife.

Service planning and delivery to meet the needs of local people

- The senior managers outlined the plans for the proposed model of midwifery care to members of the inspection team. The proposed model care was a result of contributions from midwives who worked across the service to meet the needs of women in Preston, South Ribble and Chorley.
- The service had a Maternity Services Liaison Committee. We looked at Committee minutes. We found that although two meetings had been held this year, there had been limited attendance from key stakeholders such as local commissioning groups. We spoke with a member of the committee who told us that the committee had recently been re-launched following the reconfiguration with the local commissioning groups to ensure that the service was able to work with partners in planning service delivery.
- 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 diabetes, obesity or mental health.

Access and flow

- The use of a safety huddle in the mornings on the labour ward involved all areas of the unit either in attendance or reported centrally to the meeting. They discussed women, staffing, safeguarding, all clinical areas including Chorley, community services, antenatal clinic and support of staff for which they looked at a 24-hour period including gynaecological beds.
- Policies were in place to escalate staffing issues on the unit and staff knew how to access extra support if required.
- We were told that there had been no closures of the maternity unit in the last two years.
- We were told that women were able to self-refer to the service and were able to choose where they wanted to give birth in discussion with the midwife. In the financial year 2013/14, 69.7% of women had their assessment of need performed within 10 weeks of pregnancy and

95.2% within 20 weeks of pregnancy. This included women who had transferred their antenatal care from another trust and who would have had their initial assessment of need performed by the referring trust.
- The service ran a triage unit to assess women who had concerns about their pregnancy to enable them to be seen quickly. The service also provided a 'hot' clinic every afternoon for gynaecology and the early pregnancy assessment unit, with a dedicated registrar available to see patients referred urgently from primary care.
- The service demonstrated shift-working flexibility across the early pregnancy assessment unit/gynaecology unit and the gynaecology ward.
- Staff reported that there had been delays in reviews of some patients who had been admitted to the gynaecological service with other medical or surgical conditions. We were told that actions had been taken to ensure that patients were reviewed in a timely manner.
- We looked at bed occupancy across the maternity services and found that overall occupancy was within national acceptable averages, although we were told that there had been issues with quarters one and two which had been above average, but was below average in the second two quarters of the year.
- Recent service audits showed some delays in moving patients from the induction area to the delivery suite. We were told and records showed that an action plan was in place to address the issue and ensure that people were transferred to the delivery suite in a timely manner.
- The service policy required that the on-call consultant must be able to attend within 30 minutes. Any delay in response to a call for assistance was a trigger to complete an incident report. We did not see any reported incidents for 2014.

Meeting people's individual needs

- The service had systems in place to meet people's religious and cultural needs.
- Leaflets were available for mothers to help them decide where to have their baby. The leaflets outlined the choices available for women, including the difference between midwifery-led care, consultant-led care and options for home births or attending the birthing centre in Chorley. 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 wasn't English, such as a Polish leaflet on 'Your first ultrasound scan'.
- Staff were able to describe how they would access translation services. One staff member was able to describe how they had used a sign-language interpreter and a Polish-speaking interpreter to meet the needs of a particular patient.
- Birth option appointments for women and their partners who have had a previous traumatic experience and for women 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.
- A vulnerable women service was provided by a team of three specialist midwives and rotational staff with responsibility for coordinating care for women with complex social needs, including safeguarding and domestic violence.
- Patients we spoke with told us that the visiting hours meant that they were on their own at the start of labour and would have preferred some flexibility to enable their partners to support them during a very anxious point in their pregnancy.
- We found that breastfeeding support was available across the service. The service had two designated infant feeding specialist midwives available to provide information and support about breastfeeding.

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 also found comments cards for people to fill in about the cleanliness of the service and the environment. We did not see evidence of this information available for people whose first language wasn't English.
- 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.
- Information about supervisors of midwives and how to contact them was freely available on the unit. Supervisors of midwives are experienced practising midwives who monitor the safety and quality of local midwifery care. The supervisor's role is professional and defined by law; it is independent of hospital management structures. The supervisor of midwives is able to listen to any concerns patients may have about the care they have received from their midwife and then discuss those concerns with the midwife if appropriate.

Are maternity and gynaecology services well-led?

Good

The maternity service staff felt positive about their clinical leadership with some good examples of key leadership roles. However, some staff felt that long-term temporary roles had led to a feeling of uncertainty within the service.

Staff understood the direction of travel for the service and felt engaged with the process.

Clear governance processes were embedded within the service and the culture of the service was one of continual improvement and development.

The service had tried to improve its engagement with the public. They had engaged with service users about the Department of Health's bids for birth environment and improving services for women with mental health issues staying in hospital and families suffering the loss of a baby on a delivery suite. They had also engaged with service users about midwifery research ideas and digital hand held records, but we did not see any clear systems embedded across the wider service to regularly engage with members of the public about the maternity services.

Vision and strategy for this service

- Staff told us that they were aware of the trust's vision and understood the local plans for developing an integrated community midwifery team model. Staff we spoke with were looking forward to the imminent opening of the co-located midwifery-led unit on the Royal Preston Hospital site as part of the maternity strategy.

Governance, risk management and quality measurement

- The service had robust governance and quality systems in place.
- Monthly and weekly governance meetings had a set agenda with certain standing items, including the review of incidents and monitoring of the maternity dashboard. 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 maternity service monitored all its risks and had a local risk register. The service also reviewed relevant national guidance published each quarter to ensure that they were assessing themselves in line with appropriate current national standards.
- We saw several examples of good leadership by individual members of medical and midwifery staff throughout the service that were positive role models for staff. The quality and governance midwives together with the consultant midwife role were highlighted by staff as key leadership roles for the service.
- Staff told us that they attended regular meetings and that their immediate line managers were accessible and approachable. One staff member told us that they appreciated the Chief Executive's online blog and felt that she was visible in the hospital.
- Several staff members told us that the service lead for midwifery and other management roles had been covered by a temporary or 'acting role' for over 18 months, which they believed led to a feeling of uncertainty in the service.

Culture within the service

- There was a positive learning culture among the midwives. The staff acknowledged the recent challenges about staffing but felt that managers were aware of the issues and had tried to recruit more staff.
- 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.

Public and staff engagement

- Although we noted that the service had a Maternity Services Liaison Committee, we did not see evidence of any other formal meetings or forum to engage with members of the public about the maternity service. One patient told us that they had not been aware of the new unit at Preston.
- Staff told us that they felt engaged as part of the trust and felt that the senior managers were aware of the issues within the services.
- They had engaged with service users about the DoH bids for birth environment and improving services for women with mental health issues staying in hospital and families suffering the loss of a baby on delivery suite. They had also engaged with service users on midwifery research ideas and digital hand held record.

Innovation, improvement and sustainability

- We found that the service had an improvement culture. We saw several examples of research trials the service was involved with, including projects looking at inductions and on strategies to reduce stillbirth.
- The service was externally facing and was actively collaborating with other centres to carry out further research.
- We found that the service had attained several accreditations such as the Clinical Negligence Scheme for Trusts Level 3 and Beacon Ward status. In order to be designated a Beacon Ward, a series of performance measures and quality assurance checks, directly related to the quality of care provided for patients, had to be achieved.

Services for children and young people

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

Information about the service

Ward 8 had an agreed capacity of 30 paediatric acute beds for children and young people aged 0 to 16 years, which are available 365 days a year and provided a 24-hour emergency service and elective inpatient care. The ward included a designated paediatric assessment unit (PAU) and a two-bedded paediatric high dependency bay.

The neonatal unit had provision for 28 inpatients incorporating seven dedicated intensive care cots, six high dependency cots and 15 special care cots. The unit worked in close collaboration with the women's health division to coordinate appropriate admissions. The neonatal unit was part of the Lancashire and South Cumbria Network providing Neonatal Intensive Care (Level 3). Together with East Lancashire Hospital Trust, Lancashire Teaching Hospital provides Lancashire and South Cumbria Neonatal Transport Service.

The children's outpatients department provided a dedicated paediatric outpatients service across both Royal Preston Hospital and Chorley District Hospital for children aged 0 to 16 years. Royal Preston Hospital clinic had a child friendly environment and was working towards the new NHS Outcomes Framework.

The play service consisted of two play specialist and two nursery nurses; both the play service and team had developed over the last six years. The play service extended to the neonatal unit, the children's out patient's clinics, ENT department, orthopaedics, day case unit and the general surgery clinic.

Summary of findings

We spoke with 10 parents and their children and 22 members of staff including nurses, doctors, consultants, senior managers, allied health professionals and domestic staff. We observed care and treatment and reviewed 13 care records. We took into account comments from our listening events and from people who contacted us to tell us about their experiences. We considered performance information about the trust.

The child health directorate provided services that were safe because of the systems in place and the conduct of staff protected children and young people from avoidable harm and abuse. However, medical staffing levels may have led at times when there were delays in treatment. The effectiveness of the service required improvement because the skill mix of staff was not at a high enough level to provide effective care and support for children accessing the PAU and the neonatal unit.

We saw staff treat children, young people and their guardians with kindness, dignity and respect by staff, meaning that they experienced a good standard of care and compassion. The trust's responsiveness and leadership within the child health directorate was good because plans were in place to develop the service and these plans were influenced by the results of checks made and feedback from children, young people and their guardians. Staff working for the trust maintained positive and effective relationships; staff were involved in developing plans and aware of the progress in bringing about positive change.

Services for children and young people

Are services for children and young people safe?

Requires improvement

In most aspects of care the child health division provided safe care. Incidents were reported and learning occurred, incidents and investigations were discussed within a wide range of departmental meetings across the Directorate including: weekly IR1 meetings held in both neonatal and paediatrics, weekly team leaders meetings for both paediatrics and neonatal, weekly SMT meetings, monthly clinical governance and clinical audit meetings, monthly neonatal ops meetings and fortnightly core management meetings. All of these meetings were regularly attended by the clinical governance and Risk Manager who provides regular updates.

There were policies and procedures to promote safety and wellbeing (including medication management, escalation, emergency care and protection from cross infection) were in place and were followed by staff. We saw there were robust safeguarding protocols in use to protect children and young people from abuse. Multidisciplinary working meant that children received the correct support from the most relevant professional.

Although PAU operated a triage system to ensure the most poorly patients are identified and treated quickly, we were concerned that the staff shortages meant that some less poorly children experienced long waits before they were examined by a doctor and were at risk of experiencing a delay in treatment. Plans were in place to address this risk.

We saw the risk register also highlighted the issue of children and young people with mental health needs leaving the ward and hospital unescorted The risk register also highlighted the issue of CAHMS patients absconding from the ward. There have been 30 Datix reports for adolescent patients absconding from the ward since July 2012. Measures had been taken to reduce the frequency of these events.

There were insufficient nurses trained in advanced paediatric life support to provide one for every shift as per best practice guidance.

The PAU staffing figure was below the Royal College of Nursing recommendation of two qualified nurses for assessment units and was a cause for concern because of the length of time some children and young people had to wait to be seen by doctors. The risks associated with inadequate staffing in the PAU were included on the ward and the trust's risk register, and there was evidence that action was being taken to improve the situation by employing advanced nurse practitioners and supporting staff to complete the advanced nurse practitioner qualification.

Incidents

- Incidents for this service were reported to the trust's auditors through the electronic incident reporting system, Datix.
- All risks were reviewed at both neonatal and paediatric meetings weekly and by the clinical governance and risk manager for the child health division, who met with other division risk leads to review all incidents weekly. However, we reviewed the notes for the team leaders meeting for 30 June 2014. This record showed that incidents and the Datix reports were not discussed at the meeting.
- The Directorate produces its own lessons learned on a regular basis in response to medication errors and these are circulated directly to all child health staff as required for learning from incidents.
- We discussed the management of incidents with nursing and medical staff of all grades working in paediatric outpatients, on the children's ward (ward 8) and in the neonatal unit, and all confirmed that they were able to enter data onto the system and had received training.
- The Datix incident report records provided by the trust for January 2014 to July 2014 showed 367 incidents had been reported for the directorate.
- The vast majority of incidents reported (357 out of 367) were categorised as 'low risk' or 'no harm'.
- Incidents recorded included falls, ineffective communication, medication issues, problems with equipment and staff shortages.
- The Datix record showed that senior managers actively managed and reviewed incidents and this sometimes included re-categorising incidents to ensure that they were dealt with appropriately.
- The incident reports confirmed that immediate action was taken to deal with individual incidents and plans were put in place to reduce the risk or monitor the effectiveness of the action taken.

- The incident report updates showed that additional intervention was planned if a trend was identified, for example the trust contacted the manufacturers of equipment when this was found to be the common factor in relation to a repeated type of incident.
- These findings demonstrated that there was an open culture; staff were able to report incidents so that the correct action could be taken to reduce the effect of the incident and prevent recurrence.
- We saw that although most incidents were described in full there were occasions when the information lacked detail.
- The trust provided newsletters to show how lessons were learned from incidents. We reviewed the previous five Medicine Matters Newsletters published in March 2013, September 2013, December 2013, Issues 1 2014 and Issue 2 2014. None of these provided information to staff about lessons learned and changes made to improve safety specifically within the child health division.
- We received the report from the Child Health Clinical Governance & Clinical Audit Meeting held 20 May 2014 that demonstrated that prominence was given to discussing incidents and ensuring that they received consideration and were subject to discussion.
- The incidents were reported according to their category. This information may have been more valuable if comparative figures had been provided and more comprehensive information about the action taken or plans in place to reduce the risk of recurrence.
- The items discussed also included reported incidents and progress towards dealing with issues on the child health risk register.
- We reviewed three lessons learned bulletins that had been distributed to staff, but these were not dated. The information clearly described the incident; what had been done well and the required improvements and instructions to reduce the risk of reoccurrence.

