Blackpool Teaching Hospitals NHS Foundation Trust

Inspection report

Trust Headquarters, Blackpool Victoria Hospital
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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Inadequate**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Blackpool Teaching Hospitals NHS Foundation Trust is situated on the west coast of Lancashire and operates within a regional health economy catchment area that spans Lancashire and South Cumbria and supports a population of 1.6 million. The trust provides a range of acute services to the 330,000 population of the Fylde coast health economy and the estimated 11 million visitors to the seaside town of Blackpool. Since April 2012, the trust also provides a wide range of community health services to the 445,000 residents of Blackpool, Fylde, Wyre and North Lancashire. The Trust also hosts the National artificial eye service, which provides services across England.

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

At our last inspection in October 2019, we rated safe, effective and responsive as requires improvement, caring as good and well-led for the trust overall as inadequate.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. There was significant redeployment of staff at the trust during that period to support staff in critical areas.

We carried out this unannounced inspection, from the 14 September to the 20 October 2021, of Blackpool Teaching Hospitals NHS Trust. We inspected core services at the Blackpool Victoria Hospital including urgent and emergency care, medical care, critical care and surgical care services because of continuing concerns about the quality and safety of these services. We also inspected the well-led key question for the trust overall. We rated urgent and emergency services as inadequate and surgery, medical care and critical care as requires improvement. We rated well-led for the trust overall as requires improvement.

Following this inspection, due to the concerns we had identified at Blackpool Victoria Hospital, we wrote to the trust asking for urgent action to be taken to ensure safe care and treatment.

Our findings

Details for the summary for each core service inspected can be found later within the report, a summary of the trust wide well led is below.

We rated well led as requires improvement at Blackpool Victoria Hospital because:

- There were several new appointments to the board but the plans they had developed had not yet had time to evidence their impact or sustainability. Not all leaders had the capacity to lead effectively. Not all senior leaders were visible or approachable in the organisation. Leaders were not always fully sighted with what was happening on the front line. They did not always identify their priorities and did not always develop plans to manage these in an effective and timely way.
- The trust did not have a clear vision. Although the trust had not developed a new five year vision and strategy because of COVID-19, they had taken a pragmatic approach by putting the one-year overarching strategy in place within the organisation and had started to develop a five year one; however, there were several strategies that were out of date.
- Not all staff felt supported, respected and valued by their local leaders. There was a lack of supportive inclusion for staff with protected characteristics. The trust was working towards an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt secure to raise concerns. The trust had work to do in relation to promoting equality, diversity and inclusion in daily work.
- The arrangements for governance were not clear and did not always operate effectively. Not all staff in leadership roles were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.
- Risks, issues and poor performance were not always dealt with appropriately or quickly enough. There were systems to manage performance; however, these were not used efficiently. The risk management approach was applied inconsistently and was not linked effectively into planning processes. Significant risks were not always identified or escalated appropriately and there were insufficient processes to identify actions to reduce their impact.
- The information that was used to monitor performance or to make decisions was inaccurate, and unreliable or not relevant. There was inadequate access to and challenge of performance by leaders and staff. The trust was delayed in implementing its digital strategy and had no implementation date at the time of our inspection.
- There was minimal engagement with people who used services, staff, and the public. There was a limited approach to sharing and obtaining the views of staff. There was insufficient attention to appropriately engage with people, including those with protected equality characteristics. Feedback was not always reported or acted upon in a timely way.

However:

- Senior leaders demonstrated the necessary knowledge, capability and integrity. They worked well as an executive team and with leadership teams across the trust.
- The trust did have three key ambitions for what it wanted to achieve within a one-year strategy. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy.
- All staff we met were focused on the needs of patients receiving high quality and compassionate care.
- The trust had sourced an external organisation to review and report on governance processes throughout the trust.

Our findings

- The trust was beginning to invest in continuous learning and improvement within the organisation, however there was still work to be done through the appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and the skills to implement improvement was beginning to be shared among the organisation.

We rated one of the trust's 14 services as inadequate overall and three as requires improvement. In rating the trust, we took into account the current ratings of the 10 services not inspected this time.

How we carried out the inspection

During our inspection we spoke with a variety of staff including consultants, doctors, therapists, nurses, healthcare support workers, pharmacists, patient experience, domestic staff and administrators and the trust's board. During the inspection we also spoke with patients and relatives. We visited numerous clinical areas across the hospital site. We reviewed patient records, national data and other information provided by the trust.

We held several staff focus groups with representatives from all over the trust to enable staff who were not on duty during the inspection to speak to inspectors. The focus groups included junior and senior staff from pharmacy, junior and senior nursing staff, junior doctors and consultants, allied health professionals, staff representing equality diversity and inclusion, a separate focus group for staff from a black, Asian and minority ethnic backgrounds. We also had focus groups for the non-executive directors and governors.

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

Outstanding practice

We found the following outstanding practice:

Trust wide:

- Blackpool Teaching Hospitals NHS Foundation Trust had been nationally recognised, and received awards, for the work it had done in the independent sexual violence advisor (ISVA) service. The team of the trust's ISVA's were employed pan Lancashire and were finalists for the nationalist unsung hero awards in November 2021. This work had been published in 2021. The team saw over 300 victims per year.
- The trust had been successful in a bid to secure additional funding for a hospital based independent domestic violence advisor (IDVA) service, with the role being to support patients and staff who were victims of domestic abuse and violence. This funding was for two years form April 2021 to March 2023. This funding had enabled additional resource to ensure additional IDVA provision was available across a seven-day period and out of hours. Learning from the trust IDVA programme has been shared nationally and includes services for staff who are victims of domestic violence.
- The trust launched an initiative in collaboration with the police in response to the COVID-19 pandemic and the initial lockdown where health IDVAs employed by the trust responded to victims of domestic violence with local police officers. This focused on high harm and category one calls and aimed to reach out to victims and families

Our findings

experiencing domestic violence who were no longer presenting in health settings because of lockdown and to provide timely safe responses. The project has shown that the joint working between immediate response (IR) officers and health IDVAs has increased the levels of engagement with domestic abuse victims in terms of both safeguarding support and cooperation with investigative processes by over 40%.

- The trust had implemented an emergency department navigator service following an initial scoping exercise in 2019. The service aims to reduce harm for attendances aged 10-29 years with attendances linked to serious violence including criminal and sexual exploitation. This work was presented to the current Minister of State for Crime and Policing at the Home Office, and we will continue to report our monthly figures of around 185 directly to the Home Office each month. The data showed only 5% of young people who accessed this service had reattended at the emergency department.
- The trust had been awarded Veteran Aware Accreditation. The award from the Veterans Covenant Hospital Alliance (VCHA) was in acknowledgement of dedication to treating veterans with compassion and empathy. The trust was one of 33 trusts nationally to be accredited.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 32 legal requirements. This action related to trust wide, urgent and emergency care, medical care, surgery and critical care services.

Trust wide

- The trust must ensure that it is effectively and appropriately assessing and managing the risks to service users who are waiting to receive care and treatment. This must include effective systems to identify and reprioritise service users based on changes to their presenting risks including but not limited to patients accessing emergency care and those on waiting lists. (Regulation 17(2)(b))
- The trust must ensure it has effective systems and processes to make sure incidents are reported, reviewed, and investigated appropriately so that lessons are identified and shared with teams. (Regulation 12 (2)(b))
- The trust must ensure there is continuous assessment, monitoring and improvement in the quality and safety of the services provided in the carrying on of the regulated activity including the quality of the experience of patients in receiving those services (Regulation 17 (2)(a))
- The trust must ensure that effective processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk which arise from the carrying on of the regulated activity; including an effective audit programme that monitors patient care, that contains actions that improve the care and treatment provided at the trust (Regulation 17 (2)(b))
- The trust must ensure it maintains securely an accurate, complete and contemporaneous record in respect of each patient ; including a record of the care and treatment provided to the patients and of decisions taken in relation to the care and treatment provided (Regulation 17 (2)(c))

Our findings

- The trust must ensure that it evaluates and improves its practices in respect of the processing of the information (Regulation 17 (2)(f))
- The trust must continue work to improve the recruitment and retention of medical staffing to ensure patient safety; (Regulation 18 (1))
- The trust must ensure that staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This must include improving the number of medical consultants with jobs plans and improve the trust appraisal figures for staff. (Regulation 18 (2)(a))
- The trust must ensure they are effectively assessing and managing the risks to the health and safety of patients receiving care and treatment. The trust must ensure they are doing all that is reasonably practicable to mitigate any such risk. (Regulation 12 (a)(b))

Urgent and Emergency Care

- The trust must ensure that effective and timely care is provided; including at triage and assessment to improve patient access and the flow of patients through the emergency department and the hospital so that patients are treated and admitted or discharged in a safe, timely manner. (Regulation 12(1))
- The trust must ensure that risk assessments relating to health, safety and welfare of people using the services must be completed and reviewed regularly and that staff respond appropriately and in good time to peoples changing needs. (Regulation 12(2a))
- The trust must ensure the proper and safe management of medicines. (Regulation 12(1)(2)(g))
- The trust must ensure that they have robust systems in place to assess the risk of, prevent, detect and control the spread of, infections. (Regulation 12(2)(h))
- The trust must ensure that the premises are safe to use for their intended purpose and are used in a safe way. (Regulation 12(2)(d))
- The service must ensure that medical staff receive appropriate training and professional development, this should include but not be limited to training in life support and safeguarding training, as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (1)(2)(a))
- The service must operate effective systems and processes to assess, monitor and improve the quality of services provided and mitigate any associated risks. This includes but is not limited to ensuring patients can access the service when they need it and do not stay longer than they need to. (Regulation 17 (1)(2)(a)(b))
- The trust must ensure that there are enough suitably trained medical and nursing staff in the emergency department. (Regulation 18(1))

Medical Care

- The service must continue work to improve the recruitment and retention of nursing and medical staff to ensure patient safety, including on the acute stroke unit. (Regulation 18(1))
- The service must ensure mandatory training compliance (including safeguarding) is improved to support patient safety. (Regulation 18(2)(a))

Our findings

- The service must effectively and appropriately assess and manage the risks to service users who are waiting to receive care and treatment. They must have effective systems to identify and reprioritise service users based on changes to their presenting risks. (Regulation 17(2)(b))
- The service must work to reduce the backlog of incidents which require investigation. They must ensure they have effective systems and processes in place to ensure incidents are reported, reviewed, and investigated appropriately to ensure lessons are identified and shared with teams (Regulation 17(2)(a)(b))
- The service must make sure that when a patient is unable to consent to their care and treatment staff follow national guidance regarding the requirements of the Mental Capacity Act 2005. (Regulation 11 (1)(3))
- The service must ensure that staff are made aware of and follow the trust policies relating to rapid tranquilisation and ensure that the Guidance in Relation to the Use of Control and Restraint policy reflect national guidelines for the administration and management of patients requiring rapid tranquilisation to keep them safe from harm. (Regulation 12 (a)(b)(c))

Surgery

- The trust must ensure that staff assess and record patients' mental capacity to consent to care and treatment inline with all legal requirements. (Regulation 11(1))
- The trust must ensure the service improves how it monitors, acts, and records the steps it has taken to reduce and mitigate risk. (Regulation 17(1))
- The trust must ensure the service acts and implements all identified necessary actions to mitigate risks to the quality and safety of services. (Regulation 17(1))
- The trust must ensure the service assesses, monitors and improves fundamental quality standards through a robust program of audit and improvement actions, particularly but not limited to, NEWS and the management of a deteriorating patient, patient consent, audit outcomes, patient outcomes and the WHO safer surgery standards. (Regulation 17(1))
- The trust must ensure that sufficient numbers of suitably qualified, competent, skilled, and experienced registered nurses are deployed to provide safe care and treatment to patients. (Regulations 18 (1))
- The trust must ensure that there is an effective system of annual appraisal in place, to ensure that all staff are supported to fulfil their roles. (Regulations 18 (1)(2)(a))

Critical Care

- The trust must ensure that care and treatment of service users must only be provided with the consent of the relevant person, especially in relation to the Mental Capacity Act. (Regulations 11(1)
- The trust must ensure the service has enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, including compliance with mandatory and safeguarding training. (Regulation 18 (1))
- The trust must ensure effective governance processes to assess, monitor and improve the quality and safety and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (Regulation 17)

Action the trust SHOULD take to improve:

Our findings

Trust wide

- The trust should ensure there is clarity in the roles and responsibilities of executive leads and that roles allow equitable capacity for the executive directors.
- The trust should ensure there is a clear vision that is shared throughout the trust.
- The trust should ensure there are relevant and up-to-date strategies in place within the trust.
- The trust should monitor and measure patient care and treatment to ensure quality care is being provided against the strategies and policies.
- The trust should ensure it improves equality, diversity and inclusion in daily work for all protected characteristics, including staff from a black and ethnic minority background, staff with a disability and staff who are pregnant and take maternity leave.
- The trust should ensure it improves the culture within the trust, to include ensuring the freedom to speak up guardians are more visible to allow staff to feel able speak up.
- The trust should consider engaging with staff prior to making improvement decisions and changes to strategies and frameworks.

Urgent and Emergency Care

- The trust should ensure that lessons learned from incidents are shared and new processes are embedded into practice to prevent reoccurrence of incidents.
- The trust should continue to work to recruit a paediatric emergency medicine consultant.
- The trust should ensure it securely maintains accurate, complete and contemporaneous records in respect of each patient.
- The trust should ensure that care and treatment is provided with consent from the relevant person.

Medicine

- The trust should ensure that all pages of a patient's records have their identifying details recorded and that staff sign and print their names and designation clearly against each entry in patient records.
- The trust should ensure that all patients requiring barrier nursing are placed in isolation as per national guidelines.
- The trust should review their current transcribing discharge service to ensure that there are clear lines of responsibility.

Surgery

- The trust should ensure that all staff report incidents in line with trust policy.
- The trust should ensure that patients have access to food and drink that meets their religious, personal or individual.

needs.

- The trust should ensure it takes actions and monitors the effectiveness of actions to reduce surgical site infections.
- The trust should ensure that all learning from significant incidents and never events is shared across the trust.

Our findings

- The trust should consider options to increase the visibility of the divisional management team on wards and in theatres.