Safety thermometer

- The safety thermometer we were given for the child health directorate was inaccurate and did not reflect the information provided in the incident data recorded through the hospital's Datix system.
- The thermometer suggested that for the same period no incidents concerned with medication had been reported, but we saw that at least 10 had been reported. This indicates that there was a problem that meant that auditors were not fully aware of the ward's performance in relation to current safety issues and the importance of diligence in following the prescribed protocols and policies in these high risk areas.
- At a local level we saw the result of audits displayed on the ward 8b/c and the neonatal specialist care baby unit were more accurate.
- For example, these audits did show a true reflection of the information provided by the incident reporting system.
- We saw that plans were put in place to achieve 100% compliance in particular risk areas such as educating parents and children with regards to hand hygiene.

Cleanliness, infection control and hygiene

- The trust's most recent Quality Annual Report for Child Health, dated June 2013, stated that between June 2012 and June 2013 there had been no cases of MRSA and one case of C. difficile, which investigations confirmed as unavoidable.
- In the trust incident reporting data provided for January 2014 to July 2014 there was one report of MRSA bacteraemia and no report of C. difficile. The information provided to the Child Health Clinical Governance & Clinical Audit Meeting held on 20 May 2014 stated that MRSA colonisation had been identified in the neonatal unit during April. However, records confirmed that good practice guidelines were followed, including isolating the patient, use of personal protective clothing and use of the correct prescribed medication and other treatment. All staff were checked for MRSA colonisation and hand hygiene audits were increased. The reason for the infection was fully investigated but the outcome was not available at the time of this inspection. These findings showed that the trust had systems in place to protect children and young people from infections by taking robust and effective action to discover if children and young people carried an infection and using effective systems to guard against the infections spreading.
- We observed that effective hand cleansing systems such as hand rubs; hand wash basins with liquid soap gel and paper towels were readily available.
- All the staff we observed adhered to hand hygiene guidance and used hand gel or washed their hands when entering or leaving an area and between patients.
- The children's wards, outpatients and neonatal unit were all visibly clean.

- Staff we observed adhered to the trust's key infection control policies concerned with hand hygiene, personal protection equipment and use of isolation rooms.
- All staff entering the wards and other clinical areas adhered to the bare below the elbow policy.
- The toys and play areas were clean and we saw that each area included cleaning and checking toys in their cleaning schedule.
- Staff followed the trust-wide policy 'Prevention of infection guideline for the use and care toys and play equipment'.
- Staff in specialist outpatients departments such as ENT and Ophthalmology took responsibility for ensuring that toys in their departments were non-porous and clean.
- All the toys we saw throughout the inspection were clean and intact.

Environment and equipment

- We reviewed the resuscitation equipment in all the areas we visited and saw from the equipment and medication checklists that each paediatric resuscitation trolley was complete and contained the equipment and medication recommend by the Resuscitation Council UK Guidelines 2010.
- Signed and dated checklists confirmed that all equipment and machines in use were checked at least daily to ensure all were complete and intact.
- All of the equipment checked had stickers confirming when they had been checked and calibrated by the relevant technician, in keeping with the manufacturer's recommendations.
- This showed the trust had a system in place to promote safety because steps were taken to ensure equipment available to staff was in good condition; complete and intact so that it was readily available in an emergency and gave accurate readings for staff to interpret.
- Handover reports and observation confirmed that the checking of equipment in the neonatal unit was particularly robust because this involved a full check of all equipment for each individual baby as a part of the transfer of care from one nurse to another at each shift change. This occurred three times each

Medicines

- Medication in all the areas we visited was stored securely in locked clinical rooms and cabinets, in keeping with the Royal Pharmaceutical Society's guidance.
- We reviewed 10 medication record sheets and found that all medication had been given correctly in each case.
- The medication records had been signed and dated as given.
- Medication management was audited and action taken to investigate and remedy discrepancies.
- The Datix report showed that 51 incidents were reported between January 2014 and July 2014, demonstrating that that staff adhered to the Royal Pharmaceutical Society's code of conduct requiring pharmacists and those working with medicines to report concerns in a 'candid, transparent and open way'.
- Of these incidents, 49 were presented as low risk. All of the incidents were investigated and remedial action taken to prevent a reoccurrence.
- Medication management was included on the risk register for the child health directorate and records showed that the effectiveness of the improvement plans were reviewed at team meetings and management meetings.
- The trust had introduced 'double checking' as a policy change to reduce the number of medication errors so that two nurses were required to check all medication to be administered, and the check included reviewing the dose and route of administration.
- The directorate had produced a comprehensive audit report and improvement plan 'Medication Risk Management – Prescribing Errors (2013/14)', which targeted the main area for improvement.
- Information provided by the hospital did not indicate how effective the plans had been or the progress made with respect to completing the action plans.

Records

- We case tracked the care of 13 children and young people and found that their records provided a complete picture of the care and support provided.
- Information included the time they entered the hospital, the treatment received, advice provided and the names of the doctors and nurses who attended to their needs.
- Appropriate standardised care pathways were in use, in keeping with the relevant NICE clinical or nursing guidance.
- Reports were well written and filed neatly. Information was easy to find.

- Discharge plans were detailed and confirmed that discharge letters to GPs and referral letters to community services were prepared ready to be sent without delay once discharge had occurred so that care continued seamlessly.
- The hospital was moving to a 'paper-lite' system and all records were being scanned into a computerised data management system.
- This was a relatively new system that was being closely monitored and included on the trust's risk register so that initial problems could be reviewed and dealt with quickly.
- We reviewed how this system was operating in the children's outpatients department and found that it enabled effective communication with regard to letters being sent to GPs, or referrals to the health visitor or school nurse.
- The outpatients manager said that the new system was very helpful because she could see at a glance the up-to-date information about a patient.

Consent

- Consent forms we looked at provided a space for children and young people to give consent to their care and treatment or confirm that this had been explained to them.
- The 13 case files we reviewed held documents that confirmed that consent forms had been completed correctly and as appropriate.
- Children and young people we talked with said they understood what the doctors and nurses had said about their treatment.
- Nine children and young people or their parents informed us that both doctors and nurses made an effort to talk with them and explain things in a manner that was understandable and reassuring.
- Records showed and comments confirmed that the nurses involved children and young people in producing their management plans.
- Children and young people told us that they had been able to talk to the doctors on their own because this option had been offered them.
- These findings demonstrated that appropriate guidelines were followed in relation to providing information, gaining consent and promoting the privacy of children and young people attending the child health division.

Safeguarding

- There was a dedicated safeguarding team consisting of a lead safeguarding nurse , sister and administration staff.
- Records confirmed that robust policies and protocols were in place to ensure that any concerns were followed up and to promote effective multidisciplinary working between all hospital departments and community-based statutory services including the GP, health visitors and school nurses.
- We saw that 'Safeguarding' was the home page on the computer on ward 8, which made it readily accessible to staff.
- All areas of concern were referred to the safeguarding team for follow-up.
- The most frequent referrals were from the outpatients department for children who had not attended or regularly missed outpatients appointments. These children were followed up through telephone calls and contact with community services.
- Staff also referred children from the PAU when parents left with their children before they had been examined by a doctor.
- Although the safeguarding lead confirmed that almost all of the time this was because the parents had felt their child had improved while waiting, it was policy to follow up these children with a phone call encouraging attendance.
- The safeguarding nurse visited ward 8 every day and completed a safeguarding checklist reviewing the potential safeguarding need of each patient with the ward coordinator.
- The safeguarding team was responsible for providing mandatory safeguarding training. The Trust provides child protection training as awareness (trustwide currently 90%, child health 98%) Level 1(trustwide 67%, child health 94%) Level 2 (trustwide currently 75% and child health 86%) which equates to the intercollegiate levels of 1, 2 and 3. Therefore, direct care staff receive relevant child protection training. The safeguarding team provides the Level 3 training (trustwide currently 75%, child health 86%) in the mandatory training days for midwifery, neonates and child health. There is a requirement for identified requiring Level 3 to attend an annual face to face update facilitated by the child

safeguarding team. We were informed that the training contents, which included scenarios and completing a workbook, met the requirements to be classified as 'level 3'.

- We were informed that that the trust was in the process of considering using volunteers to work on the children's wards and a volunteers handbook was in the draft stage and required formal approval by the trust management team.
- The risk register highlighted the issue of children and young people with mental health needs leaving the ward and hospital unescorted but this was not reflected in the Datix information or highlighted as a major safeguarding concern.
- We were told by staff that the number of children and young people admitted to the ward was an issue, as was the number who attempted to leave the ward or hospital unescorted, All patients who abscond from the ward were logged onto the Datix system as patients missing/absconded. There had been an issue around adolescent CAHMS patients and there had been 30 Datix reports for these patients absconding from the ward since July 2012. This remained on the risk register and was regularly reviewed. There was also the Missing Persons Policy with good practice taken from PAN Lancashire Missing from Home Protocol. The safeguarding team are alerted to all absconsions and work in collaboration with the clinical governance team and external agencies including social care. The LSCB has been made aware of these cases and a review of the CAHMS service.
- Action taken to reduce the level of unescorted leaving included use of agency staff from a specialist mental health agency and increased security at the main door.

Mandatory training

- We requested information about mandatory training completed by nurses and doctors working in the child health division.
- The trust provided an action plan and description of the planned training for staff.
- Information available about staff training at ward level showed that all established staff had completed Intensive Paediatric Life support training and those whose training was about to expire were booked onto the course.
- There were insufficient nurses trained in advanced paediatric life support to provide one for every shift, as stated in the Royal College of Nursing guidance.

Management of deteriorating patients

- The service used a Paediatric Early Warning assessment tool to score routine observations and give an early indication that additional medical intervention may be required.
- Paediatric Early Warning assessments had been completed in all 13 care pathways we reviewed.
- The observations had been completed as frequently as required, depending on the reason for admission.
- For example, records confirmed that on return from theatre these observations had been completed every 15 minutes.
- Nurses explained the process of reviewing the scores and the guidelines followed for alerting medical or senior staff to changes in the score that indicated a child's health was deteriorating so that remedial action could be taken promptly.
- Emergency care protocols were well embedded and the emergency response team could be summoned quickly through use of a dedicated telephone and call system.
- Staff told us about the process for calling for assistance in an emergency.

Nursing staffing

- Ward 8 is a 30-bedded unit divided into three areas and nurses were allocated to each area.
- Area 8a was the day ward, with seven beds for medical and surgical day cases. This was set out in two bays of three and one side room. This area was allocated staff according to the day list.
- Areas 8b/c was for inpatients and set out in three bays with capacity for four beds each and 10 single rooms available. One additional bay was also set up as a High Dependency Unit.
- The third area was the PAU that included two assessment rooms, treatment room, a waiting room and a four-bedded bay. The PAU could be used by up to 12 children at different stages of treatment or review.
- There were four different shift patterns to cover 24 hours: 'Long days', 7.30am to 8.30pm, which was worked by the ward coordinator who provided continuity between the shorter shifts; 'Earlies', 7.30am to 3.30pm; 'Lates', 12.30pm to 8.30pm; and 'Nights', 8pm to 8am.

Services for children and young people

- Nurses told us that the trust did not use an established acuity tool to decide the number of nursing staff but used local guidelines based on 'The Professional Judgement calculator'.
- The rota showed that the planned staffing establishment for the ward was one senior nurse on a 'long day' 7.30am to 8.30pm, plus nine qualified nurses and one healthcare assistant for an early shift 7.30am to 3.30pm, and eight qualified nurses and one healthcare assistant from 3.30pm to 8.30pm and overnight.
- Taking the ward as a whole with 30 beds, the staffing establishment was within the Royal College of Nursing minimum essential requirements for general children's wards of one nurse to three children under two years old and one nurse to four children over two years old.
- However, this establishment did not take into account the demands of PAU and level of observation required for day cases and the possibility of children requiring close observation on the High Dependency Unit.
- Ward nurses stated the ward was busy at times, but they were able to meet the needs of children who were inpatients.
- The shift coordinator discussed staffing needs each day and extra staff were provided through regular staff working extra shifts.
- We reviewed the nursing rosters for ward 8.
- The PAU had four beds and was generally staffed by two nurses and a healthcare support worker although at times this had been reduced to one nurse based on patient acuity across the rest of the ward. This figure was however below the Royal College of Nursing recommendation of two qualified nurses for assessment units.
- Staff we talked with said that the PAU was the busiest area and a cause for concern because of the length of time children and young people had to wait to be seen by doctors.
- Senior staff and ward staff were aware that this was a risk because children were not seen quickly enough by a doctor and parents were 'self-discharging' before an examination by a doctor.
- The risks associated with inadequate staffing in the PAU was included on the ward and the trust's risk register and there was evidence that action was being taken to improve the situation by employing advanced nurse practitioners and supporting staff to complete the advanced nurse practitioner qualification.
- Staff we talked with identified that employment of advanced nurse practitioners in this area would be a substantial improvement because patients could be reviewed, treated and discharged or admitted by advanced nurse practitioners, which would reduce the wait for care and treatment in a significant number of cases.
- Review of the ward rosters planned between 7 July 2014 and 3 August 2014 showed that during this time it was rare for the ward to be staffed at the established figure of nine qualified nurses during the day and eight at night.
- The nurse in charge told us that gaps were always filled by their own staff or regular replacement staff from the hospital.
- The matron informed us that there was a recruitment drive to employ additional nurses and this had been effective so far.
- These findings showed that the nursing establishment could be improved possibly because figures were not based on an acuity tool. However, there was an effective protocol in place for accessing additional staff when required.
- We visited the neonatal unit and saw that babies were been supported one-to-one or two-to-one to meet their assessed needs and in keeping with best practice guidelines.
- There were nursing vacancies on the neonatal unit and senior staff and the unit manager stated that the recruitment process was well underway.
- The unit provided 28 beds divided into seven intensive care beds; six high dependency beds and 14 special care beds.
- According the British Association of Perinatal Medicine best practice guidance, when the unit was full it would require 14 qualified nurses per shift. This guidance recognises that units do not employ staff on the basis of 100% occupancy and so would expect 12 suitably qualified staff to be on duty.
- Records and rosters confirmed that following recruitment the unit would achieve 10 qualified staff on duty. This is significantly below British Association of Perinatal Medicine recommendations.
- This issue was highlighted to senior managers through the risk register and business plans were in place to increase the established number of staff by 12 neonatal nurses.

Services for children and young people

- We saw effective planning in relation to providing sufficient and skilled staff to meet the needs when there was a surge in the number of babies who required one to one care, for example in the care of multiple birth babies.
- An escalation policy was in place to reduce the risk of children and babies being accepted or sent to the ward or unit if there were insufficient staff. Lack of nursing staff or skilled staff was recorded as an incident to ensure that senior managers were aware of the risks.
- Between January 2014 and July 2014 there were 12 reports about the availability or skill mix of nursing and all of these were assessed as 'low risk'.
- This meant that there were concerns raised approximately two shifts per month.
- Staff said that they could not recall the children's ward or neonatal unit being closed, although there had been occasions when they had reduced the number of beds.
- The children's outpatients department was well staffed. Two qualified nurses and one healthcare assistant were on duty to assist with booking in and chaperoning children and their parents during their appointments.
- Parents told us that the wait period to be booked in by the nurses on duty and seen by the doctor was usually within 15 minutes of their appointment.
- We observed effective handover processes between staff in all of the areas of child health that we visited.
- The hospital used the 'Situation, Background, Assessment, Recommendation' protocol for handovers in keeping with NHS Institute for Innovation and Improvement guidelines.
- There were written notes and records to support information provided during the verbal handover.
- The ward coordinator conducted regular 'ward roundings' and filled in a check sheet report outlining the condition of each child and safety issues during their shift.
- The community nurses were situated in offices adjacent to the children's department and so communication could be effective and referrals made quickly.

Medical staffing

- There was a consultant paediatrician of the week available on site Monday to Friday from 9am to 5pm. On Monday and Wednesday the consultant paediatrician of the week was available on site until 10pm.
- The roster confirmed that there was consultant paediatrician available on call for out of hours, which meant there was access to a consultant 24 hours a day.
- We also found two occasions when children in the PAU were not seen by a middle-grade doctor within four hours of entering the unit. This meant that best practice guidance had not been met.
- One patient also said that they had experienced a delay in receiving effective pain control for a significant period of time during the weekend because the nurses could not get a doctor to attend and prescribe painkillers.
- Records confirmed that each child was reviewed by a consultant every 24 hours during the week, although this did not always happen over the weekend.
- With regards to emergency surgical procedures, we saw that children were reviewed frequently by the doctors and emergency operations took place promptly.
- Medical handovers were conducted twice a day and these were attended by the medical team; the shift coordinator and ward liaison worker who acted as a conduit between patients, hospital workers including ward nurses, doctors, allied healthcare professionals, social workers and the community nurses employed by the trust.
- Medical rosters for April 2014 confirmed that there were separate rosters for the neonatal unit and the children's wards; this met with good practice guidance.
- We assessed the number of times in April 2014 that locum doctors were used to cover shifts when permanent doctors were not available.
- The roster for the children's ward showed that locum registrars were used to cover 14 shifts. These 14 shifts were generally covered by the same three doctors.
- The rosters also showed that there was always an established registrar on duty during these periods.
- No locum doctors had been used to cover the shifts of senior house officers or consultants.
- All locum cover on the children's ward had occurred during the 9am to 9pm day shift.
- The roster for the neonatal unit showed that locum senior house officer grade doctors were used on 12 occasions and on one occasion both doctors on the roster were locums; locum registrars were used on six occasions.
- The roster confirmed that these shifts were generally covered by the same four doctors.

- We also noted that 10 out of the 18 periods when locums were used were during the 9pm to 9am night-time period.
- Staff reported three incidents concerning medical staff between 7 January 2014 and 7 July 2014.
- The records showed that the trust's escalation policy was used to good effect and on two occasions additional senior medical cover was provided to ensure the needs of very sick children were met.
- There was one occasion when it was not possible to cover one senior house officer session. This was recorded as a 'no harm' incident.
- These findings showed that locums were used regularly by the service to ensure the required number of doctors were available.
- The roster indicated that these were usually the same doctors who were familiar with the running of the hospital and locums almost always worked alongside doctors who were employed by the hospital.

Major incident awareness and training

- The trust had a major incident plan for each directorate, including child health. This plan had been reviewed in January 2014 and was up to date.
- All staff were expected to read the plan. However, as a safety precaution, at the front of the plan staff are instructed to go the action card relevant to their role and division.
- We saw that action plans for the child health directorate provided clear and succinct instructions for staff to follow in the event of an incident.
- The action plans were specific to different roles and level of responsibility and identified the person responsible for leading and coordinating the responses to a major incident.
- There were four high dependency beds on the neonatal wards, but equipment was available to adapt these to neonate intensive care beds if necessary.
- Records showed that 77% of eligible staff throughout the directorate (55 out of 73) had completed advanced paediatric life support training and 83% of eligible staff (55 out of 66) had completed the more in depth paediatric intensive life support training.

Are services for children and young people effective?

Good

The child health division provided effective care and treatment because treatment was evidence-based and children achieved good outcomes. Innovative plans of care and treatment were provided and the division ensured care was based on best practice guidance and they participated in the required clinical audits. This meant that the effectiveness of treatment was compared with national and local standards so that areas for improvement could be identified. Effective multidisciplinary working took place.

Readmission rates within 28 days of discharge for children aged 0 to 14 years was 11.91, which was worse than the national average of 10.09. The service suggested that this could have been because of the complexity of treatment required on the neonatal unit.

Evidence-based care and treatment

- We found that the trust provided care and treatment to children and young people following evidence-based guidance. For example, the outpatients department used growth charts for children with Down's syndrome based on guidelines from the Down's Syndrome Medical Interest Group and Royal College of Paediatric and Child Health.
- Information provided was based on best practice evidence; for example, the leaflet about dealing with diarrhoea and vomiting was based on NICE clinical guideline 84.
- The clinical guidelines in use were up to date and met the relevant good practice guidance. Guidelines reviewed were:

- Diabetic ketoacidosis: local guidelines reviewed in 2014 and found to be in line with national guidance from the British Society for Paediatric Endocrinology and Diabetes.
- Urinary tract infection: local guidelines updated in 2014, which were in line with NICE guidance.
- Bronchiolitis: local guidelines updated 2013, which were in line with national Scottish Intercollegiate Guidelines Network guidance 91.

- The trust's Department of Clinical Audit and Effectiveness reviewed compliance with NICE guidelines and the participation in national audit completed by the child health division.

Services for children and young people

Pain relief

- We reviewed the nursing and medical records for 10 children and saw that when appropriate pain charts were used.
- The charts were appropriate for the age of the children and used formats to help children describe their level of pain as accurately as possible.
- Children and young people mostly told us that their level of pain was checked and they were given pain relief as required.
- The trust checked the effectiveness of pain management in the child health division by completing ECAP pain control audits.
- The results for this audit showed that 100% success was reported with regards to pain management in April, May and June 2014.

Nutrition and hydration

- Mealtimes on the children's ward were well managed and staff were summoned to begin preparing children and young people for their meals 15 minutes before food arrived on the ward.
- The menu choices included a variety of hot meals, vegetable and salads, and also options for children with cultural and religious requirements.
- Snacks and drinks were available so that extra food and drink could be offered.
- Baby milk was available on the ward and this was distributed by nurses; a variety of formulas were available.
- Records confirmed that children on the PAU were provided with meals and drinks at regular intervals, depending on their symptoms.
- On the neonatal unit a designated special milk fridge and freezer were used for mothers to store expressed milk. Milk was clearly labelled and the fridge was clean. Records confirmed that the fridge was kept to a safe temperature.
- The trust took innovative steps to promote and assess sucking and swallowing reflexes during the neonatal period by employing specialist speech and language therapists. They could assess and provide advice and support to parents with regards to feeding during this time.
- Our specialist adviser assessed that speech and language therapy input at this early stage was likely to improve the long-term outcomes for these children.
- This provision of a speech and language therapy service at this early stage was considered to be outstanding practice.

Patient outcomes

- The clinical audits included outcomes regarding epilepsy, intensive care, asthma, diabetes and pneumonia.
- We saw a sample of the audits and action plans, which showed that the division's performance varied compared with the averages for other child health services in the North West or England and Wales. For example:
- The findings for the National Neonatal Audit Programme 2012 showed that the trust performed in keeping with national findings.
- The results for the National Paediatric Diabetes Audit published in December 2013 were slightly worse than average for England and Wales.
- The National Asthma Audit results for 2013 were better the than national average.
- Action plans were in place for each of the audits completed regardless of whether performance was better or worse than average. This meant that the trust was proactive in taking steps to continually improve the effectiveness of the services provided to babies, children and young people.
- The trust reported in their 'Ward Average Length of Stay data 2013–14' that between April 2013 and end of March 2014 the average length of stay for children on ward 8 had been one day. This indicated effective care because this was better than the national average of 3.1 days.
- In the Quality Account 2013–14 the trust reported that readmission rates within 28 days of discharge for children aged 0–14 years was 11.91; this was worse than the national average figure of 10.09. The trust suggested that this could have been because of the complexity of treatment required on the neonatal unit.
- For children aged 15–16 the rate for the trust was 11.06. This was slightly better than the national average of 11.88.
- Records confirmed that an action plan was in place to reduce these figures further.
- Medical staff confirmed that the trust was keen to provide evidence-based care. A junior doctor said: "Everybody does an audit and I have seen improvements as a result of audits."

Services for children and young people

Competent staff

- The Appraisals Summary for June 2014 provided by the trust showed that 92% of staff (209 out of 227) within the child health division had received appraisals and were up to date.
- Nursing staff stated that opportunities for continual professional development were provided.
- However information about training provided by the trust did not give enough detail about the training completed by staff to confirm this.
- Medical staff described in detail the learning opportunities provided by the trust, but information to confirm the training received from the child health directorate was not available.

Facilities

- The day surgery pre- and post-operative facilities needed to be improved for children and young people because the main waiting area and entrance was used by adults and was not child-friendly.
- For privacy, children were prepared for theatre in the women's waiting area and this space was very cramped with no reassuring images or toys or other items to use for distraction.
- Parents were able to go through to the anaesthetic room with their child.
- The recovery room post-operatively was a children-only environment.
- Day surgery nurses said there were plans to develop a more child-friendly environment in a large room that had recently become vacant. This plan was repeated by medical director for child health and the child health division matron, but no timescales for completion were available.
- The pre-operative day unit was not ideal for children because it was enclosed and the corridor between the changing room and the anaesthetic room was dark, narrow and bleak. This could be frightening for small children. The trust should consider reviewing the décor and furnishings in this area.

Multidisciplinary working

- The trust had employed a comprehensive range of clinical specialists and allied healthcare professional to promote effective healthcare and support to babies, children and young people.
- Specialists working exclusively for the child health division included a psychologist to work with children and young people as a part of the diagnostic and treatment process when diagnosing certain conditions such as ongoing headache or dizziness and other symptoms.
- Other allied health professionals included a speech and language therapist, occupational therapist and dietician.
- The trust employed a team of play specialists to help prepare children and help them understand the reasons for their hospital admission; play specialists provided distraction therapy; and the play and 'chill-out' areas offered a place where children and young people could relax away from their bedside.
- The play specialist team held bleeps so they could be asked to provide a service to children wherever they may be in the hospital.
- Action taken to promote effective multidisciplinary working included the employment of a paediatric liaison officer to work closely with the safeguarding team and act as a conduit between patients and parents; safeguarding staff; the hospital doctors; and community staff such as health visitors, school nurses and GPs. They also worked closely with other specialist teams in the hospital such as the alcohol liaison team when required.
- Effective multidisciplinary working was promoted by having the allied health professionals teams situated in offices adjacent to ward 8, so each was accessible and staff were known to each other.
- The trust had a transfer of the sick child protocol and this was fully understood by staff in all the areas of the child health division visited.
- Staff on the ward were aware of the process for using the North West and North Wales Paediatric Transport Service for children who required critical care.
- The Neonatal unit was part of the Lancashire and South Cumbria Network providing Neonatal Intensive Care (Level 3). Together with East Lancashire Hospital Trust, LTH provides the L&SC Neonatal Transport Service. The transfer pathway and protocol was on display in the ward area and staff offices.
- Transfer notes confirmed that there was a well-rehearsed and effective process in place for transferring children from Chorley and South Ribble Hospital to the PAU on ward 8 at Royal Preston Hospital.