Critical Care

- The trust should ensure the appropriate completion of patient risk assessments such as the admission clerking for elective cardiac intensive care patients.
- The trust should ensure arrangements are in place for patients within cardiac intensive care to be reviewed by relevant specialty doctors daily in conjunction with the cardiac intensive care team.
- The trust should ensure that records are accurate and follow record keeping standards for doctors, nurses and allied health professionals.
- The trust should consider a process to improve compliance with important standards such as the Intensive Care Society standards including daily screening for delirium.
- The trust should consider the use of audit to monitor and improve patient outcomes.
- The trust should consider involving staff in the development of strategy and ensure they understand the key objectives within the divisions.
- The trust should prioritise the promotion of equality and diversity and the development of critical care services in a way that meets the needs of those with a protected characteristic.
- The trust should engage with patients, staff, equality groups, the public and local organisations to plan and manage critical care services.

Is this organisation well-led?

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

Leadership

Senior leaders demonstrated the necessary knowledge and capability however, not all leaders had the capacity to lead effectively because of the extensive range and nature of the role. They worked well as an executive team and with leadership teams across the trust. There were several new appointments to the board but the plans they had developed had not yet had time to evidence their impact or sustainability. However, not all senior leaders were visible or approachable in the organisation. Leaders were not always fully sighted with what was happening on the front line. They did not always identify their priorities and did not always develop plans to manage these in an effective and timely way.

The majority of the executive team had been appointed from 2019 onwards. The portfolios for the directors were not equally distributed with some significantly larger than others. For example, the director of finance only managed the financial affairs of the trust, whereas the chief operating officer managed estates, inpatient and emergency care, access and flow, chaired the urgent and emergency care delivery board and was responsible for the demand and capacity plans. This was similar within other executive roles. There was also a lack of clear lines of accountability for some key aspects of roles, particularly information management.

Our findings

The chief executive officer (CEO) had started in post two weeks prior to the well led inspection and had previous CEO experience in an NHS trust. They had a good knowledge and understanding of the trust and the extent of the work required including the necessity to work in partnership with the newly forming integrated care system (ICS) and provider collaborative

The medical director started in post on 1 January 2020 having previously been a non-executive director of the trust since 2018.

The director of finance was appointed in June 2021, having previously been the chief finance officer for the trust. This director's portfolio was primarily finance.

The director of nursing started in post in August 2019 initially as an interim director of nursing and was now permanent, having previously been in senior nursing positions at other NHS organisations.

The chief operating officer (COO) commenced in the role in April 2021, this being their first executive role. The accountability for operational oversight was a split role between the COO and the director of integrated care. The COO had responsibility for the inpatient bed holding divisions; integrated medicine and patient flow (IMPF), surgery, anaesthetics, critical care and theatres (SACCT) and tertiary divisions. This was from both an elective and emergency perspective. In addition, the COO had the responsibility for estates.

The director of integrated care had responsibility for out of hospital and support services; families and community care (FICC) and clinical support services (CSS) divisions. In addition, the director for integrated care had the portfolio for both performance and emergency preparedness, resilience and response (EPRR). These split roles caused a level of confusion in terms of roles, responsibilities and accountabilities in the organisation.

Blackpool Teaching Hospitals NHS Foundation Trust had a number of shared roles with another trust within the integrated care system (ICS). These roles included the director of human resources, the director of corporate governance, and company secretary. We were concerned that this gave limited capacity for executive oversight within these roles. At the time of our inspection the joint posts were under review by the chief executive officer.

The trust chair had been in post since 1 February 2021 and had experience of being a non-executive director of an NHS trust; this was their first NHS trust chair position. There was a varied mix of skills and experience across the nonexecutive directors (NEDs). The chair told us the existing skill set was reviewed to determine any specific requirements when new NEDs were recruited. There was a process for induction of NEDs. There had been some recent new NED appointments at the time of our inspection. The non-executive directors (NEDs) chaired subcommittees of the board and brought a variety of experience, which enabled them to perform their roles.

The trust had a council of governors, with regular governor meetings which were attended by varying non-executive directors and some executive directors. There was a mix of longer serving and newer governors on the Council. The collective view from council members we spoke with was that the trust was heading in the right direction. There had previously been concerns with communication between the non-executive directors and governors. However, new 'shadow committees' had been established with approximately four governors attending each one, which governors told us they had welcomed.

The trust had good succession planning in place for the medical director, chief nurse and chief operating officer posts. They had strengthened their teams with deputy posts within the corporate teams and assistant director posts within the directorates.

Our findings

There had been changes within the senior leadership team in the pharmacy department; the chief pharmacist was described by staff as being a breath of fresh air who had an open-door policy. A new full-time medicines safety officer (MSO) had been appointed. The department had a clear succession plan but were concerned about the ability to recruit some roles; pharmacists were impacted by the national shortage.

Fit and Proper Persons Requirements (FPPR)

We found that the Fit and Proper Person Procedure was fit for purpose and the files were predominantly in line with the requirements of the regulation.

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This included checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

We reviewed six executive and non-executive director files in total. Our review included checks for both newly appointed and established appointments. All files included references and signatures saying copies of original documents such as degree certificates had been seen.

The trust used a mixture of paper and electronic staff files to store information for the fit and proper persons requirements.

All the files contained a yearly self-declaration, made by the directors, to confirm they remained fit and proper. We found these were completed consistently and in line with the trust's procedure.

We also looked at the trust's fit and proper person procedure and spoke to the company secretary who was responsible for oversight and compliance with the FPPR procedure and found it was fit for purpose.

Vision and Strategy

The trust did not have a clear vision but had identified clear ambitions for what it wanted to achieve in the short to medium term this was articulated in a one-year strategy. The one-year strategy was focused on the management of immediate and emerging risk. The trust was developing a new five-year vision and strategy, delayed because of COVID-19. The five-year strategy was focused on sustainability of services and aligned to local plans within the wider health economy. However, there were several strategies that were out of date.

The trust's leadership was in the process of developing a vision and five-year strategic framework for the future. They had a plan on how they were going to achieve this.

Operational staff we spoke with could not articulate what the trust vision was or whether there was in fact a current trust vision in place. We reviewed several trust policies and strategies, there was no single vision but several differing versions. Following the inspection, the trust submitted a One Year Plan on a Page. This set out the vision to 'restore and reset services' as a one-year interim strategy whilst the trust longer term five-year strategy was being co-produced with staff and patients.

The interim one-year plan, for 2021/22 set out the ambitions for 'No Waits, No Waste, Zero Harm'.

Our findings

The trust also submitted information of board development sessions being socialised with the senior leadership team. This presented a timeline for the socialisation and development of the new trust strategy and vision from April 2022. It set out the board ambition to have only one overarching strategy and underpinning strategic plans. The strategy timeline set out the timeframe of moving the strategy from a board strategic framework to a strategy document and align business plans.

In the meantime, the trust had put in an interim one-year strategy for 2021/22 which focused on three key ambitions: zero harm, no waits and no waste. These three ambitions were underpinned by work programmes focused on getting the groundwork right, ensuring foundations were built to deliver a stronger, more resilient, fit for the future health and care service across the Fylde Coast. The aim of the one-year strategy was to ensure the foundations were in place across all services to build, collaborate and develop a new five-year strategy. All staff spoken with during inspection were aware of this one-year strategy.

At the time of our inspection the trust had a draft of the five-year strategy but had not yet engaged staff at any level in the development of this. We were told that, prior to the launch, there would be "big conversations" and further engagement with staff.

We were presented with a proposed vision "Safe effective care for everyone, everyday" as part of the draft five-year strategy, but this had not yet been shared with staff. Directors informed us the development of the new national integrated care systems and integrated care partnership were being taken into account when developing the five-year strategy. The new five-year strategy was not due for implementation until April 2022.

The trust had four clearly stated values:

- People centred: serving people is the focus of everything we do
- Compassion; always demonstrating we care
- Excellence; continually striving to provide the best care possible
- Positive; having a can-do response whatever the situation
- The values were clearly articulated in the policies and procedures that we reviewed.

There were a number of strategies out of date within the trust;

- Dementia Strategy (2016 - 2019)
- Health Informatics strategy (2016-2020)
- Employee engagement strategy (April 2019 – March 2021)
- Compassionate Leadership and just culture strategy (August 2019 – July 2021)
- Apprenticeship Strategy (September 2019 – March 2021)
- Health and Wellbeing Strategy (April 2019 – March 2021)
- Clinical Education Strategy (April 2019 – March 2021)
- Recruitment and Retention Strategy (April 2019 – March 2021)

The leadership were aware of this and were in the process of creating one, single, five-year trust strategy, which would include the current separate strategies. It was envisioned that each division would develop their own strategy to align

with the new trust five-year strategy. The new single trust strategy was due to launch in April 2022. The trust did not have an overarching people strategy in place. We requested a people strategy and were sent a variety of strategies relating to human resources and workforce; however, all but one was out of date. We were provided with a narrative that informed us the trust were reviewing their governance processes to consolidate these strategies into one people strategy. However, no date was confirmed when this process would be completed.

We requested a quality and safety strategy for the trust, we were sent a quality improvement strategy.

The trust had a medicines optimisation strategy, which included a focus on having no waits, no waste and no harm within the trust. A key strand of this was to ensure medicines reconciliation was completed within 24 hours; the trust was at 84% Monday to Friday and 19% during the weekend. The weekend medicines reconciliation figure was well below the National Institute for Health and Care Excellence (NICE) national guidelines of 90% within 24 hours. The trust board was aware of the reduced weekend figures and had given funding to recruit more staff, although we were told that recruiting staff had not been easy. The trust had a plan to move to an electronic prescribing and medicines administration (ePMA) system in 2022.

Dementia and Learning Disabilities

The trust had a new lead for dementia and learning disability with an associate director of nursing for support. The lead started in December 2020. The lead was passionate and had a vision for future achievements. There were 148 dementia champions and 156 learning disability champions who met in the respective monthly meetings.

The trust dementia strategy was developed in 2016 for use until 2019. This strategy consisted of seven key action areas which included patient-centred care, education and training, and partnership working. The trust did not have a learning disability strategy in place, but it did have some guidelines for the care of people living with learning disabilities when accessing trust services. The trust was in the process of developing a new dementia and learning disability strategic plan. Consultation events had been undertaken prior to the development of the new strategic plan.

The trust aimed to develop a skilled and effective workforce championing dementia care. The trust had a two-tier training programme for staff; however, this was not deemed to be mandatory training. Trust wide between October 2020 and September 2021, 117 members of staff had completed the tier two dementia training, and trust wide between November 2020 and November 2021, 19 had completed tier one training.

The trust advocated the use of the patient passport, “paint me a picture” cards to support staff to care for patients with dementia and learning disabilities. Staff on inspection could tell us about the “about me” documents. During the core service inspections, we saw two patients with complex care needs with an “about me” document. The trust also advocated the use of ‘John’s Campaign’ which enabled support mechanisms for patients, carers and staff members affected by dementia. The trust recommended the use of the butterfly scheme for recognising patients with dementia. However, the use of the “paint me a picture cards”, patient passports john’s campaign and the use of the butterfly scheme were not audited by the trust.

We requested evidence of the audits for the use of the tools; about me documents, paint me a picture, John’s Campaign and butterfly scheme, during interviews, with the lead for dementia and learning disabilities and they stated the Collaborative Organisation Accreditation Systems for Teams (COAST) Programme was used to gain assurance of the use of the tools. The COAST accreditation scheme is discussed further within the governance section of the report.

Our findings

The trust was in the middle 50% for three out of four measures for the national audit of dementia and performance was in line with the 2018 audit. There had been improvement in the percentage of mental state assessments carried out during admission. They were in the bottom 25% of hospitals for MDT discharge discussion. The clinical audit progress report shared with the quality and clinical effectiveness committee in April 2021 stated the Royal College of Psychiatrists (RCP) National Audit of Dementia was suspended during the COVID-19 pandemic. The trust participated in the RCP pilot audit for the initial assessments of patients aged over 75 in September 2021, this audit was to direct future audits by RCP. The trust did not undertake further audits in the care and treatment of patient's living with dementia.

The dementia and learning disability lead fed into the quality and clinical effectiveness committee twice a year. We requested evidence on the monitoring and measurements undertaken to ensure quality care was being provided to patients living with learning disabilities and dementia. The trust sent a learning disability report that was shared with the board which included an action plan. We requested but did not receive evidence relating to the care and treatment of patients living with dementia.

Culture

Not all staff felt supported, respected and valued by their local leaders. All staff we met were focused on the needs of patients receiving high quality and compassionate care. There was a lack of supportive inclusion for staff with protected characteristics. The trust was working towards an open culture where patients, their families and staff could raise concerns without fear. However, not all staff felt secure to raise concerns.

We were told that not all staff within the trust felt able to raise concerns and were afraid they would not get heard and assessed appropriately. There was a staff equality, diversity and inclusion ambassadors' network, but there were not staff forums in place at the time of our inspection. We were told by staff that the trust did not always effectively support staff from differing communities, for example LGBTQ (lesbian, gay, bisexual, transgender and queer/questioning sexuality), disability or black and minority ethnic (BaME). This meant that the staff with protected characteristics may not be heard.

The NHS Staff Survey 2020 showed that 46% of staff had suffered from work related stress. This was worse than the national average. The trust recognised that staff wellbeing was an important factor to consider especially during a global pandemic. The trust had appointed a trainee associate psychological practitioner in January 2021, the post provided therapeutic input for staff, initially focussing on COVID-related conditions, with a focus on PTSD. In September 2021, a consultant clinical psychologist started in occupational health. The remit was for three days strategic work and two days staff support. In August 2021, a mediation coordinator was appointed to re-introduce a mediation service, and eight places were funded for mediation training in November 2021.

The trust had trained 120 wellbeing and engagement champions. This was a role designed nationally to promote, identify and signpost colleagues to wellbeing support. The wellbeing team within the trust offered bi-monthly drop-in sessions for staff with a different theme each session. This was a proactive way to promote wellbeing within the trust.

The trust confirmed they did not have any mental health first aiders. Staff side told us they had funding available for training mental health first aiders but at the time of our inspection the trust had not taken up this opportunity. There was a potential that mental ill health for staff may not be recognised appropriately.

The trust had a guardian for safe working hours who reported to the board on a quarterly basis. The report was shared at the quality and clinical effectiveness committee in September 2021. The meeting minutes noted that medical staffing

was a risk to the trust with a concern with the rota structure. It was minuted that there were some parts of the report that were in relation to patient safety issues, but details had not been provided to the committee. The risk that the trust was unable to attract the appropriately skilled and representative workforce had been on the risk register since November 2020.