- This process was important because parents and relatives continued to take children to Chorley Hospital even though there was no paediatric accident and emergency service at that hospital.
- Transfer was arranged by private ambulance or an emergency ambulance would be summoned if required.
- There was a transition to adult service for children and young people with diabetes. This was managed through the outpatients department.
- The General Manager also told us that "Lancashire Teaching Hospitals NHS Foundation Trusts has been successful in being part of the Advance in Quality Alliance programme. This was to develop a model for paediatric transitional care, network-wide for long-term disability, cerebral palsy, epilepsy and diabetes. The Consultant lead for this has also been successful in becoming the clinical lead for the Strategic Clinical Network for transitional care. This will give the trust the opportunity to lead in this area for the region."
- Until this is fully embedded, transition will be managed on a case-by-case basis with the support of outreach workers and the paediatric liaison officer.
- A Children and Adolescent Mental Health Service paediatrician was available Monday to Friday 9am to 6pm and a paediatric psychiatrist was available at all times through an on-call system.
- The trust had a service level agreement with a specialist mental health nurse agency called Paramount. This service provided staff for one to one and occasionally two to one support to children and young people with mental health needs if this was required.
- The Child and Adolescent Mental Health Services team did not operate at weekends and so, unless the concern was urgent, a mental health assessment would be delayed if the young person was admitted on a Friday evening. This issue was highlighted on the child division risk register.

Seven-day services

- The duty roster showed and staff confirmed that paediatric cover was not available on the hospital site 24 hours a day, seven days a week.
- The duty roster confirmed that paediatric consultants were always on-call overnight and at the weekend.
- Records showed that there could be delays in tests being completed over the weekend, although rosters leaflets and lists confirmed that all departments had on-call staff who could be called in if the situation was urgent.
- The ward had access to an out-of-hours pharmacy service and so medication changes could be quickly fulfilled.
- The team leader for play staff is working with the trust's volunteer organiser to develop a team of volunteers who will provide play sessions over weekends.
- These findings meant that systems were in place to provide the required services out of hours based on risk.

Are services for children and young people caring?

Good

Care provided at Royal Preston Hospital for children and young people was caring and compassionate. Staff spent time with children and young people to make sure they understood the care they were to receive and processes were in place to ensure children and young people received written information about their condition.

Surveys completed by children and young people and their families stated that staff were kind, thoughtful and compassionate and those people we talked with during the inspection confirmed this.

Compassionate care

- The children's ward participated in the Friends and Family Test. The results were not displayed, but the minutes of the Child Health Clinical Governance & Clinical Audit Meeting held on 18 March 2014 stated: "Friends and family test for March was 91% which shows improvement" and "feedback from parents from both areas 225 'excellent' for paediatrics and 179 for neonatal; 182 'good' for paediatrics and 11 for neonatal and 15 and three 'satisfactory'. There were no 'poor' responses."
- We observed nurses completing satisfaction questionnaires with children who were being discharged.
- This was through an electronic system using a handheld device that presented questions in a format appropriate to the age of the child or young person.

- The play specialist team leader told us that changes made as result of questionnaires included changing the way in which meals were presented and arranging a longer period of free television with the company who provided bedside television.
- The children's outpatients department had completed a comprehensive patient satisfaction audit with children and their parents during 2013/14.
- Children attending the outpatients reported that staff were caring, friendly and pleasant.
- Families with babies on the neonatal unit had access to a family support worker with specialist training, who provided support and assistance in whatever area of need required.
- Examples of assistance provided included support with dealing with the Benefits Agency; family counselling; organising accommodation and additional support to families who live a distance from the hospital.
- Parents felt happy to leave children alone on the ward because play workers were given a bedside handover and a named nurse was introduced at every shift.
- All the interactions witnessed between patients' parents and staff were compassionate and helpful. For example, nurses took time to sit and explain the reason for certain tests; rang through to pharmacy to 'chase up' discharge medication; or responded to requests, such as for drinks.
- Children and parents told us they had been treated with compassion. Comments included: "Care has been great – could not have been better even if we had gone private we would not have had care as good as this" (Parent on neonatal unit); "Everyone is really lovely, nurses update you with what's going on and they handover to the next nurse on duty so you get to meet them and I know that they know about (patient)" (Parent on ward 8); "I have had games and puzzles provided and have been to school which I enjoyed" (Patient on ward 8).

Patient understanding and involvement

- Staff made sure that children and young people and their parents were involved in planning the care provided.
- Children and parents described very open dialogue and information sharing; for example, "Information has been timely and there is enough … We know what to expect. Easy access to doctors for any questions, we have had leaflets and explanations that were helpful … nothing we want to improve" (Parent on neonatal unit).
- The neonatal lead consultant explained the process of transfer from the neonatal unit to general paediatrics. "We have introduced open access to the PAU and show parents around and explain what to expect."
- Appraisal records confirmed that values associated with providing good quality care were discussed because topics included: Caring and Compassion; Recognising Individuality and Seeking to Involve.

Emotional support

- Staff provided initial emotional support and the family support worker and paediatric liaison workers provided additional support as well as introducing parents to relevant community-based support groups.
- The neonatal family support worker received particular praise; we were told "The family support worker provides care and warmth … she's amazing."
- Parents told us they felt that the whole neonatal team worked as hard as they could to bring about effective care and kept parents fully informed about the treatment.
- Parents described that they felt "Very very cared about and cared for."
- Parents in all areas we visited told us that open dialogue and being kept informed about their child's condition helped them to cope when difficult news was shared because they had built up a trust with the medical and nursing team.
- The trust also provided teachers and a classroom where children who were in hospital for longer than a specified number of weeks could have lessons. We found that children chose to go to the school room when this was offered.
- These provisions were caring because children and young people were provided with subjects and activities to fill their day and prevent boredom and also prevent them from worrying about being away from home.
- The trust was also in the process of developing a club for the siblings of children and young people who were admitted to hospital because they recognised the importance of giving attention to children who were spending a lot of time in hospital visiting.

Services for children and young people

Are services for children and young people responsive?

Good

The child health division had effective plans to meet the needs of local children and young people. However, a more robust and effective response was needed to prevent parents taking their sick children to Chorley and South Ribble Hospital Emergency Department.

Information from the trust demonstrated that the service responded to children and young people about individual complaints or concerns and also confirmed that outcomes were routinely analysed and used to influence the changes at ward or department level.

Service planning and delivery to meet the needs of local people

- The child health division had effective escalation policies in place for busy periods, which included additional nursing staff from a nurse agency, risk assessing patients for an accelerated discharge or diversion to other children's units.
- The trust also had plans for anticipated surges in demand, for example the 'Winter pressure' plan, which included adding additional beds as well as staff because the ward was large enough to accept up to 45 patients.
- With regards to the trust responding to the needs of children and young people locally, the inspection reviewed the trust response to two areas. One was the long waiting times in the PAU which meant that a number of parents took their children home before they had been seen by the doctor.
- The other concerned the day surgery unit because we found two occasions when elective or less urgent surgery was cancelled in order to deal with surgical emergencies.
- The reception area and pre-operative waiting area for children and young people admitted for day surgery was not suitable and staffing meant that at times day surgery patients were nursed in the main paediatric ward instead of on their designated ward. We found this on day three of our inspection.
- With regards to the PAU we saw that the trust had reconfigured the unit to provide a treatment room and two assessment rooms so that more than one child could be examined at a time. This had been achieved within a timeframe of one year.
- The effectiveness of this response had not been fully monitored, but records of the feedback provided by senior staff to the trust board and comments from staff indicated that children were assessed and triaged for medical assessment quickly.
- To reduce the risk to children, the trust also informed parents to return directly to the PAU without going to their GP or the A&E department if they had concerns about their child within 48 hours of 'self-discharge'.
- The trust had also responded by funding the training or employment of advanced paediatric nurse practitioners with specialist training to enable them to assess, manage and provide treatment, including prescribing for a wide range of common self-limiting paediatric illnesses.
- The trust had also seconded a member of staff to begin this course and job adverts had been placed for trained advanced paediatric nurse practitioners.
- With regards to the day case unit, the trust directors told us: "Currently the paediatric day case pathway is under review and a review is taking place to improve facilities in the day case unit for children. This is following feedback from staff and parents. It is anticipated completion of business case by the end of September 2014."

Access and flow

- Bed occupancy for the general paediatric ward varied between 65% and 78% between April 2013 and June 2014. An occupancy of 85% or more is considered to have an impact on the safe and effective running of a service.
- The paediatric outpatients said that there was no waiting list to see paediatric consultants and all children were seen quickly following their initial referral, but comparative data was not available.
- Flow through the outpatients department appeared satisfactory because the quarterly audit produced by the trust in May 2014 showed that between January 2014 and April 2014, 87% of children were seen by the doctor within 30 minutes of their appointment time and the remaining 13% were seen by the doctor within 60 minutes.

Services for children and young people

- Delays were sometimes caused because specialist consultants from tertiary hospitals cancelled clinics.
- At the child health directorate's Record of Risk Register meeting 20 May 2014, the number of times children attended Chorley and South Ribble Hospital's A&E department was discussed. This is a risk because no paediatric specialists work at this hospital and there was a potential for children to have a delay in their treatment while they were transported to Royal Preston Hospital by ambulance.
- The Transfer of Paediatric Patients from Chorley A&E to Royal Preston Hospital policy was detailed and mitigated risks, but we saw that this issue had been on the risk register since 2012.
- We visited Chorley and South Ribble Hospital's A&E department and saw that there were no signs on the approach to the hospital telling parents that there was no children's A&E department.
- The risk register did not highlight any practical steps to be taken so that parents and carers were made fully aware that children must not be taken Chorley and South Ribble Hospital.

Meeting people's individual needs

- The processes in place with regards to admission and escalation protocols, multidisciplinary team working and family support staff meant that the service was flexible in meeting people's individual needs.
- Staff stated that the service was flexible enough to meet the needs of all children admitted to the ward regardless of complex physical needs.
- Staff we talked with were aware of how to access a telephone translation service or face-to-face translator and invoices confirmed that translation services had been purchased. One manager told us "I spend a lot of money on translation."
- The trust uses a communication 'health passport', which enables patients and their carer to highlight care needs and allocate a red, amber or green rating to how important an aspect of care is.
- The pre-operative day unit was not ideal for children because it was enclosed and the corridor between the changing room and the anaesthetic room was dark, narrow and bleak. This could be frightening for small children. The trust should consider reviewing the décor and furnishings in this area.
- The child health directorate had taken steps to make the environment comfortable and with suitable facilities to meet the needs of children using the service and their families.
- There were private and quiet areas on ward 8 and the neonatal unit; parents were able to sleep by the bed of their children and under certain circumstance able to stay in rooms on the hospital site.
- There were food and snack preparation areas and we saw parents accessing these areas.
- The division opened a dedicated Paediatric Oncology Shared Care Unit with en-suite facilities for patients in 2013/14 to greater improve the experience of patient and their families. A substantial portion of the funds was provided through the fundraising efforts of the multidisciplinary team, ward staff and a local radio station, Rock FM, appeal 'Cash for Kids'.

Learning from complaints and concerns

- The trust monitored the number of complaints for each division and reported that 15 had been received for the child health division in 2013/14.
- Recent complaints and concerns were discussed at the Child Health Clinical Governance & Clinical Audit Meeting held on 20 May 2014, demonstrating that genuine attention was paid to the experience of patients because these were reviewed by senior managers for the division.
- We found that innovations and changes had been made as a result of feedback from children and young people or their carers.
- We noted from this meeting that plans were made to raise the profile of the Patient Advice and Liaison Service and it was evident that concerns raised with this team were fed into the complaints review process.
- This meant that the complaints review system would provide valuable results because this included both formal and informal complaints made and concerns raised.

Are services for children and young people well-led?

Good

The child health directorate had effective and open leadership. The culture of the service supported the

delivery of high-quality care, learning and innovation. We saw examples of innovative ways of working. There were robust systems in place for the identification and management of risks.

There was an open and fair culture demonstrated by clear, effective and consistent communication between staff with regard to the improvements needed and when they would be achieved. The ward managers were accessible and each of the managers we talked with held staff in high regard and reiterated that pride in their staff and excellent working relationships were strong elements of the division.

Vision and strategy for this service

- Discussion with the medical and nursing staff at all levels established that there was clear, effective and consistent communication between staff with regard to the improvements needed and when they would be achieved.
- Managers and staff were able to describe plans for the development of a child-friendly admission room in the day surgery unit, employment and development of advanced nurse practitioners to improve patient experience in the PAU and development of an out-of-hours service for teenagers within paediatric outpatients.
- The medical director provided a statement outlining local achievements and planned developments for the child health division and this reflected the areas of achievement and for development identified by nursing, medical and allied health professional staff.

Governance, risk management and quality measurement

- The management structure of the child health division included directors and board members with responsibility for monitoring the quality and safety of the service so that activities of the service were reviewed at the highest levels and there was an overview of the service.
- This meant there was effective communication from board to ward and in reverse.
- There were systems in place such as regular meetings, audit reports, newsletters and intranet updates to enable effective communication from senior managers to staff.
- There was a child health division risk register, which was reviewed monthly. This could be improved if the local register also included issues highlighting common themes identified by the Datix incident reports.
- The child health division prepared a detailed annual report that was presented to the board that included information about local and national audits. This information could be improved if it included comparative information about other child health departments where appropriate.

Leadership of service

- There were many examples of effective local leadership for each of the departments we reviewed in the child health division.
- The neonatal lead consultant provided effective local leadership by representing the team and influencing the development and improvements to the service. We were told: “Over time I have managed to get allied health professionals involved and now we have a paediatric dietician based here. We have a 0–2 (year old) service, so we consider the development and ongoing needs of the child and family.”
- The ward managers were accessible and each of the managers we talked with held staff in high regard and reiterated that pride in their staff and excellent working relationships were strong elements of the division.