The trust provided a nursing and midwifery staffing dashboard which showed from March 2021 to August 2021, there were 61 registered nursing and midwifery staff new starters compared to 97 registered nursing and midwifery staff leaving. In addition, we reviewed the resignation reasons within the dashboard sent and work life balance was the highest reasons the second and third highest reasons were for retirement. We were concerned that a number of registered nursing and midwifery staff are leaving the trust compared to joining.

At the time the trust also had 80.62 national and 42 international job offers in place. In addition, the HCA dashboard also provided detail of 83 international nurses in the trust completing OSCi training and awaiting PIN numbers. Once all PINs were received those with job offers would commence in the trust.

The trust-wide appraisal rate was low. The low appraisal rates were discussed at the operations committee in September 2021. The trust overall appraisal rates for non-medical staff were 22%. We saw there was limited assurance at senior level regarding the low compliance figures for appraisals. This meant that staff may not have had development and learning opportunities identified and implemented. However, following the inspection the trust have stated that the NHS Staff Council advised to pause the need for staff to demonstrate they met the requirements of the role for the duration of the pandemic. During the pandemic clinical staff accessed development opportunities which were funded by Health Education England continuing professional development monies.

The trust had a joint freedom to speak up office which was shared with another trust within the integrated care system; there was one full time head for the joint freedom to speak up office. Staff across told us they were not familiar with the FTSU office at the time of our inspection. However, they were making plans to relaunch the FTSU guardian's office and improve their visibility.

The lead for the FTSU guardians told us the trust had 12 freedom to speak up champions recruited and trained in the 2021 national guardian's office; "Guidance for developing freedom to speak up champions". They were aiming to recruit up to 20 FTSU champions with representatives from each protected characteristic.

In October 2021, the National Guardians Office (NGO) published a case review of the speaking up culture and arrangements at Blackpool Teaching Hospitals NHS Foundation Trust. The review was undertaken from October to December 2020 due to information received relating to the speaking up culture. The report described the key findings under three key headings and reported concerns that included:

Speak up Culture

- Most workers we spoke to described long-standing issues with the speaking up culture.
- Speaking up had not always been responded to in accordance with good practice.
- Speaking up training had variable reach and uptake and was not always in line with good practice.

Freedom to speak up guardian

- Some groups of workers faced barriers to speaking up not necessarily experienced by other workers.

Our findings

- Understanding of and support for the freedom to speak guardian role was not always consistent.
- There was ineffective continuity planning for the freedom to speak up guardian role.
- The freedom to speak up champions/ambassadors' network was not functioning effectively.

Leadership

- The speaking up strategy required updating, including a comprehensive speaking up communications strategy.
- The positioning of the freedom to speak up executive lead role was perceived by some workers as a conflict of interest.
- Workers who had spoken to national bodies had variable and sometimes less than good experiences.

The FTSU guardian told us that the NGO report had highlighted changes required to the speaking up culture within the trust. There was an action plan under development at the time of our inspection.

The FTSU guardian had executive director sponsor, this being the executive director of human resources and organisational development. The trust did not have a non-executive director sponsor at the time of inspection but were in the process of recruiting into this position. The FTSU guardian attended the board meetings and presented their report.

The executive lead for FTSU stated that there had been an improved speaking up culture year on year We asked the FTSU guardian for the figures and they were similar to the previous quarters. In quarter one 2020 the trust had received 54 FTSU concerns, this dropped to 15 concerns raised during quarter two 2020. The trends of the FTSU concerns raised were similar in the following quarters. In quarter one in 2021, 17 concerns were raised.

Compliments

The trust had been capturing the compliments through electronic forms, social media, thank you cards, parcels and praise that wards and departments received. The trust reported 6,054 compliments were registered by divisions on the experience platform between October 2020 and October 2021. The trust was working towards ensuring compliments were shared to allow the board oversight of the feedback about staff, wards and departments.

In addition, the trust had developed the recognition rainbow that was on display in the main reception entrance of the hospital to show the compliments and positivity within the trust. The recognition rainbow was updated every quarter by the patient experience department with compliments taken off the experience system from the past three months. This was an effective way to share positive patients' experiences to staff and visitors to the trust.

Inclusion and Diversity

The trust had work to do in relation to promoting equality, diversity and inclusion in daily work.

A key theme in the trust's one-year strategy was addressing inequality, with an example of creating staff networks. The description of work, activities and deliverables for this included:

1. Transparent culture; staff work in support of trust policy on equality and diversity.
2. We have a very diverse workforce.

3. Mentoring support is available; clinical supervision programme for all staff is in place. Available staff coaching.
4. Prompt escalation of any concerns.
5. Equality and access across the network.

However, at the time of our inspection we did not see evidence of how the trust was meeting this objective. There was a staff equality, diversity and inclusion ambassadors' network, but there were no other staff networks within the trust to offer staff with protected characterises support and advice. Staff we spoke with, who had protected characteristics, were not aware of any mentoring support available to them in relation to equality, diversity and inclusion.

We were told the executive sponsor for equality, diversity and inclusion was the executive director of human resources, but ambassadors and other senior leaders were not aware of this. There was no current non-executive director sponsor for equality, diversity and inclusion as the previous non-executive director sponsor had left the organisation. No staff we interviewed knew who the previous non-executive director sponsor was for equality, diversity and inclusion.

The trust told us that they held equality, diversity and inclusion committee meetings quarterly. Executive directors told us these committee meetings were not well attended.

Additionally, the trust held equality, diversity and inclusion ambassador network meetings which were held and chaired by the head of equality, diversity and inclusion. We received the ambassadors network meeting minutes for October 2020, April 2021, and August 2021; these were the only meetings held between October 2020 and the time of our inspection. The meeting agenda followed a set meeting framework. From the meeting minutes there was limited evidence as to how effective the meetings and any subsequent actions were.

These ambassador network meetings were reported to be poorly attended and with poor representation. Senior leaders told us there were 26 ambassador members in total and on average 11 attended meetings. However, the meeting minutes showed that between four and six ambassadors attended these meetings, and 11 in total when including apologies. This evidenced concerns that ambassador meetings were not well attended or effective.

We requested the most up-to-date equality, diversity and inclusion report presented to the board, the trust shared the October 2020 bi-annual equality, diversity and inclusion monitoring report to the board, which was for data between April 2020 and September 2020. There was limited evidence of discussion or oversight from senior leaders about equality diversity and inclusion within the past 12 months.

Senior leaders told us that there was a disconnect in relation to what staff were disclosing on the electronic staff record (ESR) in respect of health concerns (3%) compared to what staff disclosed on the staff surveys (18%). This posed the trust a problem in relation to ensuring staff had the correct support and reasonable adjustments in place. In the equality, diversity and inclusion report to the board in October 2020, the figures for disclosing a disability or long-term health condition were just under 3% which was similar when compared nationally. However, the trust report showed that above 24% of staff had chosen not to declare a disability or long-term health condition, which was just under double when compared nationally. This evidenced that staff did not feel comfortable to disclose protected characteristics and showed concerns that there was a lack of support inclusion for staff with protected characteristics.

In the equality and diversity report to the board in October 2020, the trust stated that data relating to pregnancy and maternity including human resources procedures, leavers, recruitment and training are not currently recorded. However, the trust did monitor the number of staff on maternity leave.

Our findings

The trust provided two equality, diversity and inclusion strategies; the first dated October 2019 to March 2022, the second was in draft form from January 2021 to March 2024. There was no evidence that either of the strategies were approved and signed off at the board or any committee. There was no equality impact assessment in the finalised October 2019 strategy.

Most trust policies reviewed contained an equality impact assessment, but it was not clear if these had been completed with the consideration of people from equality groups. The assessments were completed by the author and co-author but there was no evidence on the assessment that people with protected characteristics had been consulted or if the policies had been through the equality, diversity and inclusion committee or ambassador group for consultation in terms of any potential impact from an equality, diversity and inclusion perspective.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce. The trust WRES data for 2020 showed the latest assessment of race equality at the trust showed an improvement on seven of the nine indicators. The trust had identified priorities for WRES which would be to focus on recruitment processes and talent management opportunities. This was supported in the October 2020 equality, diversity and inclusion report to the board where there was a noted decrease in BaME and unknown categories of staff applying for promotions.

The WRES race disparity ratio indicated the trust had a progression disparity ratio for middle to upper 'Agenda for Change' staff of 1.1, which was below the goal of 1.5. The trust told us that the BaME workforce had grown from 8% in 2018/19 to 12% in 2020/21. This was an improvement compared to our previous inspection.

The WRES data was not shared across the trust. Senior leaders were unsure of how or if this information was shared across the trust. Staff interviewed had not seen this information being shared or any resulting action plans from it.

The trust had commenced the reciprocal mentorship for inclusion programme in October 2021 for a period of 18 months; this was led by the organisational development team. We were told that historically staff from a BaME background were less likely to apply for training. Therefore, the trust was keen to encourage staff from a BaME background to be involved in the reciprocal mentorship programme. The intention was that other staff with protected characteristics will be involved in the future.

Governance

The arrangements for governance were not clear and did not always operate effectively. However, the trust had identified this as a concern and had sourced an external organisation to review and report on governance processes throughout the trust. Not all staff in leadership roles were clear about their roles and accountabilities. Processes were not always effective and completed in a timely manner.

Key information regarding service quality and emerging risks was not always clearly and effectively communicated for the trust board to be able to respond to with actions. At senior level, there was a reliance on reassurance rather than assurance in board level processes. This was acknowledged by a number of board members during interview.

The trust had a committee structure in place to manage the board's business. There had been a recent restructure of the committee's due to COVID-19 which had reduced the number down to three; quality and clinical effectiveness, operations and audit. However, the committee structure at the time of the inspection did not appear effective. For example, the operations committee had a wide remit and included workforce, finance and performance. The incoming CEO had acknowledged this and was reviewing the committees with a view to creating a revised structure.

Our findings

We found when issues were raised through the governance structure, they did not always reach the board and the board were not always fully aware or sighted on the operational issues. The operations committee received corporate risk register updates which included the number of risks open within the trust and the status of the risks. Key issues of risk and patient safety were not always represented within board papers to the full extent of the concerns and minutes of meetings did not detail that these issues were fully acknowledged and acted on. In the operations committee meeting board paper for July 2021, it was minuted that "although risk scores were reducing it was not clear how they were being managed and stated that more assurance was required around this". We were concerned that there was a disconnect in how risks were managed divisionally and the oversight from the board.

We reviewed minutes of the clinical effectiveness committee and operations committee and also minutes of the board meetings. We did not always see evidence of constructive challenge from the NEDs to the executive directors recorded in meeting minutes.

We reviewed the annual governance report 2020/21. The report identified that the board committees monitored and reviewed the board assurance framework to ensure it was effective and reported to the board of directors on the assurances. This report also identified that the risk management policy assigned responsibility for the ownership, identification and management of risks to all individuals at all levels of the trust, this was to ensure that risks which could not be managed locally were escalated through the trust in a timely and methodical way.

The trust strategy identified that the board assurance framework was an essential tool for the board to seek assurance against the delivery of key organisational objectives. We reviewed the trust's board assurance framework (BAF), which was generic and was not fully used by the board. For example, the minutes of the clinical and quality effectiveness committee showed the BAF as the seventh agenda item rather than a tool that was used throughout the meeting. In the September 2021 board report, it was agreed that the BAF would be discussed at the audit committee just twice yearly from September 2021. It was not clear how the board could be assured that the committee's understood risks, participated in informed engagement and implementation of risk management opportunities. We requested a board assurance standard operating procedure and the trust confirmed that they do not have one.

Board private meeting minutes were provided by the trust for the months of March, May and July 2021.

The BAF detailed the trust's five priority areas of risk. A summary of these is below:

1. Quality and clinical effectiveness
2. People and workforce
3. Finance
4. Performance
5. Partnership working

(Source: Trust Board Assurance Framework – September 2021)

The risks were evaluated according to a red, amber and green (RAG) rating system. Although they had residual (current) controls in place, all five were RAG rated red at the time of our inspection, with the exception of one element of people and workforce which was RAG rated as amber.

Our findings

Each division held quarterly divisional performance reviews but it was not clear how directors gained assurance from the divisions. The trust told us but did not provide evidence that the divisions reported on operational performance, quality and safety, risks and governance, workforce, finance, and forward view on the division's priorities.

During our inspection we heard from several directors who described how workstreams were delegated to the divisions. However, we did not see, and executives did not effectively describe evidence of clear reporting lines from the divisions back to the board.

The trust had commissioned an external company, from April to September 2021, to support the development and improvement of quality and clinical governance within triumvirate divisions. The company undertook workshops, providing a structured means to allow for self-assessment and organisational performance against a range of indicators of good governance for each division. This allowed each division to gain an understanding of their governance processes and created action plans where they felt improvement was required.

The chief pharmacist had reviewed the lines of communication and accountability between the chief pharmacist and the board and had found gaps in the structure. The structure had changed to plug these gaps. The medicines risks within the trust were raised via the medicine's safety group.

Medicines Safety committee was internal only and represented by pharmacy only staff. This committee reported into the multidisciplinary medicine's management committee. The Medicines Management Committee included various members from the multidisciplinary teams and had good divisional representation. The trust used 'The Model Health System' data-driven improvement tool to benchmark themselves against other trusts to improve on quality and productivity.

Clinical audit

The trust provided quarterly clinical audit reports to the board regarding the clinical audit annual work plan (CAAWP). The CAAWP had been approved by the quality and clinical effectiveness committee and trust board. The clinical audit and effectiveness department, with oversight from the quality and clinical effectiveness committee, monitored audit progress and circulated published national reports to divisional management teams with details of action plans to be completed. The trust required divisions to re-audit in order to provide assurance of the improvements made within six months of completion of action plans. The system allowed for escalation up to board and to divisions, however it was not clear how the communication of audits and learning was shared through the trust and within the departments. Not all staff who we spoke with during the core service inspections were aware of any audit activity taking place. Some senior nurses were not able to tell us how patient outcomes and performance was being monitored. Following the inspection, the trust reported they had appointed a new associate medical director for mortality, governance and clinical audit who started in October 2021.

We requested the most up-to-date clinical audit progress report and the trust provided the audit report from April 2021. The report was for quarter four, March 2021, 278 audits had been identified on the trust's clinical annual audit work plan were to be undertaken between 2020 to 2021. These included 50 audit proposals received during the quarter. Report data results showed;

- 33% of audits had been fully implemented to date including completion of associated action plans
- 46% of audits were progressing to time
- 6% of audits were behind timescale with a plan in place to complete

Our findings

- 3% of audits were awaiting the nation report and action plan
- 8% of audits were completed to date with an action plan implemented and being monitored by divisions
- 4% of audits were behind timescale and there was a cause for concern, with no evidence of progress. These had been escalated as per policy to the speciality audit leads and quality managers

Following the inspection, the trust provided audit reports for quarter one and two which showed 94% of audits were on track for completion.

A total of 43 audits were being carried out as a result of a previous or potential risk, incident, claim or complaint occurring to the organisation. The trust was participating in 51 national audits; some national audits had been suspended due to the COVID-19 pandemic. However, the clinical audit progress report did not show results of changes and improvements to practice and patient outcomes. The trust could not always demonstrate how they were assured that audit outcomes had been appropriately reviewed and that actions required to improve services and patients' outcomes had been identified and implemented.

We noted in the September 2021 quality and clinical effectiveness committee meeting minutes that the committee had stated there was a need to review audit processes and assurance frameworks to identify improvements that were required. There was recognition in the meeting that both national and internal audits were being completed but that the assurance framework needed to be strengthened.

Collaborative Organisation Accreditation System for Teams (COAST)

The trust used the accreditation system known as collaborative organisation accreditation systems for teams (COAST) programme. COAST programme was a new accreditation programme which commenced in January 2021. The purpose of the COAST programme was to give senior leaders oversight of wards and departments against a set of approved standards. There was a related policy, approved in May 2021, which reflected the procedure of the COAST assessments for the ward and clinical area accreditation. In the data received from the trust in November 2021, the trust had completed assessments of 45 out of the 67 wards and departments listed. The trust reported improvements in 23 of the 29 wards or departments that had been reassessed so far in the process, the remaining six reassessed wards or departments were given the same rating.

The trust had a corporate team of COAST members who were supported by different professional bodies across the trust to complete the assessments. By having a core COAST membership team, it ensured that consistency was achieved in assessments and the associated reports.

The reports were sent to the responsible managers and they were expected to share these with the divisional performance boards with an action plan for improvement. The reports contained an overall rating and reassessment was completed based on the ratings;

The trust used a bronze to platinum rating scale with re-assessment being required within varying timescales dependent on the rating, the COAST trust policy states;

- Bronze was equivalent to the inadequate rating, reassessed within eight to 10 weeks
- Silver was equivalent to requires improvement, reassessed within four months
- Gold was equivalent to good, reassessed within eight months

- Platinum was equivalent to outstanding, reassessed annually

Staff in some areas reported to feeling proud of the silver rating, whereas this equated to requires improvement status. This demonstrated a potential disconnect between staff's understanding of where their ward was at and gave them a false sense of security in terms of compliance. However, it did ensure that staff felt positive in their ward or departments improvement journey within the accreditation scheme.

We reviewed the assessment process for the COAST programme, and the COAST assessment report reviewed did not specify how many records were reviewed, or how many patients or staff were spoken with during the assessment. The trust policy stated that the COAST assessment would involve at a minimum, one third of patients and two thirds of staff. We were told during the inspection that the COAST team only reviewed enough records until they felt they had adequate assurance. The report reviewed did not include the sample sizes. Therefore, it was unclear how consistency is gained in the approach and could lead to a lack of assurance and oversight at board level.

The COAST team shared quarterly reports were shared at the quality and clinical effectiveness committee. This was evidenced in the August 2021 meeting minutes.

Management of Risks, Issues and Performance

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. There were systems to manage performance, however, these were not used efficiently. The risk management approach was applied inconsistently and was not linked effectively into planning processes. Significant risks were not always identified or escalated appropriately and there were insufficient processes to identify actions to reduce their impact.

In interviews with executives and senior leaders, they were clear about the trust's top risks and articulated a coherent consistent narrative. These included medical staffing, finances and access and flow.

Following the inspection, we formally wrote to the trust twice under our powers requesting assurance about key patient safety risks identified by CQC at the core service inspections. This was specifically in relation to patients receiving care and treatment in a timely way, access and flow, staffing and infection prevention and control. The trust provided an action plan to address our concerns and we continue to monitor progress through routine engagement and system wide meetings.

We also issued a section 29a warning notice specifically relating to;

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

The corporate risk register listed organisational risks which scored 15 and above. As of October 2021, there were 23 open risks on the corporate risk register rated 15 and above. Of these, eight were rated as a risk score of 20, two of which were identified as having insufficient assurance in place. Seven of 23 open risks were identified as having insufficient assurance, including a risk that had been on the register since 2009.

Our findings

We saw one risk had been put on the corporate risk register in April 2021 and discussed at board in May 2021 as a new risk. The risk related to the trust failing to meet accessible information standards. At the May 2021 board meeting the initial risk scoring was identified as likelihood three and impact as five making a risk scoring of 15. However, this was put on the risk register as likelihood of four and impact of four, making a risk scoring of 16. There was no challenge, rationale or update at the subsequent board meeting as to the change in risk scoring.

The trust had a risk management strategy and policy which had been approved by the board in March 2021. It was evident the strategy and policy had been signed off by two corporate managers as well as the operations committee and the clinical effectiveness committee both in February 2021. The scope of the policy and strategy was to promote an integrated and consistent approach across all parts of the organisation to managing risk. The implementation of the risk strategy was through the risk management policy. However, we saw that the risk management policy was not always fully implemented across the organisation. For example, we saw risks scoring 15 and above on the divisional risk register that were not on the corporate risk register.

There was an electronic risk management system in use which meant that the risk registers were more accessible across the organisation.

One of the actions on the risk register for medical staffing was to ensure job planning consistency, to provide scrutiny, equity and fairness to all job plans. Staff raised concerns about the current job plan status at the trust. We were told while on inspection that less than 20% of consultants had signed off job plan across the trust. This was not on the corporate risk register as a current risk. The executive director of human resources was not aware of the current position. Their understanding was that no less than 70% must have job plans. The trust provided data in November 2021 stating 55% of consultants had a signed off job plan and 38% of consultants had job plans which were in progress. Senior leaders did not have a clear understanding of this risk or a robust action plan to improve medical staffing and job planning. However, at the time of the inspection the management of and improvement in job planning was recently being addressed through the newly established workforce committee, the trust had allocated a programme manager to focus on workforce transformation to support the development of a medical, nursing and workforce transformation programme.

At the time of our inspection, the trust could not undertake any agenda for change job matching as there were no trained staff representatives to undertake the consistency checking.

The trust had undertaken significant improvement in the nursing staffing vacancies since our last inspection in 2019. In March 2020, the trust had a fill rate for nursing staff at 88% of the 2120 established nursing posts required. In August 2021, the fill rate increased to 99.5% for nursing staff as well as increasing the required establishment to 2182. The trust had created plans to increase the required establishments and subsequent actual nursing staff to 2245 by February 2023.

Incident Reporting

Following the inspection, we issued a section 29a warning notice in relation to how the trust was assessing and managing the risks to patients who were waiting to receive care and treatment. The warning notice also related to how the trust managed, reviewed and investigated incidents to ensure lessons were identified and shared with teams.

Our findings

The trust did not have effective systems and processes to ensure incidents were reported, reviewed, and investigated appropriately to ensure lessons were identified and shared with teams. We were not assured appropriate action was taken following incidents to make improvements, share learning and to reduce the possibility of the same incident occurring again.

There were 1469 open incidents across the trust as of 11 October 2021. There was limited evidence of any clinical review of those incidents where the harm was categorised as moderate harm or below. There was also evidence that some incidents were miss-categorised as moderate harm or below.

The corporate risk register did not contain a risk relating to the number of incidents which had not received appropriate and timely review. The failure to record this risk on the risk register meant that trust could not evidence that the risk had been appropriately identified and escalated to board-level, or evidence that appropriate mitigating actions and controls had been implemented.

In the quality and clinical effectiveness committee meeting minutes for June 2021, there was reference to the volume of low harm and no harm incidents that had passed their closing date but confirmed that plans were in place in the divisions to address this. However, this did not identify the extent of the problem, we saw no evidence of challenge and it was not discussed at subsequent committee meetings. The committee meeting minutes for August and September 2021 showed no evidence that this was further reviewed.

We were concerned about the systems and processes for monitoring and taking appropriate action of histological findings relating to potential cancer diagnosis. There was a lack of senior oversight and assurance that learning from previous serious incidents had been actioned and embedded. Senior leaders were not assured by this process.

In the quality and clinical effectiveness committee meeting minutes for August 2021, serious incidents were not reported on. The August 2021 meeting was an extra-ordinary meeting with a reduced agenda due to operational pressures. In the September minutes serious incidents were reported on in terms of what the serious incident related to, the numbers of serious incidents that had occurred and how many investigations were completed. However, the minutes did not specify how learning was shared or demonstrate assurance or challenge about learning. This was because the September meeting did not have an update scheduled.

The trust had a learning from incidents, risk, and complaints committee and it reported to the quality and clinical effectiveness committee every six months.

The trust did not have a system which evidenced a trust wide approach to sharing lessons from incidents / never events. We heard evidence from staff there had been a lack of learning from never events that had happened in the trust where they had no knowledge of the never event happening in their department or the subsequent actions/learning. We looked at this on inspection and saw there was nothing to support the trust had systematically shared lessons learned.

We heard evidence from staff there had been a lack of learning from recent serious incidents that had happened in the division where they had no knowledge of the serious incident or the subsequent actions/learning. We looked at this on inspection and saw there was nothing to support the trust had systematically shared lessons learned.

Our findings

We saw an example where the failure to effectively share and implement lessons learnt from incidents resulted in an incident recurring. Following our inspection between 14-16 September 2021 we issued a letter setting out our serious concerns in respect of the use of rapid tranquilisation. Whilst on inspection on 14 October 2021 we saw a further patient had been given Lorazepam without the required monitoring. When we asked staff if they knew about the staff alert for rapid tranquilisation, they recalled receiving it but not the content.

Operational Performance

We were not assured that the trust had effective procedures in place to manage the elective waiting lists and ensure that patients waiting more than 18 weeks were appropriately reviewed and clinically prioritised. Executive directors stated there was assurance that all patients were reassessed and reprioritised whilst on the waiting lists between 18 and 100 weeks. We requested but did not receive the patient tracking list (PTL) meeting minutes. However, we did receive the PTL ongoing action plans which does not evidence any reprioritisation of patients. We found that the ongoing action tracking document contained limited detail and lack of assurance. Examples included:

1. The PTL ongoing action tracking document identified there was an ongoing concern for priority 1 “P1” defined as procedures that were needing to be performed in less than 24 hours and up to 72 hours, coding issues from the 6 September 2021, with no actions or reports produced. On 12 October 2021 there were actions stating the team were working on an electronic solution to review the P1 patients prior to this date. However, the focus was on the coding and the electronic issues rather than the harm to the patients.
2. A further point on the PTL ongoing action tracking document was to ensure on the 04 October 2021 the surgery, anaesthetics, critical care and theatres (SACCT) division was micromanaging the 186-week waiting patients. However, there were no details or actions put against this point.
3. Staff raised concerns that patients were coming to harm whilst waiting significant lengths of time on the waiting list. They informed us patients were not contacted or reassessed between 18 weeks and 100 weeks.

Senior leaders identified that administration staff were following an informal process to contact patients on the waiting list and ask for an update in their clinical condition. We asked for a copy of the process and the trust confirmed there was no current ratified process to support staff with this.

During our inspection, some staff told us there was limited visibility of the senior leadership team within the emergency department. Staff consistently told us they thought the department was not always safe. We observed the clinical command meeting on 15 September 2021 where site pressures including patient and clinical safety issues and risks were discussed. However, staff told us that they did not always see action was taken to manage risks and support staff.

The trust’s patient flow and escalation policy was approved in May 2021 at the quality assurance committee. The policy did not have any documented consultations or acknowledgements with stakeholders. The policy described the Operational Pressures Escalation Levels (OPEL) as the standardised one to four; one being the default hospital status and four being final hospital status of escalation. After an OPEL level four was declared the policy stated that a patient flow meeting should be held to enact the full capacity protocol. The full capacity protocol described the accelerated transfers to inpatient areas. However, the policy did not contain board recommendations for the next steps once the full capacity protocol had been enacted and there were still significant concerns relating to access and flow within the hospital. This indicated that there was no process or procedure to follow and meant patient care and treatment could be at risk.

During inspection, we were told by staff and leaders that the trust was experiencing unprecedented pressures. However, the trust was on OPEL three which given issues with demand, capacity and safety in the department, did not seem

appropriate. The trust patient flow and escalation policy outlined when the trust OPEL level four should be triggered. One of the criteria was ambulance turnaround times being over one hour. During the week commencing 26 September 2021, the trust had 84 ambulance handovers over one hour, with six being over three hours and the longest turnaround time being four hours and 20 minutes.

There were not always effective processes in relation to access and flow of patients into and through the hospital. These were creating and contributing to significant delays in admitting patients onto wards to enable them to receive timely and appropriate care and treatment. The trust was working with the system to enable access and flow into and through the hospital. On the 13 October 2021 the chief operations officer told us that 20% of patients within the hospital were medically optimised and did not meet the criteria to reside within the hospital. Senior leaders told us the availability of adult social care beds was limited and this was being escalated to gold command.

The trust had made improvements in the discharge process since the focussed inspection in January 2021. The trust had developed a transfer of care hub and undertook twice daily meetings regarding patient who were medically optimised. The meeting was chair by a deputy director of operations and included membership from the local Clinical

Commissioning Group, community care facilities, local authority, representatives from local community hospitals and local authority bed facilities, care navigation care home finders, and transfer of care hub staff from within the trust. On 15 September 2021, we observed the second meeting which focussed on patient who had been medically optimised for over three days. During the meeting we observed the team discuss 26 of the 77 patients who were medically optimised and did not meet the criteria to reside; all patients had at least one discharge plan identified for action.

Information Management

The information that was used to monitor performance or to make decisions was inaccurate, and unreliable or not relevant. There was inadequate access to and challenge of performance by leaders and staff.

There was heavy reliance on manual systems to provide information with a lack of assurance in the data available. This was recognised by the trust and was incorporated into the digital strategy. The trust told us of the weaknesses in their record systems for example unable to update programmes due to old operating systems. Ward-based nursing forms were a mix of paper based and electronic records, this meant patient records could not be reviewed in their entirety unless all records were together. This meant there was a risk that staff may not have the appropriate information to care for patients safely.