Culture within the service

- Observations and discussion with staff indicated that there was a supportive and healthy culture within the child health division.
- Staff were able to name the chief executive and confirmed that members of the board and senior directors had visited the ward.
- Comments about team work included “Very supportive team”, “We look after each other and we’re always there for each other”.
- The results of the 2013 staff survey for the child health directorate achieved better than average scores in all questions relating to the culture and values of the organisation. For example, 5% of respondents agreed with the statement: ‘Would not feel confident that organisation would address concerns about fraud/ malpractice/wrongdoing’. This was better than the 15% average for all trusts.
- There was a culture of listening to parents; for example, we were told in reference to complaints “It is key to listen to the parents; we need to hear it from the family.”

Services for children and young people

Public and staff engagement

- The child health directorate had been effective in attracting public engagement through fundraising efforts, such as development of the paediatric family facility for oncology patients.
- The results of the 2013 staff survey for the child health directorate achieved better than average scores in all questions relating to staff engagement. For example, 12% of staff disagreed with the statement 'Not able to make improvements in my area of work'. This was highlighted by the market research company as 'significantly' better than the 19% average score for all trusts.

Innovation, improvement and sustainability

- The child health directorate produced effective business plans that were successful in attracting recurrent and one-off funds required to make improvements identified.
- The middle and senior managers for the child health directorate made reference to the 'Big Plan', which was the trust's future development vision for 2014/15 and beyond. These managers identified that ideally this would mean being fully involved in the design of a new build hospital.
- It was acknowledged that the general plan for the division needed to be reviewed in order to match the 'Big Plan' initiative.
- Staff we talked with described developments and their involvement in planning and pushing forwards innovation and changes in their departments.
- These findings demonstrated that child health leadership was effective because they were able to influence the trust's board in relation to ongoing improvements in the service.

End of life care

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

Information about the service

End of life/palliative care services were provided throughout the trust. People with palliative/end of life needs were nursed on the general wards in the hospital. They were supported by a consultant-led specialist palliative care team. This team coordinated and planned care for patients at end of life on the wards. There was 24-hour consultant-level advice to all wards and departments via the telephone helpline.

We visited three wards where end of life care was being provided. We spoke with three patients and a range of staff, including healthcare assistants, nurses, doctors, consultants and matrons. We observed care and treatment and we looked at care records. We looked at appropriate policies and procedures as part of our inspection of this service. The end of life team worked closely with primary and secondary healthcare professionals to adopt nationally recognised best practice tools.

Summary of findings

Care for patients at the end of life was supported by a consultant-led specialist palliative care team. Staff effectively followed end of life care pathways that were in line with national guidelines. Staff were clearly motivated and committed to meeting patients' different needs at the end of life. Nursing and care staff were appropriately trained and supervised and they were encouraged to learn from incidents.

The palliative care team staff were clear about their roles and benefited from good leadership. We observed that care was given by supportive and compassionate staff. People spoke positively about the care and treatment they received and they told us they were treated with dignity and that their privacy was respected. The nursing staff and doctors spoke positively about the service provided from the specialist team.

End of life care

Are end of life care services safe?

Good

End of life care was safe and met the needs of patients. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were well cared for on the wards we visited. There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

The end of life care teams monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents, accidents, near misses, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers. The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood-borne diseases. Do Not Attempt Resuscitation forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves or, when that was not appropriate, patients who did not have capacity to consent to end of life care were treated appropriately.

Incidents

- The mortuary team told us they used the incident reporting system as required and received feedback during regular meetings.
- Staff were aware of the process for reporting any identified risks to patients, staff or visitors. All incidents were logged on the trust-wide electronic reporting system. Staff had access to the system and confirmed that incident reporting was encouraged by managers.
- The National Reporting and Learning System data does not have a specific end of life category for reporting patient safety incidents. Staff told us any themes from incidents were discussed at ward meetings.
- We spoke with staff who confirmed they attended multidisciplinary ward meetings to review issues relating to care.

Cleanliness, infection control and hygiene

- Ward areas were clean and domestic staff undertook audits of the environment to ensure continued cleanliness.
- During our inspection we observed staff adhering to infection control guidance, including bare below the elbow guidance, washing their hands, wearing gloves and aprons, and using hand gel as necessary.
- There were systems in place within the mortuary to ensure good hygiene practices and the prevention of the spread of infection. The mortuary team informed us that they felt individual staff's knowledge of infectious deceased patients was limited, which resulted in inadequate transfers that could lead to contamination issues. Staff confirmed they completed an incident report for each occasion to highlight the area of concern. The incidents reported over the last six months showed that six incidents had been reported relating to infection control. Four were via the coroners reporting system relating to funeral directors. The other two were dealt with appropriately.

Environment and equipment

- The ward areas were clean and free of clutter. Staff told us the wards had sufficient moving and handling equipment to enable patients to be safely cared for.
- Equipment was maintained and checked to ensure it continued to be safe to use.
- Access to syringe drivers for people needing continuous pain relief was available. Staff were aware of how to use these effectively. This included checking the needle site, battery and volume of infusion remaining in the syringe.
- The trust had systems in place for patients to go home with syringe drivers in place. We were informed there was a process for their return to the hospital after use, although we found no evidence to confirm this. The trust might find it useful to note that staff told us that the supply of syringe drives was an issue within the hospital with many syringe drivers being lost and not being returned.
- Care was delivered on the medical wards and side rooms were made available whenever possible.

Medicines

- Anticipatory end of life care medicines were appropriately prescribed. We saw evidence of anticipatory prescribing guidance for 'potential symptoms in the last days or hours of life'. Staff were also able to obtain advice from the specialist palliative

care advice line at St Catherine's hospice. Examples of areas covered included pain, agitation, nausea and vomiting, and dyspnoea (sudden shortness of breath or breathing difficulty).

- We looked at the medication administration record charts for a number of patients and saw where appropriate end of life medicines were prescribed. Medical staff told us they were provided with advice and support from the trust's specialist palliative care team.
- Staff confirmed the syringe drivers were accessible if an end of life patient was being discharged home into the community and required this as part of their treatment package.

Records

- We saw from two patients' records we examined in detail that care and treatment was recorded by the specialist nursing staff. We saw that risk assessments were reviewed daily, for example, for VTE to minimise the risks of patients developing blood clots, and for falls, nutrition and pressure relief.
- We looked at three Do Not Attempt Resuscitation forms on the wards we visited. We saw these were signed appropriately by a senior member of staff in line with guidance published by the General Medical Council.
- We saw that records were stored securely to ensure they could not be accessed by people who did not have the authority to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence of best interest meetings when discussions about Do Not Attempt Resuscitation and end of life care took place. These included discussions of conversations with people's families or the involvement of independent mental capacity advocates.
- Patients who did not have capacity to consent to end of life care were supported appropriately.

Safeguarding

- There were adult safeguarding procedures in place supported by mandatory staff training. Staff told us they were aware of how to raise and escalate concerns in relation to abuse or neglect of both vulnerable adults and children.
- We saw there were safeguarding policies in place with clear procedures for staff to follow if they had concerns.
- We found that safeguarding was included in the ongoing mandatory training programme and staff confirmed they had attended the training for safeguarding.

Training

- Some staff had undertaken specific training that included an introduction to palliative care/end of life, communication skills and end of life care and discharge.
- The specialist palliative care team were promoting the development of end of life care champions through ward-based link nurses for palliative care. Two staff spoke with us about promoting end of life care. They felt that communication with patients, relatives and staff had improved on their wards in relation to end of life care.
- There was an education and training programme in place. The trust had appointed two specialist nurses to support the development and implementation of personalised end of life care planning, to train doctors and nurses in care of the dying patient and facilitate sustainable improvement to practice. Training was ward based to maximise attendance.

Management of deteriorating patients

- Staff described the National Early Warning Score used throughout the trust, which alerted medical and nursing staff to changes in the patient's health so appropriate and timely action could be taken.
- Specialist support was available when required and out-of-hours specialist advice could be sought from on-call consultants or medical/nursing staff at the hospice.

Nursing staffing

- Patients with palliative/end of life needs were nursed on the general wards in the hospital. Therefore, nursing care was reliant on the staffing arrangements on the individual wards.
- One patient spoke positively about the staffing levels on the ward. They told us housekeepers and care support workers "brighten up my day" and the porters are "great".
- We observed there were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were safe and well cared for.

End of life care

- We observed that handover took place at the bedside and the patient was brought into the conversation if required. There were no concerns with confidentiality because the handover was done quietly and discreetly.

Medical staffing

- For patients with palliative/end of life needs, medical cover was provided on the general wards in the hospital.
- The hospital provided 24-hour consultant support as well as access to the local hospice for advice.

Major incident awareness and training

- There was a clear policy of action to take if the hospital was involved in a major incident.
- There were business continuity plans in place to ensure the delivery of the service was maintained.

Are end of life care services effective?

Good

Patient's care and treatment achieved good outcomes, promoted a good quality of life and was evidence-based. During our inspection we tracked the care of two patients who the specialist palliative care team had identified as receiving end of life care. In addition, we spoke with patients on the ward areas. Patients spoke positively about the way they were being supported by all staff to meet their care needs.

Staff on the wards were aware of the approach the trust was using for patients receiving end of life care and how to contact the specialist palliative care team. We saw that end of life champions had been appointed as leads in the clinical areas to share any new information about end of life care with ward staff.

Evidence-based care and treatment

- All relevant policies and procedures were accessible for staff using the trust's intranet system and had been updated in line with NICE guidelines.
- All changes in policies and procedures were passed on to staff by e-mail.
- The specialist palliative care team had acted on the Department of Health's national End of Life Strategy recommendation. They had implemented a national pilot within the trust for transforming end of life care in acute hospitals. The pilot scheme is a three to five year plan that aims to transform the strategy for end of life care. Examples of areas to be addressed include enhanced use of advance care planning tools, amber care bundles that incorporate management plans for patients with uncertain recovery – 'Think Clear' at Royal Preston Hospital – and rapid discharge processes for patients at end of life.
- We saw the literature relating to the trust's care of the dying guidance. The guidance outlined five priorities for end of life care. The five priorities enabled staff to recognise those who may be dying, ensured communication was undertaken both sensitively and effectively, involve patients and carers in making decisions, explore the needs of families including what support they may require, and finally ensure that individualised care plans were documented clearly and kept under review.
- The amber care bundle project (called "Think Clear" at Lancashire teaching Hospitals) included ward-based training for staff. One member of staff told us they thought the 'Think Clear' strategy enabled them to have clear discussions with patients and their families around prognosis. It had made shared decision-making better and had raised staff's awareness of the deterioration of patients.
- We saw that staff had been given a pocket-sized laminated version of the 'Think Clear' tools and five priorities for end of life care.

Pain relief

- We saw that pain relief was available when required. Anticipatory prescribing took place to ensure pain relief was administered to patients in a timely manner.
- Medical and nursing staff could contact the specialist palliative care team for advice and appropriate pain relief if required.
- We did not see evidence of local audits to assess the effectiveness of treating pain and pain management.

Nutrition and hydration

- The ward staff supported patients to eat and drink normally for as long as possible. We saw patients had access to drinks and patients who were able to tell us said the food was good.
- We saw that fluid and nutrition was accurately recorded when it needed to be. The ward areas maintained fluid balance charts, and these were accurately totalled. This information could be used to influence clinical decisions as necessary.

End of life care

- Patients had access to drinks that were within their reach on the wards we visited.
- Patients were screened using the malnutrition universal screening tool to identify those who were nutritionally at risk. Staff we spoke with were aware of these patients.
- Staff were able to tell us how they addressed people's religious and cultural needs regarding the meals provided for them.

Patient outcomes

- All staff were highly motivated and committed to meeting patients' preferences about where they ended their life.
- The trust had contributed to the national Care of the Dying Audit and we were given a summarised copy of the results that had been published in May 2014. Areas covered included organisational and clinical key performance indicators. In addition to the national audit, the Hospital Specialist Palliative Care team had undertaken a subsequent audit of Care of the Dying in November 2013. The results of Care of the Dying Audit pre and post the Liverpool Care Pathway review are due to be analysed at the End of Life Steering Group in June 2014 to further inform and continuously improve future care.

Competent staff

- All new staff were provided with an induction programme where they undertook mandatory training.
- Staff told us that they received annual appraisals and that they had regular supervision or clinical reflection times within their ward areas.
- Staff told us they could get support from the specialist palliative care team when they needed advice.
- The end of life care coordinator and palliative care consultant told us that training was ongoing and there were plans to continue this throughout 2014.
- Senior staff told us that 160 staff had been trained in the care of the dying, with eight wards being completed. Training for a further two wards was due to be completed every eight weeks thereafter.

Multidisciplinary working

- The multidisciplinary team worked well together to coordinate and plan the care for patients at the end of life.
- There was a daily multidisciplinary meeting on all the wards to discuss and manage patient risks and concerns. Patients at the end of life were included in this discussion so all disciplines could contribute to effective and consistent care for patients at the end of life.
- The palliative care consultant told us that they worked alongside the community discharge coordinator and case manager to ensure rapid access to homecare and that people's preferred place of death was achieved as far as reasonably possible.

Seven-day services

- The specialist palliative care team was available 9am to 5pm Monday to Friday, excluding bank holidays.
- Outside of those hours, support was provided using a 24-hour telephone service to the on-call consultant and/or local hospice providing nurse and medical advice.

Are end of life care services caring?

Good

During the inspection we observed caring interactions and staff treating patients with dignity. Patients' feedback and the views of bereaved families of their experiences are regularly collated for the trust to act on. Feedback from individual patients was positive about caring staff. Staff were very supportive to patients and those close to them, and offered emotional support to provide comfort and reassurance.

The bodies of deceased patients were treated with dignity when going from the wards to the mortuary. Information on 'do not attempt resuscitation' was discussed with patients or their relative or carer.