The effectiveness of information management within the trust was not robust. The trust recognised the need for an electronic patient record system (EPR) across the organisation but were in the early stages of procuring this. The trust was looking to implement the EPR with partner trusts across the integrated care system. Senior leaders identified concerns around the quality of data collection and management in the trust and recognised they were behind the national curve regarding digital development. Although there were plans in place to address this, implementation of an EPR was at least two to three years away.

Trust wide records were not always accurate and did not always follow the record keeping standards for doctors, nurses and allied health professionals. The trust undertook an annual record keeping audit in February 2021, overall trust compliance for record keeping was 68%. The report in April 2021, did not demonstrate how the trust would improve the compliance and accuracy in line with the record keeping standards. This could lead to inaccurate records and delays to patients receiving treatment, inappropriate care and duplicate records.

Our findings

Records were mostly stored secured across the core services inspected, except for within the emergency department;

The trust used several data systems across the organisation, which captured and recorded relevant clinical and demographic data about patients along their pathway. This meant the trust experienced challenges bringing all information sources together to improve and record patient outcomes and data. We saw evidence of where data was not presented in a format that could provide senior leaders with assurance. We also heard from staff and board members that they did not always trust the data or where they were content with data being 'close enough', including for committee meetings.

At the time of our inspection, the trust was experiencing some technical difficulties with the patient administration system (PAS). The PAS system was not compatible with the priority code waiting list system which was causing data issues and patients potentially being put on the incorrect priority code.

We were supplied with a spreadsheet prior to inspection when assurance was requested from the trust in relation to who was risk assessing patients on the waiting list and how patients were prioritised when waiting for extended periods of time. The spreadsheet was not fit for not purpose and contained data dating back to 1998 for priority 3 (P3) patients. We requested but did not receive any further up to date data containing assurance in relation to current priority codes.

At the time of our inspection the trust was not meeting the accessible information standard (AIS), which became a legal requirement in 2016; this was due to not providing information in different formats to patients. The trust was not providing information, or appointments in other formats to people who required it unless a request was made, including in Braille, text messaging, large font, emails, audio. The trust did not have the systems to support this work and the project to implement this had not moved on since the AIS came into effect in 2016. This was identified as a risk on the corporate risk register, with a risk score of 15. The Trust had a patient portal that allowed information to be sent in the preferred format. However, it was not embedded in all outpatient areas.

The deputy chief executive officer held responsibility for the digital agenda, but the trust did have a director of digital services. The trust provided their health informatics strategy which was dated 2016 to 2020. In addition, the trust shared their health informatics strategic summary which was written in September 2021. The strategy made references to "the trust" but did not specify Blackpool Teaching Hospital NHS Foundation Trust, and the integrated care system for Lancashire and South Cumbria and the integrated care partnership for the Fylde Coast. In the strategic summary the trust had agreed to adopt the integrated care services system which aimed to allow better communication with acute and community services. The trust had committed to update and improve the core infrastructure to build the digital ambition. The trust was aware of their current risks to the health informatics systems in place and were working towards improving their digital services which will take time to complete. The trust supplied their current digital strategic plan for 2021/22 that prioritised the EPR agenda and strategy summary and detailed the key foundations needed to establish an EPR and build on the digital agenda.

There were clear and robust service performance measures, which were reported to the board. The number of discharge prescriptions coming down to the dispensary had reduced, which in turn had decreased the discharge turnaround time.

The trust had a system in place for staff to record the reason a medicine was not given, and these were reviewed by the pharmacy team.

Engagement

Our findings

There was minimal engagement with people who used services, staff, the public. There was a limited approach to sharing and obtaining the views of staff. There was insufficient attention to appropriately engage with people, including those with protected equality characteristics. Feedback was not always reported or acted upon in a timely way.

The executive directors recognised the importance of partner organisations to support them in providing safe and effective care. The executive team actively engaged with the integrated care system and integrated care partnership.

The trust was part of the Lancashire and South Cumbria Integrated Care System (ICS) which consisted of organisations across primary care, community services, social care, mental health and acute and specialist services. We saw evidence the trust was trying to engage with system partners to support patients who did not meet the criteria to reside and had processes in place to do this.

The trust had a patient and carer experience strategy in place for 2019 to 2022, which had three main objective:

1. Listening and acting on patient / carer feedback
2. Always consulting with patients and carers
3. Improving the quality and accessibility of information

The trust provided an action plan related to the patient and carer involvement strategy, dated 2019 to 2022. The action plan included the items from the 'tell us' programme which was in place within the trust to encourage people to give feedback about the services they had received. The trust had a non-executive director which led the complaint review panel and the quality and clinical effectiveness committee.

The trust told us that there had been a noted reduction in attendees at the patient focus groups; specifically, the patient influence panel recent attendees were between eight and 10. The poorer uptake was a result of the COVID-19 pandemic. The trust had contacted the local clinical commissioning group to develop a wider Fylde Coast patient influence panel to enable patient engagement; the first joint patient influence panel meeting was held in January 2020. This was a good example of how the trust engaged with patients and listened to the patient voice during the challenging pandemic circumstances.

In the quality and clinical effectiveness committee meeting minutes in June 2021, the trust discussed the high risk of disability discrimination around data standards and confirmed that a significant amount of work was being done to put appropriate mitigations in place. The risk register actions taken to mitigate the risk included to raise awareness, gain an understanding of how other services met the accessible information standards and communicate with patients to see if patients would like visual impairment flagged on their records. The actions to improve the accessible information standards did not give assurance to meeting these standards. We requested further evidence from the trust as discussed below.

The trust had an interpretation policy which was created in May 2021 and was approved in the equality, diversity and inclusion meeting. Interpreter services were available face to face and through a telephone system for patients with different spoken languages. There were hearing loops available for those identified with hearing impairments. Interpreters trained in basic sign language could be sourced for planned visits. Translation services for the visually impaired could be arranged in a variety of formats and different colour fonts and paper as well as other formats such as brail. However, some staff were not always clear on how to access this information. It was not clear to visitors to the hospital that accessible options were available.

Our findings

The interpretation policy stated the equality, diversity and inclusion group will monitor compliance through a quarterly review of the trust expenditure and the number of interpreting and translation assignment to build up a picture of the local language need. This data would also be discussed at the learning from incidents and risk assurance group.

In August 2020, the trust launched the hidden disabilities "sunflower scheme" to offer additional support to patients whose disability may not be visible. The trust had engaged with local services to share the sunflower scheme with patients who had visual and audiological impairments. The trust had distributed 5,000 lanyards from Blackpool Victoria Hospital including sharing them with local GP services. While on inspection there were clear signs advertising the sunflower scheme in the main reception of the hospital. This was an effective initiative to allow patients with hidden disabilities to feel protected and cared for whilst at the hospital.

The trust results for the 2020 NHS Staff Survey was aligned with the national average in all ten themes when compared nationally, regionally and against the other organisations in the local integrated care system (ISC). The 2020 Staff Survey was completed by 49% of staff at the trust. A trust wide action plan had been formulated to address key themes at organisational level from the NHS staff survey 2020.

Staff engagement was not always effective. The trust employee engagement strategy was out of date in March 2021 and had not been renewed.

The trust engaged with staff by encouraging the sharing of compliments through the 'staff shout out' initiative where patients and relatives can nominate any staff who provided exceptional care. Monthly winners were chosen by a staff poll in the patient experience department. Winners were announced and publicised on the patient experience social media accounts, in trust communications and in the monthly experience of care reports. Staff who won a 'staff shout out' received a certificate and voucher to recognise the good work from the staff member. This enabled staff to feel proud of the good work they had achieved and showed that the trust recognised them.

The trust also had a Going the Extra Mile award scheme which enabled staff and patients to nominate a colleague who went the 'extra mile'. Since January 2021, over 1600 Going the Extra Mile cards and badges had been distributed to staff.

Learning, continuous improvement and Innovation

The trust was beginning to invest in continuous learning and improvement within the organisation, however there was still work to be done through the appropriate use of external accreditation and participation in research. There was knowledge of improvement methods and the skills to implement improvement was beginning to be shared among the organisation. However, improvements were not always identified, and actions were not always taken. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance and it was not monitored.

The trust had an up-to-date quality improvement strategy from 2019 to 2022 which linked to the trust's values. The board of directors supported the three quality initiatives; reduce preventable deaths, reduce avoidable harm and improve the last 1000 days of life. The quality improvement directorate feeds into the quality and clinical effectiveness committee. The trust used the NHSI quality, service improvement and redesign (QSIR) methodology. The trust was undertaking three collaborative quality improvement programmes;

Our findings

- The eliminating pressure ulcers programme where twenty teams participated in the programme which included six community teams. The progress from phase one in October 2021 was that the programme had achieved 53% reduction in category two hospital acquired pressure ulcers. There had been a 47% reduction category three and four pressure ulcers and an 84% increase in days between reporting grade three and four pressure ulcers. There had been a 43% reduction in community acquired pressure ulcers.
- The identification and management of the deteriorating patient collaborative programme aimed to reduce the number of cardiac arrests outside of critical care by 50% by September 2021. The programme launched in February 2021. Phase one was completed in September 2021 which included nine areas taking part in the collaborative work; the areas had developed several initiatives that were being trialled. We were provided with data in October 2021 that stated the statistics have not showed an overall improvement in the outcome measures, but participating wards have seen longer times between cardiac arrests.
- The reducing fracture neck of femur in care home collaborative programmes aim was to reduce the number of fractured neck of femurs (the joint at the top of the hip) in care homes by 70% by March 2022. The trust had reached out to system partners, local council and the local Clinical Commissioning Group, and eight care homes have joined the collaborative programme. The first learning session took place in September 2021. The programme was due to be completed in March 2022. This programme showed a positive multidisciplinary initiative to work across the NHS and partners to make foundations for positive changes to patient safety.

These quality improvement collaborative programmes showed that the trust was supporting improvements that focused on the outcome for the patients. The trust's quality improvement journey was in its infancy but effective foundations were being built.

The trust was starting an academy for clinical leaders. The academy consisted of eminent leaders of quality improvement, including associated of the Institute for Healthcare Improvement (IHI) and were partnered with a local university. Staff that participated in the programme would have an opportunity to achieve continuing professional development points, which could be used towards a higher education qualification. During the inspection the programme was in its early stages, the trust had received 27 applications and 10 teams had been successful. The equality and diversity team assisted with adapting the application process to support staff from black and minority ethnic backgrounds; over half of the successful applicants were from BaME consultants or SAS doctors (includes staff grade doctors and associate specialist doctors).

The trust's occupational health and wellbeing department had been recognised for the standard of service it provided to staff with a nationally recognised re-accreditation. The team had achieved and was awarded with the Safe Effective Quality Occupational Health Service (SEQOHS) Accreditation following a formal, independent assessment.

The trust had been awarded Veteran Aware Accreditation. The award from the Veterans Covenant Hospital Alliance (VCHA) was in acknowledgement of dedication to treating veterans with compassion and empathy. The trust was one of 33 trusts nationally to be accredited.

Blackpool Teaching Hospitals NHS Foundation Trust had been nationally recognised, and received awards, for the work it had done in the independent sexual violence advisor (ISVA) service. The team had won a national award in the 2020 HRH Prince of Wales integrated approaches to care for the ISVA service. The team of the trust's ISVA's are employed pan Lancashire and were also finalists for the nationalist unsung hero awards in November 2021. This work had been published in 2021. The team see over 300 victims per year.

Our findings

The trust had been successful in a bid to secure additional funding for a hospital based independent domestic violence advisor (IDVA) service, with the role being to support patients and staff who were victims of domestic abuse and violence. This funding was for two years form April 2021 to March 2023. This funding had enabled additional resource to ensure additional IDVA provision was available across a seven-day period and out of hours. Learning from the trust IDVA programme has been shared nationally and includes services for staff who are victims of domestic violence.

The trust launched an initiative in collaboration with the police in response to the COVID-19 pandemic and the initial lockdown where health IDVAs employed by the trust responded to victims of domestic violence with local police officers. This focused on high harm and category one calls and aimed to reach out to victims and families experiencing domestic violence who were no longer presenting in health settings because of lockdown and to provide timely safe responses. The project has shown that the joint working between immediate response officers and health IDVAs has increased the levels of engagement with domestic abuse victims in terms of both safeguarding support and cooperation with investigative processes by over 40%.

The team won a national award for their service in the 2020 Nursing Times awards in the category of patient safety improvement for health's response to victims of domestic abuse/violence during COVID-19. This service had been expanded and had seen over 1000 victims since the pandemic began.

The trust had implemented an emergency department navigator service following an initial scoping exercise in 2019. The service aims to reduce harm for attendances aged 10-29 years with attendances linked to serious violence including criminal and sexual exploitation. This work was presented to the current Minister of State for Crime and Policing at the Home Office, and we will continue to report our monthly figures of around 185 directly to the Home Office each month. The data showed only 5% of young people who accessed this service had reattended at the emergency department.

The ED navigators were finalists for a national award for their service in the 2020 Nursing Times awards in the category of emergency and critical care for the emergency department navigators work in relation to serious violence and knife crime. The trust provided this service across Lancashire in collaboration with the Home Office and the Violence Reduction Unit.

Incident reporting has been discussed under the risk management of the report due to the concerns around how the trust managed, reviewed and investigated incidents to ensure lessons were identified and shared with teams.

Complaints

The patient and family relations team managed general enquiries, concerns and complaints. The trust had increased the staffing establishment within the team from 3.8 to 9.6 whole time equivalent staff since our previous inspection in 2019. The patient experience lead told us that complaints performance had improved. Between September 2020 and October 2021, the trust received 399 formal complaints; 58% had been responded to within the timeframes set out in the policy and 10% were ongoing at the time of our inspection.

Complaints received were logged and acknowledged by the complaints team within one day, instead of three days. Each complaint was investigated and managed, within the division; they had the responsibility to respond appropriately. The letter and report were sent to the patient and family relations team for quality checking. The letter and report were shared with the divisional director of nursing for a signature and grading before the executive sign off. The team did not close complaints until the evidence had been provided to prove the actions had been completed.

Our findings

We reviewed six complaints and they were aligned with the processes, five included the trust's complaint letter responses. Each letter acknowledged and apologised to the complainant and they were written in a personal way. An investigation report was included in the letter and was reflective of the findings. The letters included information on how to contact the Parliamentary Health Service Ombudsman (PHSO) if complainants were not satisfied with the response and a satisfaction questionnaire regarding the complaint process was included. This was an improvement from the previous inspection in 2019.

The complaints overview report was shared at the quality and clinical effectiveness committee. In June 2021, the quality and clinical effectiveness meeting minutes noted that additional training was required for complaints reviews within divisions. However, only the lead within the patient and family relations had received formal training in the complaint's procedures. We requested but did not receive the formal training figures for the complaints team. The trust sent us figures that five divisional complaint managers received complaint handling training in July 2021. The trust trained 271 staff in overview complaints process training in October and November 2021. This gave us concern that there was no succession planning within the complaints team.

Complaints were monitored on a dashboard and during the weekly patient tracking list (PTL) meetings. The trust held a quarterly learning forum within the risk committee. The patient experience lead sat on the learning forum for the risk committee to ensure learning from complaints was embedded.

The patient experience team provided a monthly report to the board regarding complaints; during September 2021 the trust received 27 formal complaints; 70% of complaints were sent out on time, the other 30% breached the target timeframes. The trust noted a decrease of 38% in second complaints received in September 2021, compared to August 2021. This evidences the improvements being made within the patient relations team.

Duty of Candour

The trust did not have effective systems and processes to ensure incidents are reported, reviewed, and investigated appropriately to ensure lessons were identified and shared with teams. We were not assured that the trust maintained effective records to evidence adherence to duty of candour. In the serious incidents we reviewed the initial duty of candour had been completed. However, there was no evidence of the final response letter or meeting with the family to share the findings, in the reports reviewed it stated, "to be done".

The trust provided their management of incidents, incorporating serious incidents policy which was approved in December 2020. The policy had good representation from senior leaders consulting and acknowledging the policy. The policy contained information relating to the requirements the trust must follow regarding applying duty of candour when things go wrong with care and treatment. Duty of candour applies to incidents that contained a harm rating of moderate and above. The policy stated that once the level of harm was confirmed, the trust must initiate duty of candour, which included a letter of apology and explanation of the next steps to be completed and sent out to the patient or family within 10 working days.

We were concerned about the trust applying written duty of candour within the trusts policy of 10 working days as the complaints reports reviewed stated "to be done". We requested evidence of the trust monitoring of the duty of candour. The trust sent us a spreadsheet containing incidents from October 2020 to March 2021, however the date the incident occurred went back as far as March 2017. The spreadsheet was not fit for purpose so for example, out of the 82 incidents on the spreadsheet; 23 were not completed within 10 days, seven were identified as being completed before the incident occurred and seven were identified as not needing the final duty of candour.

Our findings

Learning from death reviews

The trust had made improvements in their learning from deaths processes and had a responding to deaths policy in place. The process was that once a patient had died, the medical staff caring for the patient would complete a referral for the medical examiner if required, the medical examiner would review the patient's death and complete a structure judgement review if needed. Once this occurred the medical certificate of cause of death could be completed and released to the family of the patient. We reviewed the medical examiner forms; they were clear and it was an effective process.

During our inspection staff told us there had been difficulties releasing medical staff from the wards to complete the relevant paperwork to start the process for the medical examiner. So, in May 2021, the trust began using an electronic 'learning from deaths' application enabling the monitoring and tracking of the process after a patient had died. The deceased patient would be kept virtually on the ward dashboard so staff on the wards could follow the process through. The application created a tracking board which contained information to streamline the process. This was a new application within the trust at the time of our inspection. The learning from deaths application was not fully embedded but showed forethought to make the process more visible for all staff, it allowed for continuity of care for the patient even after death and it created learning opportunities for more junior staff.

The trust had a mortality governance committee which was chaired by the executive medical director and reported to board quarterly and published their report publicly. The medical director attended the mortality governance committee meetings. We requested the most recent learning from deaths report, the trust shared their May 2021 report. Data within the report showed that the trust had 502 in-hospital deaths in this quarter, 53% of these were reviewed by the medical examiner. During our inspection we were told that they did not always have a medical examiner available. There were three medical examiners in post at the trust, the trust was in the process of looking to increase their medical examiners with the aim to cover community deaths from April 2022.

In the May 2021 report, it stated engagement with the processes of mortality governance, such as morbidity and mortality meetings at departmental and divisional level, and completion of structured judgement reviews (SJRs), remains sub-optimal. Senior leaders had oversight of the learning from death reviews and were working on improvements. The foundations were being built to create a robust process.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Jan 2022	Requires Improvement →← Jan 2022	Good →← Jan 2022	Inadequate ↓ Jan 2022	Requires Improvement ↑ Jan 2022	Requires Improvement →← Jan 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Blackpool Victoria Hospital	Requires Improvement → ← Jan 2022	Requires Improvement → ← Jan 2022	Good → ← Jan 2022	Inadequate ↓ Jan 2022	Inadequate ↓ Jan 2022	Inadequate ↓ Jan 2022
Fleetwood Hospital	Requires improvement Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Clifton Hospital	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Overall trust	Requires Improvement → ← Jan 2022	Requires Improvement → ← Jan 2022	Good → ← Jan 2022	Inadequate ↓ Jan 2022	Requires Improvement ↑ Jan 2022	Requires Improvement → ← Jan 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Blackpool Victoria Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↔ Jan 2022	Requires Improvement ↑ Jan 2022	Good ↔ Jan 2022	Requires Improvement ↑ Jan 2022	Inadequate ↔ Jan 2022	Requires Improvement ↑ Jan 2022
Services for children & young people	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Critical care	Requires Improvement ↔ Jan 2022	Requires Improvement ↔ Jan 2022	Good ↔ Jan 2022	Good ↑ Jan 2022	Requires Improvement ↔ Jan 2022	Requires Improvement ↔ Jan 2022
End of life care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Surgery	Requires Improvement ↔ Jan 2022	Requires Improvement ↔ Jan 2022	Good ↔ Jan 2022	Inadequate ↓ Jan 2022	Requires Improvement ↔ Jan 2022	Requires Improvement ↔ Jan 2022
Urgent and emergency services	Inadequate ↓ Jan 2022	Requires Improvement ↔ Jan 2022	Good ↔ Jan 2022	Inadequate ↔ Jan 2022	Inadequate ↓ Jan 2022	Inadequate ↓ Jan 2022
Maternity	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Outpatients	Good Oct 2019	Not rated	Good Oct 2019	Inadequate Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Overall	Requires Improvement ↔ Jan 2022	Requires Improvement ↔ Jan 2022	Good ↔ Jan 2022	Inadequate ↓ Jan 2022	Inadequate ↓ Jan 2022	Inadequate ↓ Jan 2022

Rating for Fleetwood Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires improvement Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019
Overall	Requires improvement Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019

Rating for Clifton Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Outpatients	Good Oct 2019	Not rated	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Overall	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist community mental health services for children and young people	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019	Requires improvement Oct 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019
Community health services for children and young people	Good Oct 2019	Good Oct 2019	Good Oct 2019	Requires improvement Oct 2019	Good Oct 2019	Good Oct 2019
Community health services for adults	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Outstanding Oct 2019	Good Oct 2019	Outstanding Oct 2019
Community end of life care	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019
Community health sexual health services	Good Oct 2019	Good Oct 2019	Outstanding Oct 2019	Good Oct 2019	Good Oct 2019	Good Oct 2019

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Blackpool Victoria Hospital

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Description of this hospital

We last inspected the location in June 2019; the urgent and emergency care services, surgical services and critical care services received an overall rating of requires improvement. The medical care core service received an overall rating of inadequate in June 2019.

We carried out a comprehensive inspection of four core services at Blackpool Victoria Hospital's;

- Urgent and emergency care service from 14 to 16 September 2021. We also carried out a focused visit from 11 October 2021 to 12 October 2021 to follow up on concerns identified during the initial inspection.
- Medical core service from 14 to 16 September 2021, inspecting 11 medical wards.
- Surgical services from 11 to 13 October 2021, inspecting 20 areas including surgical wards, theatres, recovery areas and anaesthetic rooms.
- Critical care services from 13 to 14 October 2021, inspecting cardiac intensive care, general intensive care and the high dependency unit.

Prior to our inspection, we considered nationally available performance data and intelligence provided by the trust. We inspected against all five key lines of enquiry. Each of our inspections were unannounced (staff did not know we were coming) to enable us to observe routine activity.

The urgent and emergency care services were part of the division of Integrated Medicine and Patient Flow. The division was formed by the trust in April 2021.

The medical care services, as defined by the CQC, crosses two divisions within Blackpool Victoria Hospital. These were the Integrated Medicine and Patient Flow (IMPF) division and the Tertiary Services division. The two divisions were formed by the trust in April 2021 and both divisions had a separate senior leadership team (SLT).

The surgical services crosses two divisions within Blackpool Victoria Hospital. Surgical services were managed by the division of surgery, anaesthetics, critical care and theatres (SACCT) and the division of tertiary services. The two divisions were formed by the trust in April 2021 and both divisions had a separate senior leadership team (SLT).

Our findings

The critical care services were led by two separate leadership teams within different divisions which were newly formed in April 2021. The general intensive care unit was led by the surgery, anaesthetics, critical care and theatres (SACCT) divisional leadership triumvirate. Cardiac intensive care was led by the tertiary service's divisional leadership triumvirate.

We rated urgent and emergency care services as inadequate at Blackpool Victoria Hospital because:

- Managers monitored mandatory training but did not always make sure everyone completed it. Not all staff had training or understood how to protect patients from abuse. The service did not control infection risk well. The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not always assess, monitor or manage risks to people who used the services. Opportunities to prevent or minimise harm were missed. Substantial or frequent staff shortages increased risks to people who used the service. Patient records were not easily accessible for all staff and not always kept securely. Incidents were not always investigated in a timely way or appropriately graded. Lessons from incidents were not always shared widely and embedded to prevent reoccurrence of incidents. Monitoring information was not always used to improve patient safety. Patients did not always receive critical medications in a timely way.
- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Care assessments did not always consider the full range of people's needs. There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was in line with guidance and legislation. Decision-makers did not always make decisions in the best interests of people who lack the mental capacity to make decisions for themselves, in accordance with legislation.
- The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services. People were frequently and consistently not able to access services in a timely way for an initial assessment, diagnosis or treatment. People experienced unacceptable waits for some services. It wasn't always easy for patients to make complaints. When the trust investigated complaints, learning was not always shared with all staff.
- Leaders were not always visible in the department and did not always have a clear understanding of the risks, issues and challenges in the service. They did not always act in a timely manner to address them. Staff did not know about the strategy and vision for the trust. Staff did not always feel respected, supported and valued. Leaders did not operate effective governance processes through the service and safety was not a sufficient priority. Actions to reduce the impact of risks were not always effective. The service did not always collect reliable data and analyse it. Staff did not always feel listened to. Leaders did not always effectively share learning.

However:

- Staff training rates on how to recognise and report abuse were positive. Staff were trained to use equipment. The induction programme for permanent and agency staff was comprehensive.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Key services were available seven days a week.
- Staff treated patients with compassion and kindness and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff had a good understanding of quality improvement methods and had the skills to use them.

We rated Medical care services as requires improvement at Blackpool Victoria Hospital because:

Our findings

- The overall compliance rate for completion of all mandatory training was low. Completion of mandatory safeguarding training, amongst medical staff, was low across the directorate. Risk assessments were not always completed at the required intervals. The service did not always have enough substantive registered and unregistered nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service did not have enough substantive medical staff, managers regularly reviewed and adjusted staffing levels and skill mix. There was a variation in systems used and reliability of those systems, across the trust, which could cause a reduction in the accuracy, monitoring and reliability of record keeping. We found there were some delays in provision of medication and that there were times when medications had not been provided where patients were withdrawing from drugs or alcohol use. The service did not always manage the investigation of patient safety incidents well.
- We saw a small number of gaps in food and drink assessment records. Whilst staff monitored the effectiveness of care and treatment. Managers did not regularly appraise staff's work performance or hold supervision meetings with them to provide support and development. Decisions about patients care and treatment were not always decision specific. The documented reason for assessments for patients who lacked capacity to make their own decisions or were experiencing mental ill health were not always decision specific.
- The service did not always plan or provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisations to plan care. People could not always access the service when they needed it. There were issues with flow and the effects of COVID-19 on services, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Leaders did not always understand or manage the priorities and issues the service faced. Not all senior leaders were visible and approachable in the service for patients and staff. The vision for the service was not something that the staff were aware of nor had they been engaged in developing. Staff did not all feel respected, supported and valued. The service was working towards an open culture where patients, their families and most staff could raise concerns without fear, however, this was not yet embedded. We were not assured that leaders operated effective governance processes throughout the service. Actions to reduce the impact of relevant risks and issues were not always effective. The service did not collect reliable data and analyse it well. Staff could not always find the data they needed to understand performance, make decisions and/or improvements. The information systems were not all integrated within the core service. Leaders and staff did not always actively and openly engage with patients, staff, the public and local organisations to plan and manage services. There was a lack of engagement with equality groups.

However:

- Staff told us they understood how to protect patients from abuse and how to recognise and report abuse, the service worked well with other agencies to do so. The service mostly controlled infection risk well and displayed clear signage to indicate COVID-19 risk areas. Staff used equipment to protect themselves and others from infection and they kept equipment and most of the premises visibly clean. In most areas inspected the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. Staff mostly kept detailed records of patients' care and treatment. Records were mostly clear, up to date, stored securely and easily available to all staff providing care. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team and the wider service, however, these were not always completed in a timely manner. When things went wrong, staff apologised and gave patients honest information and suitable support. The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Our findings

- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. The service mostly made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care. Staff gave patients practical support and advice to lead healthier lives. Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service was mostly inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Leaders had the skills and abilities to run the service. The service had a vision for what it wanted to achieve and a one-year strategy to turn it into action. Staff were mostly focused on the needs of patients receiving care. Staff were mostly clear about their roles and accountabilities and had some opportunities to meet, discuss and learn from the performance of the service. Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. The service collaborated with partner organisations to help improve services for patients. Staff were committed to continually learning and improving services. They understood quality improvement methods and had some skills to use them. Leaders encouraged innovation and participation in research.