Compassionate care

- Patients were treated with dignity, respect and compassion from the ward to the mortuary. We saw evidence of a number of 'thank you' cards on the wards.
- Staff told us they generally had enough time to spend with patients and their relatives when they were delivering end of life care. They told us how important it was to have the time for relatives and their families at this difficult time. Staff were observed closing the curtains when a patient required privacy and were heard speaking with them in an understanding way.

End of life care

- There was a relatives' room or office on each ward where sensitive conversations could be conducted.
- Normal visiting times were waived for relatives of patients who were at the end of their life.
- Staff we spoke with demonstrated commitment and compassion to providing good end of life care and the importance of dignity after a patient had died.
- We visited the mortuary and the staff demonstrated how they continued to treat patients with dignity and respect after their death.
- The chaplaincy staff had a caring and compassionate approach towards patients, relatives and staff.

Patient understanding and involvement

- "brightened their day".
- We observed doctors and nurses speaking with patients about their care and checking they understood what they had been told. This meant that patients were involved in decision making. We were not able to speak with some patients about their involvement in care because they were too unwell. We saw from patients' notes that discussions had taken place with patients and their families about care, treatment, prognosis, discharge and preferred priorities for care.
- We saw that, where patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.
- Do Not Attempt Resuscitation forms were in place for patients where indicated. The forms had been completed by the consultant. There was evidence that decisions had been discussed with the patient and their relatives.
- Acting on referrals from ward staff, the bereavement and donor support team (B&D) work with families and patients to support them through the last days and hours of life. During this phase of care, the team receive and proactively act on feedback involving ward/ departmental teams if necessary. Within 24 to 48 hours of death, phone calls are made to the recorded next of kin for all patients who die in the hospital. Any feedback received is, with the next of kin's permission, passed on to the relevant wards and departments.
- During this call the next of kin is made aware that the hospital will send out a survey in eight weeks' time that explores their experiences of care at the end of life. If they decline to receive this, it is not sent. Formal feedback is sought eight weeks after the death occurred. This timescale itself is based on feedback from bereaved families. A freepost envelope is included and a request made for the survey to be returned within two weeks. Information on feedback received is reported to all wards and departments quarterly.

Emotional support

- The specialist palliative care team, the chaplaincy and nurses provided emotional support to patients and relatives.
- Chaplaincy staff were visible within the hospital and staff within the ward areas told us they could access religious representatives from all denominations.
- The chaplaincy provided a post bereavement support service whereby individual support was offered to relatives and children and young people.

Are end of life care services responsive?

Outstanding ☆

The palliative and end of life patient journey was supported by three teams who all worked in close collaboration: the specialist palliative care team, the bereavement and tissue donation team (including the mortuary team) and the chaplaincy team. The skills and commitment of these teams ensured that the whole patient journey and support for the patient's family was responsive and sensitive while meeting the individual needs of each patient. Palliative care was offered on all wards and supported by St. Catherine's hospice. Service support was available 24 hours a day. Wards were using the AMBER care bundle – 'Think Clear', an alternative communication method to highlight when there was clinical uncertainty about whether a patient may recover and to ensure that their preferences and wishes around end of life care could be identified and met. All faiths were able to use the chapel and a prayer room and prayer mats were available. The chaplaincy service was available 24 hours a day, seven days a week. The hospital ensured that families were contacted within 24 hours to establish the family's support system and provide advice. Relatives were able to attend a children and young people's or adults' post bereavement support group, facilitated by the bereavement team.

The palliative care multidisciplinary team worked across the hospital and worked closely with the Hospice and community teams. This showed us their close working relationships, good communication and how staff could

respond to patients' changing needs. Patients referred to the specialist palliative care team were seen promptly according to their needs. The specialist palliative care team were working hard to ensure patients receiving end of life care had a positive experience. The team sensitively used the opportunity to pursue eye tissue donation if the deceased met the criteria to donate.

Service planning and delivery to meet the needs of local people

- The trust had a relationship with St. Catherine's hospice to ensure medical and nursing support was available 24 hours a day.
- The specialist palliative care team had provided training for end of life champions, who then cascade training within the ward areas where patients and their families who required end of life care were supported.
- Across the trust, work was focused on ensuring care was carried out in the patient's preferred place. The specialist palliative care team supported patient preferences to ensure a rapid discharge home, where possible and in most cases this could be arranged within four hours. This ensured that patients wishing to die at home had choice at the end of their lives.
- Patients referred to the specialist palliative care team were seen promptly according to patient needs. The specialist palliative care team's responded within 48 hours of referral or sooner for urgent cases.
- The trust had links with St. Catherine's hospice to deliver a monthly bereavement support group. The trust also had a children and young people's bereavement group to support children and young people who had experienced a loss through death.
- Senior staff told us that every death was assessed for potential eye tissue donation. We reviewed 'Bereavement and Donation: A Collaboration Model of Care' within the trust, which identified that trust tissue donation had increased tenfold and noted that relatives were supported by the bereavement and donation support nurse.
- The mortuary manager told us they had close links with representatives from the local mosque who would update them about any new religious requirements within the Muslim community as necessary.

Access and flow

- We were told patients were generally seen within 48 hours of referral or earlier for urgent cases.
- We saw that multidisciplinary team board rounds were undertaken on each of the ward areas on a daily basis where plans for discharge were discussed.
- Rapid response for discharge to the preferred place of care was coordinated by the Specialist Palliative Care Team, Case Managers and Community Liaison Team. Staff told us there was a multidisciplinary approach to discharge planning, which involved the hospital and the community staff facilitating a rapid but safe discharge for patients.

Meeting people's individual needs

- Spiritual and religious care was provided to dying patients and their families by chaplains, who also provided pastoral care to patients, their relatives and the trust staff. There was access to chaplains from a number of Christian denominations and Muslim Imams.
- A multi-faith chaplaincy was available 24 hours a day, seven days a week. Arrangements had been made with the mortuary and local coroners to ensure, where necessary for religious reasons, bodies could be released promptly.
- We were given literature regarding bereavement support services within the community for both adults and children and young people.
- Each bereaved family was sent a feedback card and offered the opportunity to attend a bereavement follow-up clinic if events surrounding their relative's death needed further explanation.
- During our inspection we observed the ward accommodating the needs of a patient of different faith and saw arrangements in place for prayers to be conducted.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- Ward staff told us they worked hard to understand and support the needs of patients with dementia or complex needs. For example, they checked with the patient's relatives regarding their wishes.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. If a patient or relative wanted to make an informal complaint then they would speak with the shift coordinator. If they were not able to deal with their concern satisfactorily they would be directed to the

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Patient Advice and Liaison Service. If they had further concerns following this they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the trust.

- The bereavement team told us they would not always be consulted if a complaint specific to end of life care had been raised directly to senior level; they felt they would be a valuable resource to contribute towards this.
- The specialist palliative care team and bereavement teams engaged with recently bereaved relatives and used the feedback to consistently improve their service.
- We reviewed the complaints records and identified that the trust had received one complaint within the last year. This had been addressed effectively.

Are end of life care services well-led?

Good

The trust had a vision in place and had developed some new values for the organisation. Staff felt the trust's executive management team was visible. We found that risk management systems were effective. For example, complaints, incidents, audits and quality improvement projects were discussed at division level and at sisters meetings. Senior staff were able to describe areas they had identified as risks within their own departments and what action they were taking to minimise the risk. However, it was noted that patients' experiences were not monitored consistently.

There was good local leadership and enthusiasm within the service and the three associated teams. The staff worked well as a team and were supportive towards each other. Staff said they had confidence in their managers and all disciplines worked together for the benefit of patients. End of life care was not monitored consistently across the hospital in ward areas to ensure standards were being met. However, it was noted that the bereavement and tissue donation team felt undervalued by the trust and identified the work they do as a 'Cinderella' service.

Vision and strategy for this service

- In line with national guidance, the trust had phased out the Liverpool Care Pathway for end of life care. The trust had launched a pilot scheme for transforming end of life care in acute hospitals.
- The trust's strategy for 2014/15 was to provide excellent care with compassion. This vision was highlighted throughout the noticeboards and walls in outpatients departments. Staff said they were aware of the trust's strategy, which was discussed during appraisals.
- The end of life care coordinator told us that patients should expect a good end of life care experience that offered them choice.
- The vision for end of life care was noticeable within the ward areas. The end of life champions were enthusiastic about their role and how they were going to put their learning into practice.

Governance, risk management and quality measurement

- could see the standard the trust was aiming for.
- Complaints, incidents audits and quality improvement projects were discussed at division level, ward level and in departmental meetings.
- Senior staff were able to describe areas they had identified as risks within their own departments and were able to describe what action they were taking to minimise the risk.
- Information relating to risk management was disseminated to staff through staff meetings and information placed on staff noticeboards within the departments.
- We found patient surveys had not been undertaken to measure quality and identify areas for improvement.
- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and that they felt able to report incidents and raise concerns through these processes. The training records identified that training for safeguarding had been completed.

Leadership of service

- It was evident the teams responsible for end of life care were passionate about ensuring patients and their families received a good end of life care experience.
- Staff told us that the clinical nurse specialist educators were visible and were supporting them to develop leadership skills in palliative care.
- Palliative care champions were being established on each ward as part of transferring end of life care in acute settings.
- The Trust funds a bereavement and support nurse. This post is complemented by additional specialist nursing support that is funded by income received from the eye retrieval service.

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- However, the team expressed they do feel undervalued as there are currently only 2 additional specialist nurses funded externally. The external funding arrangements (and the potential for this to be reduced/ withdrawn) have affected the team's confidence in job security, contributing to feelings of frustration as they provide a valuable service welcomed by wards, departments and relatives.
- The end of life teams said they had thorough and effective communication with ward staff and families.

Culture within the service

- Staff in the specialist palliative care team spoke positively about the service they provided for patients.
- Staff reported positive working relationships and we observed that staff were respectful towards each other, not only in their specialties, but across all disciplines.
- Staff were positive about the service they provided for patients and expressed that they wanted to do their best for patients.

Public and staff engagement

- The trust had been part of the National Care of the Dying Audit. We reviewed the summary and saw the action the trust was taking in response to the outcomes identified. In addition to the national audit, the Hospital Specialist Palliative Care team had undertaken a subsequent audit of Care of the Dying in November 2013. The results of Care of the Dying Audit pre and post the Liverpool Care Pathway review are due to be analysed at the End of Life Steering Group in June 2014 to further inform and continuously improve future care.
- We observed good interaction between people, their relatives and staff. Staff were able to respond to the needs of people.
- Patient surveys were not carried out routinely within end of life care. We did not see evidence of the result of patient surveys.

Innovation, improvement and sustainability

- The end of life care team had rolled out the amber care bundle (Think Clear at LTH) to support teams in identifying and responding to a person's end of life care needs when their recovery was uncertain.

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

Information about the service

Royal Preston Hospital has a large outpatients department that provides outpatients services across a wide range of areas, including vascular and spinal injury. The general outpatients area catered for a variety of specialisms, including ophthalmology, neurology and plastics. The trust had approximately 491,438 outpatients appointments in 2012/13.

We visited the general outpatients area, ophthalmology, neurology, cardiology, plastics and both spinal and fracture clinics. We spoke with 10 patients and relatives and 14 staff, including nurses, healthcare assistants, medical staff, ward sister, administrators and receptionists. We observed care and treatment, and looked at records. During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

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. Staffing numbers and skills mix met the needs of the patients. There was a clear process for reporting and investigating incidents, although staff told us they had not received outcomes of incidents submitted. The outpatients departments we visited were clean and well-maintained.

We found concerns within the ophthalmology department; clinics were sometimes cancelled at short notice and frequently ran late. There were issues regarding medical staffing and maintaining services, especially in ophthalmology, which was currently under review. The cancelled clinics were a concern within the department and the quarterly audits showed an increase over the last four quarters. There were also concerns noted with the partial booking queue within ophthalmology for patients needing follow-up appointments. The staff told us that delayed appointments also caused confusion with ambulance transport services. The hospital has plans in place to address the issues in the ophthalmology service that are already beginning to demonstrate improvements in this service.

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other. The trust had in place guidelines to meet the needs of the local population, for example

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an interpreter service. While we found robust and well-led local service provision, the trust-wide leadership needed to be more visible and responsive to frontline staff. The evidence seen showed that improvements were required to demonstrate that the service reviewed, understood and managed the risk to people who use the service and staff.

We found that improvements were required by the trust to ensure that staff received regular feedback on performance and were involved in the 'lessons learned' process. We noted that staff needed to be kept updated with developments within the outpatients department. We observed that staff had not received clinical supervision, as required by the hospital's own policy and procedures.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Care within the outpatients departments required improvement. We found there were issues regarding medical staffing and the maintaining of the services, especially in ophthalmology, although these issues were under review.

We found that some hospital medicine prescriptions had required later changes by both the pharmacist and consultants.

Although staff knew how to complete incidents reporting forms, we found no evidence to support lessons learned. Staff told us they had not received feedback on those incidents submitted. We found that staffing numbers and skills mix met the needs of the service. There was an ongoing programme of mandatory training for staff to ensure they maintained knowledge and skills in carrying out their role safely.

The outpatients departments we visited were clean and well-maintained. There was a clear system in place for managing patients' records and ensuring that medical staff had timely access to patient information. However, regular audit had demonstrated a shortfall in the supply of records for clinics and this was being addressed in the longer term through the introduction of electronic records.

There were policies and procedures in place in relation to consent and the Deprivation of Liberty Safeguards. Staff were clear on how to obtain informed consent and to assess people's capacity to make decisions for themselves.

We found that there were safeguarding policies in place, and clear procedures to follow if staff had concerns. Staff confirmed they were aware of how to raise and escalate concerns in relation to abuse or neglect for both vulnerable adults and children.