We rated Surgical care services as requires improvement at Blackpool Victoria Hospital because:

- The service did not provide mandatory training in key skills to all staff. The mandatory training and safeguarding training compliance rates did not meet the trust's target in all modules. The service did not always take action to prevent surgical site infections. The service did not manage patient safety incidents well. Staff did not recognise and report all incidents and near misses. The service did not consistently share lessons learned with the whole team and the wider service. When things went wrong staff had not always apologised and gave patients honest information and suitable support in a timely manner.
- The service made limited adjustments for patients' religious, cultural and other needs. The service had not used the findings to make improvements. Most clinical audit outcomes were comparable to expected national standards, although the service performed worse than expected for some national audit indicators. Managers had not appraised staff's work performance and had not held supervision meetings with them to provide support and development. Key services were not all available seven days a week to support timely patient care. Not all staff followed national guidance to gain patients' consent or knew how to support patients who lacked capacity to make their own decisions and not all staff used agreed personalised measures that limit patients' liberty.
- The service was not inclusive and did not take account of patients' individual needs and preferences. People could not access the service when they needed it and did not receive the right care promptly.

Our findings

- Leaders were not all visible and approachable in the service for patients and staff. The service had a one year strategy but it was not developed with all relevant stakeholders. Staff did not all feel respected, supported and valued. The service did not promote equality and diversity in daily work. Leaders did not operate effective governance processes, throughout the service and with partner organisations. Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and identified actions to reduce their impact. The service did not collect reliable data and analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not integrated. Data or notifications were not consistently submitted to external organisations as required. Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. They did not collaborate with partner organisations to help improve services for patients.

However;

- Staff had training on how to recognise, report and protect patients from abuse and they knew how to apply it. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service mostly had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment in most areas. The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff collected safety information and shared it with staff, patients and visitors.
- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment and achieved good outcomes for most patients. The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Staff gave patients practical support and advice to lead healthier lives. staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who were experiencing mental ill health.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Leaders had the skills and abilities to run the service. Leaders understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. The service had a one year

vision for what it wanted to achieve and a strategy to turn it into action. Staff were focused on the needs of patients receiving care. The service provided opportunities for career development. Staff at all levels were clear about their roles and accountabilities and did have regular opportunities to meet, discuss and learn from the performance of the service. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. The information systems were secure. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We rated Critical care services as requires improvement at Blackpool Victoria Hospital because:

- The service had gaps in mandatory training compliance for medical staff but measures were in place to address this and compliance was monitored and improving. Safeguarding training was not meeting expected levels. A new unit was being built to address the recognised limitations of the current unit which did not follow national guidance. Some equipment was not always available. Staff did not always complete admission assessments. Access to mental health support was not readily available. The service did not always have enough medical staff or enough of some allied health professionals, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. Records were not always clear, accurate or up to date. Staff could not always access records when required in the cardiac intensive care unit.
- Managers did not always check to make sure staff followed trust guidance. Patients were not always given enough food and drink to meet their needs or improve their health. Staff did not effectively monitor care and treatment provided within critical care. They could not always demonstrate they used the findings to make improvements and could not always demonstrate achieving good outcomes for patients. Managers did not appraise all staff's work performance although they held supervision meetings with them to provide support and development. Key services were not always available seven days a week to support timely patient care. Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. Some staff did not know how to support patients who lacked capacity to make their own decisions.
- Staff were not always clear of what the strategy for the department was. The service did not promote equality and diversity in daily work. The services were working towards an open culture where patients, their families and staff could raise concerns without fear. Leaders did not operate effective governance processes, throughout the service and with partner organisations. Whilst staff and leaders had opportunities to meet and discuss the performance of the service there was limited evidence of how effective this was. Leaders and teams had identified and escalated relevant risks; however, they did not identify actions to reduce their impact in a timely manner or effectively manage those risks. Leaders and teams did not effectively use systems to manage performance. The service did not always collect reliable data and analyse it. Staff did not always have access to the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were not always integrated. Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

However;

- The service had provided mandatory training in all the key skills for most nursing staff. Staff understood how to protect patients from abuse and understood how to report concerns and the service worked well with other agencies to do so. The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. The maintenance and use of facilities, premises and equipment kept people safe and staff managed clinical waste well. We saw that relevant risk assessments were completed for each patient. Staff identified and quickly acted upon patients at risk of deterioration. The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to

provide the right care and treatment. Staff on the general intensive care unit kept comprehensive and accessible records of patients' care and treatment. Records were stored securely in both intensive care units. The service used systems and processes to safely prescribe, administer, record and store medicines. The service managed patient safety incidents well. The service used monitoring results to improve safety.

- The service provided care and treatment based on national guidance and evidence-based practice. Staff used special feeding and hydration techniques when necessary. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. The service made sure staff were competent for their roles. Doctors, nurses and other healthcare professionals worked together to provide good care as a team to benefit patients. Staff gave patients practical support and advice to lead healthier lives.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- The new leadership team had the skills and abilities to run the service. They understood and were starting to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. The service had a one-year strategy in place which was focused on sustainability of services. Leaders understood and knew how to apply the strategy and monitor progress. Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care and provided opportunities for career development. Staff at all levels were clear about their roles and accountabilities. They had plans to cope with unexpected events. Leaders contributed to decision-making to help avoid financial pressures compromising the quality of care. There was a developing focus on continuous learning and improvement. There was some knowledge of improvement methods and the skills to use them.

How we carried out the inspection

We spoke with 172 staff across a range of disciplines including junior and senior registered nurses, ward managers, matrons, bed managers, advanced nurse practitioners, pharmacy technicians, pharmacists, physiotherapists, occupational therapists, operating department practitioners, theatre manager, junior doctors, locum doctors, middle grade doctors, consultants, unregistered nursing staff including emergency department assistants, ward clerks, housekeepers, administrative staff, domestic staff, discharge co-ordinators, clinical service managers, specialist cancer nurses and the lead cancer nurse. We also spoke with paramedics who had conveyed patients to the emergency department and the ambulance liaison officer.

Between our inspections, we held several staff focus groups with representatives from all over the trust to enable staff who were not on duty during the inspection to speak to inspectors. The focus groups included nursing staff, allied health professionals, hospital governors and junior medical staff and consultants.

Our findings

We reviewed 85 patient records, including nursing records, medical records, risk assessments, prescription charts, do not attempt cardiopulmonary respiratory (DNACPR), and mental capacity and Deprivation of Liberty Safeguards (DoLS).

We observed patient care, treatment and support being delivered including infection and control management. We spoke with 48 patients, relatives and care givers. We were limited to the number of relatives and care givers who were present in the hospital due to the COVID-19 pandemic. However, we reviewed comments from patient feedback cards.

During our medical care service inspection, we used Talking Mats technology to interact with ten patients who struggled to communicate verbally.

During the inspection we attended a bed meeting, a clinical command meeting, and trust level staffing and flow meetings. We observed seven staff handovers, four ward safety huddles, one morning theatre team brief and one staff meeting.

On this inspection we were limited to the wards we could visit due to the COVID-19 infection risk. We visited;

- Medical wards which included the acute medical unit (AMU), the ambulatory emergency care unit (AECU -Ward 18), the stroke unit (wards 32-33), the gastroenterology and endoscopy unit, wards C, 3, 6, 12, 23, 24, 37 and 38.
- Urgent and emergency care team visited the accident and emergency department including the paediatric emergency department and the ambulatory emergency care unit.
- The inspection team for surgery visited ward 14 – ear nose and throat surgery, ophthalmic and surgical high care, ward 15a – general surgery and urology, ward 15b - general surgery, ward 16 - elective orthopaedic, ward 35 – trauma and orthopaedic, ward 38 – cardiac, ward 39 – cardiac, Lancashire suite – a six bedded private cardiac ward, surgical admission unit, surgical assessment unit (SAU), same day emergency care (SDEC) unit, pre-op assessment unit, ophthalmic surgical unit, day surgery unit, cardiac day surgery unit, discharge lounge, several theatres, the recovery areas and anaesthetic rooms.
- The critical care team visited general intensive care unit, cardiac intensive care unit and the high dependency unit.

Critical care

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service had provided mandatory training in all the key skills for most nursing staff but there were gaps in compliance for medical staff. Measures were in place to address this and compliance was monitored and improving.

At the last inspection we told the trust it should ensure nursing staff kept up to date with mandatory training, at this inspection we found that this had improved. We saw there was a system and process in place to monitor mandatory training compliance. Staff had worked hard to achieve these compliance figures following waves of the pandemic which had seen demand and workload within the department increase dramatically. Overall compliance rates for registered nursing staff was 92% against a trust target of 95%.

The mandatory training was comprehensive and met the needs of patients and staff. Modules such as blood collection and infection prevention and control were included which were relevant to the department in caring for patients.

Nursing staff completed training on recognising and responding to patients living with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted nursing staff when they needed to update their training. Full time practice development nurses were in post within the department including a medical devices practice development nurse to monitor training and ensure the staff were kept up to date. Electronic notification was also received by the practice development nurses and the relevant staff member giving them notice when a module was due to expire.

Mandatory training compliance rates for medical staff did not meet all the required standards. The pandemic affected the ability of the unit to provide training that was previously delivered face to face. This included safeguarding level 3 and moving & handling (higher levels), however, these were being run virtually, including safeguarding training e-learning and bitesize sessions which meant compliance was improving.

The mandatory training log board was updated monthly by managers.

Safeguarding

Staff understood how to protect patients from abuse and understood how to report concerns and the service worked well with other agencies to do so. However, staff training was not meeting expected levels.

Staff were offered training specific for their role on how to recognise and report abuse. Compliance with safeguarding adults' level 3 for registered nursing staff was 92% in the cardiac critical care unit and 67% for the general critical care unit. The trust compliance target was 95%.

During the pandemic safeguarding training was altered from face to face training to remote learning in order to comply with COVID-19 restrictions and still provide key training for staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010).

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. During our inspection we saw an example of this in practice at a department safety huddle.

The department had arrangements in place to provide extra observations or supervision if required and there was a policy for enhanced care to protect and support patients at risk of suicide or self-harm including a point of contact for additional staff guidance both in hours and out of hours.

Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns.

Training regarding female genital mutilation was delivered as part of the safeguarding adults and safeguarding children training.

Compliance with safeguarding adults' level 3 for registered nursing staff was 92% in the cardiac critical care unit and 67% for the general critical care unit. The trust compliance target was 95%.

Mandatory training compliance rates for medical staff did not meet all the required standards. Compliance with safeguarding adults' level 3 for medical staff was 64% in the cardiac critical care unit and 60% for the general critical care unit. The trust compliance target was 95%.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. There were clear monitoring processes in place to monitor infection rates within the department.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning audits were undertaken regularly, and compliance reports were produced on a monthly basis. Cleaning records demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE) and cleaned equipment after every patient contact. Equipment was labelled with a green tag to show when it was last cleaned and ready for use. Surfaces were cleaned as a minimum twice daily to reduce the 'burden of virus' upon contactable surfaces.

There was a clear process for the safe insertion of urinary catheters and intravenous cannulas which staff understood. This was in line with the National Institute for Health and Care Excellence quality statement 61 (four and five).

Critical care

Infection rates for the cardiac intensive care unit demonstrated that no incidences of unit-acquired Methicillin Resistant Staphylococcus Aureus (MRSA) occurred in July, August or September 2021 and two instances of unit-acquired Clostridium difficile infection (C- Diff) occurred during the same period. Data for the general intensive care unit showed three incidences of unit-acquired Escherichia coli (E. coli).

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe and staff managed clinical waste well. Staff were trained to use them. However, a new unit was being built to address the recognised limitations of the current unit which did not follow national guidance and some equipment was not always available.

The general critical care unit based at Blackpool Victoria hospital is a 16 bedded unit which supports a population of 1.6 million people. Between April 2020 and March 2021, 3162 patients were discharged from the unit.

In addition to the general critical care unit, there is a cardiac intensive care unit which is a 20 bedded unit that cares for patients requiring intensive care following cardiac surgery. This unit can take up to 16 ventilated patients at any one time however runs on a daily basis based on 12 level three patients and eight level two patients.

During the pandemic the unit altered its way of working so that both the intensive care unit and high dependency unit could both accommodate level two and three patients. Two additional beds were created which increased the unit from 14 to 16 beds and a physical divide was created between the middle of the high dependency unit. This allowed the department to care for people with COVID-19 separately.

Patients could reach call bells and staff responded quickly when called.

At the last inspection it was identified that the department did not meet regulations around bed spacing and there were concerns raised around equipment. However, at this inspection it was clear that building work on a purpose-built emergency village that included a new critical care facility had begun and was due for completion in September 2022. However, this had impacted upon current provision of storage but this was being managed in the short term.

The new building had been designed to meet building standards and included 16 individual patient rooms. Two of which were isolation rooms with a separate lobby area designed to provide simultaneous source and protective isolation for immune-suppressed patients. The Department of Health, Health Building note 04-02 for critical care beds recommends that no unit should have less than 20 percent of their beds as isolation rooms. All 16 beds were to be individual and separate rooms.

In addition, the quality manager reviewed all non-compliant medical devices and represented the division at the trust wide medical device committee.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment checks were recorded and submitted online. If the checks were not undertaken within a specified timescale then senior leaders were alerted.

The service had suitable facilities to meet the needs of patients' families at the time of our inspection; however, we were told that due to ongoing building work the overnight facilities for relatives were to be temporarily removed as the area was being rebuilt. At the time of our inspection, due to the pandemic, visiting restrictions were in place and there were no plans to lift the restrictions over the winter period. This meant that by the time the restrictions would be lifted it was likely the new facilities would be in place.

Critical care

New ventilators had been installed in both the general and cardiac intensive care units. All were the same type of ventilator and monitoring system; this helped to reduce incidences where staff members who cross-worked between the units were unfamiliar with equipment. Continuous positive airway pressure (CPAP) and high flow nasal oxygen could now be given through the ventilators. And arterial gas machines were available on both units.

Staff disposed of clinical waste safely.

All beds within the department had been altered to enable use by both level two and three patients as required. This allowed 'flex' in the beds to meet the varied level of nursing supervision and intervention and meant that if more patients with COVID-19 needed level three (more intense) care and treatment it could be provided safely within the high dependency area which was completely separate to the intensive care unit.

In addition, a four bedded thoracic high care unit had been established within the cardiac intensive care unit to support patients requiring level two care following thoracic surgery.

Assessing and responding to patient risk

Staff did not always complete admission assessments. However, we saw that relevant risk assessments were completed for each patient. Staff identified and quickly acted upon patients at risk of deterioration. Access to mental health support was not readily available.