Incidents

- Staff were confident and aware of how to report incidents and 'near misses'. Staff were supported by the ward sisters in charge of outpatients to do so using the online reporting system.

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- Staff were knowledgeable about the incident reporting procedure and confirmed they had received training. Staff were able to describe the types of incidents they would report.
- There were concerns noted with the partial booking system within ophthalmology for patients needing follow-up appointments. The trust completed a root cause analysis on two patients who were identified as 'lost' to follow-up. One was found not to be lost to the follow-up procedure and the other was confirmed and had experienced harm, although it was reported as "not significant harm and had no impact on activities of daily living".
- On 23 June 2014 a third patient was identified as a potential lost to follow-up, and as a result the trust commissioned a full review of patients to ensure no others have been lost to follow-up.
- We noted that reported incidents were investigated by senior managers and themes and trends were discussed at governance meetings.
- We found no evidence of learning from incidents having been shared with staff to prevent future avoidable incidents. Staff told us they were unaware of the results of incidents submitted and had not received any feedback.

Safety thermometer

- 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. There were no specific details available relating to outpatients.
- Senior staff were able to describe areas they had identified as a risk within their own department, and what action they were taking to minimise the risk. For example, by monitoring clinic start and finish times staff told us they had identified that the highest risk was the lengthy waiting times for patients because of clinics overrunning their allocated time.
- We were informed and observed that the staff rota had been amended over the past two weeks to address the peak times for clinic over-runs. We were informed this was a work in progress and the information would be analysed to evaluate its effectiveness.

Cleanliness, infection control and hygiene

- All the outpatients areas we visited were found to be clean and well-maintained.
- We saw staff observed bare below the elbow guidance and adhered to the hospital's control and prevention of infection guidance. Personal protective clothing, such as gloves and aprons, were used by staff when required to deliver personal care.
- There was an ample supply of alcohol hand gel dispensers and hand washing facilities were readily available.
- Toilet facilities were clean and soap and hand towel dispensers were adequately stocked.
- The department carried out internal audits and checks relating to infection prevention and control.
- Infection prevention and control policies and procedures were available and accessible to staff on the staff's intranet.

Environment and equipment

- Equipment in the departments was regularly serviced, tested and appropriately cleaned.
- Resuscitation trolleys were located in or close to each outpatients area and regularly checked and maintained.
- 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.
- The environment in the general outpatients area was well maintained, although we found that some areas of outpatients were crowded and lacked an effective ventilation system.

Medicines

- The hospital used the services of a local pharmacy company to dispense all hospital prescriptions.
- The service monitored all errors on written prescriptions, which were discussed at monthly intervention meetings with the trust.
- We reviewed the records held by the pharmacy company for the week starting 8 July 2014 and found that every day 60% of written hospital prescriptions had the reference to allergies omitted and 10% of data was incomplete, which included incorrect patient details and doctor's signatures.

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- The company's hours were from 9am to 6pm Monday to Friday. Patients attending clinics that had over-run this time or clinics held at weekends did not have access to pharmacy facilities and had to return the next day. However, we noted the company had recently introduced a service so that these patients could go to their local pharmacy to pick up their prescription so they did not need to return to the hospital.
- We observed the pharmacist explaining to patients about their medicines and noted patients were asked if they had any questions.
- We noted that most medicines were dispensed within the company's turnaround key performance indicator of 20 minutes, which meant that patients' medicines were dispensed in a timely way.

Records

- Some people told us they had attended outpatients appointments and their medical records had not been available.
- Regular monthly audits were undertaken to monitor availability of records and reported to the trust board. The audit demonstrated that 33,551 records were requested for June 2014 with 54 total notes missing.
- Both nursing and medical staff told us it was very rare for them not to have the full set of patient's notes available for an appointment.
- Staff told us some information, such as test results and x-rays, were accessed electronically and computers were available in all clinics.
- 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.
- All records were in the process of being scanned onto the EVOLVE electronic system, which will, over time, reduce the need for physical case notes in clinic.
- The records department is aiming to achieve the Merseyside Internal Audit Agency Standard BS1008. On achieving this standard, the trust will be able to destroy case notes three months after scanning.
- We reviewed the audits undertaken in scanning records and that only two errors were identified in the sample of records audited and we saw the action taken to address these errors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place in relation to consent, and the Deprivation of Liberty Safeguards.
- Staff explained how they obtained consent. Staff were aware of the consent form that needed to be completed and confirmed that consent was obtained by the consultants when they were treating people.
- Staff told us the majority of patients attending appointments had capacity to give consent to examination or treatment. Staff were clear on how to assess patients' capacity to make decisions for themselves. They described how they would involve others to support people who did not have capacity.

Safeguarding

- When we spoke with staff it was clear that they were aware of how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns.
- We saw safeguarding was included in the ongoing mandatory training. This confirmed staff received regular mandatory training.

Mandatory training

- The trust had a core mandatory training programme for staff.
- Training uptake was reported and monitored across the division.
- We reviewed the record of staff update of mandatory training, which was at 70%. Senior staff informed us that because of the reform of the outpatients department they were in the process of reviewing all outstanding training and arrangements were in place for staff to complete their training using the e-learning system.

Management of deteriorating patients

- management of patients' deterioration was an ongoing process, with each patient's needs being individually assessed and addressed during their visit at clinic. If a patient suffered an acute episode or collapse in clinic, staff summoned emergency medical support.

Nursing staffing

- Senior nursing staff described how staffing arrangements were planned to meet the requirements

of the clinics. The numbers of nursing staff and skills mix was determined by the nature of the clinic to ensure there were sufficient personnel with the appropriate skills to safely run the clinic.

- There were no agreed national guidelines as to what constitutes 'safe' nursing staffing levels in outpatients departments.
- Nursing, support staff and consultants we spoke with confirmed there were sufficient numbers of staff to meet the needs of the different clinic outpatients departments.
- We observed the staff rota identified staff working extra shifts to support the extended evening and weekend clinics. We noted that staff worked within the working time directive set out by the Advisory, Conciliation and Arbitration Service.
- The ward sister told us they did not use an agency but had

Medical staffing

- Medical consultants and other specialists arranged outpatients clinics directly with the outpatients department to meet the needs of their specialty.
- Consultants were supported by junior colleagues in some clinics, where this was appropriate.
- We were informed there was a shortfall of five consultants who oversaw the outpatients department, which resulted in reduced clinics and on occasions cancelled clinics.
- There were concerns identified within the ophthalmology department about the locum ophthalmologist whose contract had been terminated. The trust had commissioned a full review of all patients seen by the locum doctor, about 4,000 patients.

Major incident awareness and training

- There was a clear policy of action to take if the hospital was involved in a major incident.
- There were business continuity plans in place to ensure the delivery of the service was maintained.
- Senior staff were aware of these policies and procedures.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The outpatients units were able to demonstrate that people received effective care and treatment by competent staff. Staff appraisals had been conducted annually, although we noted that staff had not received any clinical supervision. There was good continuity of nursing staff and they received the support of specialist nurses. The service was delivered Monday to Friday. Evening and weekend clinics were arranged to meet service demand.

Staff worked well together in a multidisciplinary environment to meet people's needs. Information relating to patient's health and treatment was obtained from relevant sources before clinic appointments, and information was shared with the patient's GP and other relevant agencies after the appointment to ensure seamless care.

Evidence-based care and treatment

- We noted that all policies and procedures were accessible for staff using the trust's intranet system and had been updated in line with NICE guidance.
- All changes in policies and procedures were passed on to staff by e-mail.

Pain relief

- 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 outpatients reception area.
- Patients could be referred to the pain management clinic by their consultant.

Patient outcomes

- We found no evidence was available on outpatients surveys.
- Patients' and families' responses to the service were variable, with some telling us they were happy with the service provided while others were unhappy with the overall waiting time.

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- The parking facilities at the hospital were a concern for the people we spoke with. Two people told us they were late for the appointment because of how long it took to both park and walk to the department.

Competent staff

- 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. The records identified all staff as having received an annual review.
- Staff completed a variety of competencies exercises to assess their ability and review the effectiveness of the guidance provided. Examples included the removal of wound closure materials.
- We reviewed the record of staff uptake of training, which was currently at 70%. Senior staff told us that because of the reform of the outpatients department they were reviewing and identifying all outstanding training. We noted that the relevant staff had been notified of the need to address the gaps in their training attendance.
- 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.
- Staff told us they had not received clinical supervision. This was confirmed by senior staff.
- Staff told us the service lead had an open door policy and that they were able to discuss any concerns with them.

Multidisciplinary working

- There was evidence of good multidisciplinary working in outpatients. We found that doctors, nurses and allied health professionals such as physiotherapists and occupational therapists worked well together.
- Letters were sent out by the outpatients department to people's GP to provide a summary of the consultation and any recommendations for treatment.
- We saw good evidence of patient pathways within the units. This was demonstrated by those care and treatment records we reviewed. A pathway is the route a person will take from their first contact with a member of staff to the completion of their treatment. A patient informed us they had received marvellous service on visiting a pre-operative ward.

Seven-day services

- Outpatients department clinics ran Monday to Friday with morning and afternoon lists.
- Evening and weekend clinics had been scheduled because of the number of patients who had been referred and were waiting for treatment or follow-up appointments.
- We reviewed the follow-up appointments for the hospital, which ranged from two weeks to 28 weeks within cardiology. We spoke with a consultant cardiologist who confirmed that the follow-up waiting time had been reduced considerably to six weeks because of extended clinics.

Are outpatient and diagnostic imaging services caring?

Good

Outpatients services were delivered by caring and compassionate staff. We observed that staff treated people with dignity and respect and planned and delivered care in a way that took into account the patients' wishes. The trust might find it useful to note that people's personal information was disclosed while accessing the reception area of the outpatients department.

We found that staff were good at involving people, family and friends in all aspects of their care and treatment.

Compassionate care

- Throughout our inspection we witnessed patients being treated with dignity and respect.
- The environment in the outpatients department did not allow for confidential conversations in reception areas. This was apparent when waiting areas overflowed into the corridors within different outpatients departments. We observed people's personal details being freely discussed by staff.
- There was sufficient nursing staff to ensure patients had a chaperone during appointments that required an intimate examination, or when requested.
- We noted that staff listened to patients and responded positively to questions and requests for information.

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- Patients spoke positively about the care provided by staff. One patient said they had received "good care" and another said that arrangements had been made for them to have a post-operative visit and staff had been "marvellous".
- We found that vulnerable patients were managed sensitively and attended to as quickly as possible.
- Nursing staff told us patients were offered drinks if clinics were running late and patients had access to several vending machines within outpatients
- Patients' feedback on the booking system was variable; some did not have any concerns while other informed us they had their appointments cancelled several times. One patient told us their appointment had been cancelled six times.
- All staff spoke with pride about their work, including those who were working in difficult circumstances.

Patient understanding and involvement

- We spoke with 10 patients regarding the information they received in relation to their care and treatment.
- Patients stated they felt that they had been involved in decisions regarding their care. One patient told us that everything had been explained to them.
- Patients were aware of why they were attending the outpatients department.
- We noted that requests for consent to treatment included a clear explanation of the benefits and risks of the proposed treatment so that patients could make an informed choice about their treatment options.

Emotional support

- Patients and relatives told us they had been supported when they arrived at the service. They had been helped to find the correct clinic and had noted that waiting times were regularly updated on the noticeboard. People told us they would have liked more explanation from staff regarding why there were delays, which would have given them a better understanding.
- We observed staff responding to and speaking with people who appeared distressed in a supportive way.
- Staff had good awareness of people with complex needs and those people who may require additional support if they displayed anxious or challenging behaviour during their visit to outpatients. Staff had received training in positive resolution, which helped staff to support people with challenging behaviour.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The organisation of clinics was not responsive to patients' needs. Many clinics frequently over-ran and some patients told us they had experienced long delays in their appointment time. Clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled. Staff told us that it was difficult to arrange patient transport, which was confirmed by the patients we spoke with.

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 the department because of poor signage. This made them late for appointments and made them feel anxious.

Clinicians were required to alert the service to the cancellation of their clinic because of planned leave at least six weeks in advance. This did not always happen and clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled.

We reviewed the cancelled clinics figures for the last four quarters for the trust and noted that the largest increase in figures belonged to the ophthalmology department, which had increased each quarter. For example, in the first quarter 63 clinics had been cancelled with less than six weeks' notice and this had increased to 87 for the last quarter. The four-week cancelled clinics had increased from 19 to 69 clinics.

We were informed that the ophthalmology department had a follow-up waiting list shortfall that the hospital had been working hard to reduce. In addition the medical director had commissioned an external review of ophthalmology services. This was being undertaken by a senior clinician recommended by the Royal College of Ophthalmologists and was due to be completed by the end of July 2014. The outcome of the review was not known at the time of our inspection.

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Service planning and delivery to meet the needs of local people

- We found no evidence of regular audits within outpatients of service delivery or feedback on patients' experience to ensure the service met the needs of the local population.
- The service had identified that the high number of people who did not attend appointments had an impact on service delivery.
- The service had introduced a text message service to remind patients of their appointments. Staff reported this was having a positive impact on non-attendance. People said they liked the text message service but would have liked to receive the venue alongside the date and time. One person told us they had arrived at their appointment to be told the venue had been changed. Staff told us they had on occasions had to arrange transport for patients who had turned up at the wrong clinic.
- We were informed that the appointment times for patients within the fracture clinic who required a plaster service had been re-arranged to mornings. This arrangement was to accommodate the plaster technicians who worked within the A&E department.
- We noted that the plaster technicians were available in the afternoon for emergencies up to 4pm. We were informed that after 4pm patients who required the service of a plaster technician were provided with temporary splints by the consultants and patients were asked to re-attend the following day. Staff said this impacted on the next day's clinic because of additional patients having to be seen by the plaster technicians.
- Staff informed us that all plaster technicians attended the trauma services, which affected the fracture clinic. Staff said that patients were given the option of waiting for the major trauma to be dealt with or go home. On occasions the fracture clinic had been closed because of an emergency trauma situation, which had resulted in delays in patients' follow-up appointments.

Access and flow

- The initial appointment letters sent out to patients were clear. They contained information about where the clinic was located in the hospital and contact numbers for cancellation or re-arranging appointments.
- The information also included contact details to arrange transport for their appointment if this was required. This gave patients the autonomy to make their own transport arrangements.
- There were not enough seats for people in certain outpatients areas. Patients were seated on chairs in an adjacent corridor.
- Patients had a high level of satisfaction with the new reminder system, although there were concerns about some patients arriving at the wrong venue and occasionally the wrong hospital.
- Staff from the booking centre and outpatients departments informed us that consultants and specialists using the outpatients department for clinics were required to inform both the outpatients department and booking centre of a cancellation of their clinic because of planned leave at least six weeks in advance. They told us this did not always happen and clinics were sometimes cancelled at short notice. This led to patients having appointments cancelled and re-scheduled.
- We reviewed the cancelled clinics figures for the last four quarters for the trust and noted that the largest increase in figures belonged to the ophthalmology department, which had increased each quarter. For example, in the first quarter 33 clinics had been cancelled with less than six weeks' notice and this had increased to 110 for the last quarter. The four-week cancelled clinics had increased from 19 to 69 clinics.
- During our inspection we observed some clinics running late by up to 75 minutes. We saw information regarding the waiting times was displayed on whiteboards in the waiting room areas.
- We observed one patient leaving because they were unable to stay longer because of family commitments and another left because they were not prepared to wait.
- Patients informed us they would like to have been given a reason for the delay to give them an informed choice of whether to stay or leave.
- Staff we spoke with confirmed many clinics frequently and consistently over-ran. One explanation was to meet a patient's individual clinical need where it was not appropriate to wait for the next available appointment. This was confirmed by one patient we spoke with who spoke positively about how they had been added onto

the clinic list at short notice. This indicated the service was responsive to patients' needs; however, this had a negative impact on the waiting times experienced by other patients.

- Most patients told us they had unusually long delays in their appointment time, with an average waiting time of an hour. One patient told us that is was unusual today because they had been seen "fairly quickly".

Meeting people's individual needs

- Staff told us how they would provide support to patients if they displayed anxiety or had complex needs. Staff told us they occasionally received advanced notice from a patient's family or carers, which enabled them to manage the situation more easily, especially when the clinic was busy.
- Staff were able to provide distraction techniques to support children waiting for long periods. Staff also assisted children and their relatives through consultations or procedures where required.
- Contact details for interpretation services were available on the trust's intranet. Staff told us interpreters were booked in advance at the same time as the appointment booking was made.
- Staff told us they had also accessed the lip reading service to support a patient who was profoundly deaf.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Initial complaints were dealt with by the outpatients senior staff. If they were unable to deal with the person's concerns satisfactorily, they would be directed to the Patient Advice and Liaison Service. If the person still had concerns, they would be advised how to make a formal complaint.
- In all the areas we visited, information on how to make a complaint was displayed.
- Staff confirmed that they were aware of complaints and had received feedback through staff meetings.
- We observed a consultant's secretary attending to a patient's concern about their appointment, which appeared to have been attended by another person of the same name. This resulted in the patient not being seen until the secretary had investigated the matter, with a further appointment to be arranged. The secretary informed us they would produce an incident report as a result of the initial concern. We observed that this complaint was addressed in line with the trust's policy and procedures.

Are outpatient and diagnostic imaging services well-led?

Good

Although there had been recent improvements to this service staff told us they felt they had not been listened to on key service changes and that outpatients had not been a priority for the trust. However, staff said they had confidence in their immediate staff team lead and that all disciplines worked together for the benefit of patients.

The trust had a vision in place and had developed some new values for the organisation and staff felt the trust's executive management team was visible. We found that risk management systems were effective. For example, complaints, incidents, audits and quality improvement projects were discussed at division level and at sisters meetings.

Senior staff were able to describe areas they had identified as risks within their own departments and were able to describe what action they were taking to minimise the risk. However, it was noted that patients' experiences were not monitored consistently.

Vision and strategy for this service

- The trust's strategy for 2014/15 was to provide excellent care with compassion. This vision was displayed throughout the outpatients departments' noticeboards and walls. Staff said they were aware of the trust's strategy, which was discussed during appraisals.
- Most staff told us they felt well supported at a local team level, although we identified some staff concerns about the management of re-organisation that had involved changes of job roles.

Governance, risk management and quality measurement

- Complaints, incidents and audits were discussed at division level and sisters meetings. Staff said they had not received feedback regarding the outcome of incidents.
- Senior staff were able to describe areas they had identified as risks within their own departments and were able to describe what action they were taking to minimise the risk.

Outpatients and diagnostic imaging

- Information relating to risk management was disseminated to staff through staff meetings and information placed on staff noticeboards within the departments.
- We found patient surveys had not been undertaken to measure quality and identify areas for improvement. People we spoke with said they had concerns regarding the cancellation of appointments and the waiting times within the clinics attended.
- Staff told us they were aware of the trust's whistleblowing and safeguarding policy and that they felt able to report incidents and raise concerns through these processes. The training records identified that training for safeguarding had been completed.

Leadership of service

- The outpatients department had been reformed over the last 18 months. Staff said this had had an impact within the department with morale being low, although they confirmed this was now improving.
- Staff worked well as a team and supported each other.
- Staff said they had confidence in their immediate staff colleagues and we observed all disciplines worked together for the benefit of patients.
- Staff at all levels were aware of the challenges within the service, such as the long waiting times and over-running clinics. They demonstrated a commitment to address these challenges and to improve their service.
- Staff told us that they received annual appraisals (personal development reviews), but had no clinical supervision.

Culture within the service

- We found that staff were very loyal and flexible. Many staff members had worked for the trust for a number of years and were committed to working at the trust.
- There was an overwhelming view from staff that services worked so well because of the 'goodwill' of staff.
- Staff coped well with the continual challenges within the service and demonstrated a commitment to address them.
- Staff moral varied, with some staff very positive but others felt that their views were not being listened to.
- Staff told us they worked well together and there was obvious respect between different roles and responsibilities within the multidisciplinary teams working in the different outpatients departments.

Public and staff engagement

- We observed good interaction with patients, their relatives and staff. Staff were able to respond to the needs of people visiting outpatients.
- Patient surveys were not carried out routinely within the outpatients departments. We did not see evidence of the result of patient surveys.
- People we spoke with voiced their concerns with regard to waiting times and parking facilities. Positive comments included "staff are really friendly" and that they provide an "excellent" service.

Innovation, improvement and sustainability

- The appointment booking centre had introduced a text phone reminder service. This was intended to reduce the number of patients who do not attend their appointments.
- Patients within the fracture and spinal clinics could request a scanner that allowed them to leave the clinic for refreshments. The scanner would 'buzz' to inform patients their appointment was due. We saw the scanners being used during our visit to the clinics. Patients said they liked the idea of being able to go away from the clinic area if there was a long wait without having to worry about losing an appointment.

Outstanding practice and areas for improvement

Outstanding practice

- Data from the College of Emergency Medicine (CEM) consultant sign-off audit showed that 100% of patients at Preston Emergency Department were seen by an emergency department doctor, compared with a national average of 92%. Also 25% of patients were seen by a consultant, which is well above the national average of 13% in 2012/13.
- Ultrasound-guided blocks for patients with neck of femur injuries in the Emergency Department.
- Children's safeguarding review meeting in the Emergency Department.
- Chaplaincy service engagement with patients in the Emergency Department.
- Consistently rapid handover times for patients arriving by ambulance to the Emergency Department.
- Responsive and flexible training using 'simulation man' to deliver trauma training within the Emergency Department at quiet times.
- The trust was committed to becoming a dementia-friendly environment. An older people's programme was developing this work and we saw several excellent examples of how this was being put into practice during our inspection. The proactive elderly care team helped staff to identify and assess the needs of older people. The team worked proactively with intermediate care services to ensure the safe discharge of older people and people living with dementia. Activity boxes had been introduced throughout the division to promote and maintain cognitive and physical function and help reduce the unwanted effects of being in a hospital environment.
- The trust had won the Clinical Innovation category at the North West Excellence in Supply Awards for developing a disposable female urinal.
- The alcohol liaison service had been nominated for a national Nursing Standards award. Staff spoke highly of the service and the positive contributions they had made in supporting patients with alcohol-related conditions.
- Our specialist adviser assessed that speech and language therapy input for neonatal babies was likely to improve the long-term outcomes for these children and considered this to be outstanding practice.
- The end of life team coordinated rapid response for discharge to the preferred place of care. Staff told us there was a multidisciplinary approach to discharge planning, which involved the hospital and the community staff working towards a rapid but safe discharge for patients.

Areas for improvement

Action the hospital MUST take to improve

Staffing

- Ensure that there are enough suitably qualified, skilled and experienced nurses to meet the needs of medical patients at all times.
- Ensure that there are enough suitably qualified, skilled and experienced midwives to meet the needs of patients at all times.
- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times within the medical division and outpatients.
- Ensure that medical staffing is appropriate at the location, including medical trainees, long-term locums, middle-grade doctors and consultants.

Supporting staff

- Ensure that relevant staff receive advanced paediatric life support and moving and handling training.
- Take steps to enable the trust to confirm the status of mandatory training that staff have completed in the child health directorate, so that staff have received information about the actions required to maintain and promote safety.
- Improve patient flow throughout the hospital to reduce the number of bed moves and length of stay – particularly in the medical division.
- Prevent the cancellation of outpatients clinics at short notice and ensure that clinics run to time, particularly within ophthalmology outpatients.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

In the Emergency Department:

- Improve mechanisms to achieve and maintain performance to meet the four-hour target set by the government for emergency departments.
- Address the reasons why patients wait for up to nine hours in the department before being admitted to an inpatient area.
- Address the appropriateness of the environment for the children's treatment area in the Emergency Department with regard to visual or audible separation.
- Address the appropriateness of the environment for the delivery of modern emergency medicine.
- Review how the constraints of the environment would negatively affect plans to increase services within the department.
- Review privacy and dignity for patients being handed over by ambulance crews in the corridor area.
- Address the effectiveness of how services for acute gastrointestinal bleeds are provided out of hours.
- Review mechanisms for supporting and recording clinical supervision within the Emergency Department.

In the medical division

- Improve the management of people with diabetes and stroke in line with national guidance.
- Improve the consistency of access to emergency upper gastrointestinal endoscopy and interventional radiology.

In the surgical division

- Consider reviewing the overnight provision for ophthalmology patients who require unplanned overnight stays.
- Consider reviewing unused theatre capacity within the surgical division.
- Ensure that checklists for daily cleaning jobs within the surgical division are completed and current.

In critical care

- Ensure that the use of critical care beds is factored into any trust-wide discussions and solutions for improving patient access and flow. This should include continuing to monitor and report on delayed discharges, cancelled elective procedures and the use of theatre recovery at times of peak demand.
- The trust is not currently providing a critical care outreach service 24/7. In the absence of this 24/7 service, the trust should ensure that all staff employed within the hospital at night team are suitably qualified and competent to cover the critical care support role.
- Consider the impact of not having a weekend pharmacy service in the intensive care unit (ICU). Appropriate care of critically ill patients requires frequent review and re-assessment of therapies, including medication.

In maternity services

- Continue to review patient flow with regard to managing induction of labour and transfer of mothers to the delivery suite.

In children's services

- Ensure that all incidents are described in a consistent manner so that details and the action taken can always be easily reviewed.
- Ensure that the information in the audits is accurate so that the trust can be confident that appropriate steps are taken to promote safety.
- Consider the security and safety of how expressed milk is stored, as the kitchen and fridge were accessible to anyone on the unit.
- Be able to provide a comprehensive training record for each member of staff.
- Review the décor and furnishings in the children's day surgery waiting room and pre-operative area.
- Ensure that the Child Health directorate completes a comprehensive audit of the Day Case Unit that includes feedback from all stakeholders to ensure plans incorporate all aspects of the services strengths and weaknesses.
- Ensure that all opportunities are used to alert staff about the risks identified in relation to safety.
- Ensure that staff always report all incidents that are concerned with child safety.
- Ensure that information provided about the safety of children's services is accurate and consistent.
- Take more robust action to prevent parents from taking children to Chorley and South Ribble Hospital Accident and Emergency (A&E) department, as there are no children's A&E services at that site.

Regarding end of life care

- Audit the care that people received from the End of Life service.

Outstanding practice and areas for improvement

- Review the processes in place for the return of syringe drivers from the community to ensure availability.
- Ensure that audits are carried out on pain management and pain relief for end of life care.

In outpatients

- Ensure that the trust receives feedback from patients within the outpatients departments to monitor and measure quality and identify areas for improvement.
- Ensure that appropriate checks are in place to provide assurance that medicines prescriptions are correctly completed.
- Ensure that members of staff have the opportunity to discuss any issues or concerns they may have on a regular basis within clinical supervision.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: People who use services and others were not protected at all times against the risks associated with unsafe or unsuitable staffing due to the vacancies within both nursing, midwifery and medical staff establishments particularly within the medical division and outpatients. (Regulation 22)

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: All staff were not appropriately supported to receive appropriate mandatory training updates. (Regulation 23(1)(a))