Staff did not always complete risk assessments for each patient on admission / arrival, using a recognised tool. During our inspection we looked at five patient records and found the admission clerking for elective cardiac intensive care patients had not been undertaken in any of them. Admission clerking is an important part of the patient journey used to collect key pieces of information about the patient's history such as medications and previous illnesses.

Access to mental health liaison and specialist mental health support could be made via telephone referral however, staff we spoke to during the inspection told us that due to capacity issues within the mental health support teams referrals were rarely accepted unless the patient was ready for discharge. At the time of our inspection we were told that a psychologist was working alongside patients in the follow up clinic once they had been discharged and also with staff members to support their wellbeing.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. National Early Warning Scoring 2 (NEWS2) system and sedation scoring were used within the department. From information provided by the trust, patients were not always screened daily for delirium on general critical care unit which was not in line with the Guidelines for the Provision of Intensive Care Services V2 (GPIC). However, from notes we reviewed on site delirium checks were frequently undertaken, twice daily, and there was a clear system in place to escalate any deterioration in a patient's condition. There was a critical care outreach team (CCOT)/ acute response team (ART) in place 24 hours a day seven days a week to support patients from general intensive care who may have deteriorated throughout the hospital. CCOS's primary function was to support rehabilitation after critical illness and were available Monday to Friday from 7.30am to 4.30pm. ART was available out of hours to respond to bedside assistance and resuscitation calls. This was not available to cardiac intensive care patients when discharged to ward 38 and 39. However, these were managed by the same registrars as cardiac intensive care. A cardiac critical care outreach team of advanced critical care practitioners had been trialled and found not to be relevant and had no impact on readmission rates.

Critical care

Staff knew about and dealt with any specific risks including sepsis and venous thromboembolism (VTE). Sepsis and falls risk assessments were completed upon patient arrival and then routinely repeated twice weekly thereafter unless a patient deteriorated and this triggered a sepsis pathway. Skin bundles – a checklist of actions to monitor, prevent and detect pressure wounds was in place and patients received two hourly checks and movements as part of the bundle. Allied health professionals had been working closely with the unit to provide training on gentle passive movements to prevent pressure damage for patients in a prone (face down) position which was an important part of the management of a patient who had COVID-19.

Staff shared key information to keep patients safe when handing over their care to others. A formal Situation, Background, Assessment, Recommendation (SBAR) handover document was in place for patients when stepping down their care from intensive care. This was to ensure that standardised key information was shared appropriately.

Shift changes and handovers included all necessary key information to keep patients safe. Since the last inspection in 2019 the critical care unit had introduced safety huddles in addition to medical and nursing handovers. Safety huddles are short multidisciplinary briefings which focus on patients deemed to be elevated clinical risk and are found to be necessary to support the reduction of patient harm.

The unit followed National Safety Standards for Invasive Procedures (NatSSIPs) designed to reduce the number of safety incidents occurring following an invasive procedure. Local Safety Standards for Invasive Procedures (LocSSIPs) had been developed and assessed against all procedures carried out within the department. A folder was kept in the critical care staff room which had NatSSIPS for; intubation, bronchoscopy, central venous catheter insertion and tracheostomy.

The unit had service level agreements in place in the event that a patient required transfer to another NHS trust and all members of staff were trained in the transfer of a deteriorating patient and the use of all equipment required.

There was a difficult intubation trolley sited in both units for patients requiring additional assistance with the maintenance of their airway.

Nurse staffing

The service did not have enough of some allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

As of May 2021, the general intensive care unit had a nursing establishment of 106 qualified nurses and the cardiac intensive care unit had a nursing establishment of 100 qualified nurses.

The service had reducing vacancy rates. Cardiac intensive care at the time of our inspection had a registered nursing vacancy rate of 4.5 whole time equivalent (WTE). We were told these posts had been recruited to and the department were waiting on start dates of the new team members. General intensive care had recruited four band 5 vacancies at the time of our inspection. Information requested about the vacancy rates for general intensive care was requested but not returned.

Critical care

The service had high sickness rates of 10% at the time of our inspection. From September 2019 to March 2021, the sickness rate for critical care was 7.2% which was higher than the trust overall sickness (5.3%), and the acute England average (4.8%).

Managers were working hard to support staff both in absence and those who remained working in various ways including flexing the staffing to the needs of the patients. An uplift from two to four health care assistants had been introduced and in-house training for band 3 members of staff was underway in conjunction with the critical care network. Sickness for the cardiac intensive care unit was 3.5% at the time of our inspection.

No information was returned by the trust about turnover rates or rates of bank and agency nurses.

However, on inspection we saw that managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. Staffing templates for the general intensive care unit and high dependency unit indicated 15 registered nursing staff based upon 10 level three patients and six level two patients. However, as the two areas had been altered during the pandemic to accommodate either level two or three patient's dependent upon need, staffing was monitored closely and flexed accordingly. We were also told that additional training for health care support workers was being rolled out. This would allow them to provide additional support in times of need.

The ward managers on both the general intensive care and cardiac intensive care unit told us they could adjust staffing levels daily according to the needs of patients which had become especially important throughout the pandemic due to the unpredictability in the acuity, length of stay and number of the patients. This was evident within the general intensive care staffing rotas which demonstrated occasions where up to 19 qualified nurses were on duty to match the number of level 3 patients within the unit. The number of nurses and healthcare assistants matched the planned numbers. Staffing boards were in place on the wards so that visitors and patients could see the staffing numbers. During our inspection the actual numbers of staff matched the planned number of staff in all areas.

Managers told us they limited their use of bank and agency staff and requested staff who were familiar with the service. We saw examples of this within the cardiac intensive care unit where staff were selected specifically for their knowledge, skill and ability by the matron and ward manager who also looked at each individual curriculum vitae. In the general intensive care unit staff described a similar process and told us that the majority of shifts were covered by bank staff familiar to the department.

Managers made sure all bank and agency staff had a full induction and understood the service. This included orientation to the area, local induction, task orientation and knowledge of policies and procedures. Agency staff could not complete an incident report having not completed digital security but would escalate any concerns to the nurse in charge if required. Agency staff were also unable to access drugs unless they had undertaken the trust medicine management training and a medical device self-assessment was completed on the initial shift by the agency staff member.

The service did not meet the Guidelines for the Provision of Intensive Care Services (GPIC) standards for allied health professionals. Dedicated speech and language and occupational therapy provision in the general intensive care unit did not meet the recommended levels.

Critical care

In the general intensive care unit, the 1.2 whole time equivalent (WTE) speech and language therapists failed to meet the 1.6 WTE standard recommendation and the 2 WTE occupational therapists was below the 3.5 WTE required standard. However, dietetic provision was in line with **t**he GPICS standard 0.8 -1.6 WTE were required to enable the recommended provision of care. At the time of our inspection there was 1 WTE Band 7 & 0.2 WTE Band 6 for the unit. Cover for absence was provided by the general hospital dietetics team. The service covered five days.

There were two incidents reported in March 2021 relating to patients not receiving adequate nutrition whilst the dedicated intensive care unit dietitian was on annual leave.

On the cardiac intensive care unit there was no dedicated funding in place for dietetics or occupational therapy or speech and language therapy. However, we noted that patients moved quickly through cardiac intensive care to discharge to a ward and therefore there was less need for these therapies during their stay on the unit. Relevant therapy referrals were made at the point of discharge to a ward.

Mental health liaison also did not have any funding attached and referrals were made on a “needs basis” however staff we spoke with during our inspection told us that referrals were rarely accepted. Mental Health Liaison services were provided by another NHS Foundation Trust, located in the Mental Health Urgent Assessment Centre.

Physiotherapy on both general and cardiac intensive care was in line with GPIC standards.

Medical staffing

The service did not always have enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The service had high vacancy rates for medical staff which had not improved since the last inspection. Within the general intensive care unit. There were three consultant vacancies as well as a vacancy for a consultant intensivist within the cardiac intensive care unit. At the time of our inspection only consultant anaesthetists and cardiac surgeons were undertaking patient ward rounds. This fell outside of the guidelines for the provision of intensive care services which required patients falling outside of protocolised pathways to be reviewed by a consultant trained in cardiac intensive care not covering a second speciality whilst undertaking the task.

Sickness rates for medical staff were zero at the time of our inspection according to information provided by the trust.

Managers made sure locums had a full induction to the service before they started work.

The service did not always have a good skill mix of medical staff on every shift.

In cardiac intensive care advanced critical care practitioners supported the medical rota and worked within the cardiac intensive care unit Monday to Friday in the daytime only. This meant that at weekends and evenings there was one registrar between 20 patients which was worse than the minimum standard of one to eight. The department had vacancies for consultant cardiothoracic anaesthetists, which had been recruited to, and had also identified a need for a consultant intensivist which they were recruiting to. A locum consultant intensivist from abroad was due to start in November 2021 but had been delayed due to COVID-19 restrictions.

Critical care

The patient to consultant ratio for the general intensive care unit was one consultant to eight patients within the day and one consultant to 16 patients out of hours. Despite the high number of consultant vacancies this met the standard required to provide safe care and treatment to patient set out within the Guidelines for the Provision of Intensive Care Services. Managers were working hard to rectify the number of vacancies and staff worked flexibly to provide the necessary cover. However, the British Medical Association identified that:

"*Inadequate staffing means that consultants are often pressured to cover rota gaps or even take on the work of more than one doctor. Many consultants work significantly beyond their contracted hours in order to ensure patients get the care that they need. Where that is the case this can contributing to burnout, low morale and disengagement with the organisation, and leads to doctors leaving the medical profession*."

We saw that an international recruitment drive was underway, this included use of the Certificate of Eligibility for Specialist Registration (CESR), a route to specialist registration for doctors who have not completed a GMC approved programme. Managers were working closely with the critical care network to develop flexible working and the department was attempting to develop staff from within as a medium-term solution.

At the time of our inspection leaders told us that consideration was being given to alternative staffing models and flexible working however this was not yet in place.

Patients are managed by a team comprising of a cardiologist, cardiothoracic surgeon and anaesthetist. Where required the team would seek advice outside of the unit. Patients would not be seen by the speciality doctor on a daily basis as there is no requirement.

Patients within cardiac intensive care requiring other specialty care were not always reviewed by their specialty doctor on a daily basis in conjunction with the intensive care team.

A consultant microbiologist discussed all relevant patients daily between Monday-Friday via telephone call.

Records

Records were not always clear, accurate or up to date and staff could not always access records when required in the cardiac intensive care unit. However, staff on the general intensive care unit kept comprehensive and accessible records of patients' care and treatment. Records were stored securely in both intensive care units.

Records were not always accurate and did not follow the record keeping standards for doctors, nurses and allied health professionals. An annual record keeping audit was undertaken by the trust. In the February 2021 report, critical care scored overall as 68%; medical staff scored 67% and nursing staff scored 57%. The report did not demonstrate how critical care would improve the compliance and accuracy in line with the record keeping standards. This could lead to inaccurate records and delays to patients receiving treatment, inappropriate care and duplicate records. The trust had a divisional action plan for improvements to record keeping in place. It was the division's responsibility to oversee improvements to record keeping through audits.

However, while on inspection, we saw that patient notes within the general intensive care unit were comprehensive, correctly completed and all staff could access them easily.

Critical care

In the cardiac intensive care unit records were very difficult to understand. There were three different record folders where information could be stored and of the seven records that we checked within the unit, we found there was no standardisation in the order of information and that staff also struggled to assist us in finding the information.

Key pieces of information such as primary venous thromboembolism (VTE) risk assessments could not be found in the records within the cardiac intensive care unit. Managers told us plans were in place to produce a standardised booklet of care. We saw the working template of this which had been trialled for one month and comments and suggestions fed back. At the time of our inspection this document was awaiting final sign off before being printed for use.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in both the general and cardiac intensive care units.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw that oxygen was prescribed and regular medicine management audits took place. Following on from identified medication errors the department had introduced 'bungs' for controlled liquids to support the accurate measuring of them and dedicated checks had been introduced by the departmental pharmacy team.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Antibiotic prescriptions had a review date in line with best practice guidance and all ten prescription charts we reviewed during our inspection were legible, date and documented appropriately with pharmacist input.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Following a medication incident. we saw that information was disseminated to staff via safety huddles and additional training was provided on an individual basis as required.

The cardiac intensive care unit had installed a key tracker system so that each nurse could have an electronic peg to open the drugs cupboard. This left a digital footprint and created a trail which could be used to identify who by and when the cupboards had been accessed. The nurse in charge held the controlled drug key.

Incidents

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

Managers shared learning about never events and serious incidents with their staff in safety huddles and via newsletters. We saw an example of this from a serious incident which had occurred when a nasogastric tube was placed incorrectly.

Critical care

We saw that staff were notified via safety huddles, and managers told us that a red alert was sent across the trust led by the trust risk department. In addition to this, managers were finalising a podcast of learning from an incident to disseminate to staff at the time of our inspection. However, we did not see that staff across the trust were aware of this incident or subsequent learning.

There was evidence that changes had been made on the critical care unit as a result of a serious incident. For example, pH testing had been introduced to the unit following the insertion of a nasogastric tube and staff trained in how to appropriately undertake the test.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with trust policy. We saw there was a system in place for reporting incidents and for managers to review them to identify immediate actions, learning and severity of the incident. This process was supported by a trust incident management team who ultimately decided whether a serious incident should be declared. We saw that incidents were discussed at various meetings within the department and division. However, we were told that attendance at meetings was poor.

Staff we spoke with during the inspection understood that when something went wrong, they should be open and transparent and offer patients and families a full explanation.

Staff received feedback from investigation of incidents, both internal and external to the service. Three monthly newsletters were sent out to staff containing learning from any serious incidents.

Timescales for incidents were monitored and a divisional panel pre-meet took place before any incidents were sent to the trust safety panel. Key areas such as the quality of the root cause analysis, any contributory factors or identified learning and action plans were all reviewed. If a trainee was involved in an incident the training committee was also informed.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw that patient experience sessions were included in the divisional board meeting. This was where a patient or relative was invited to share their experience either positive or negative so that managers from the intensive care unit could gain greater insight into the patient experience.

Managers debriefed and supported staff after any serious incident. We saw that individual feedback was in place and a system of support working alongside practice development nurses was also in place.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From August 2020 to July 2021, there were no never events reported for critical care. *(Source: Strategic Executive Information System (STEIS))*

Safety thermometer

The service used monitoring results to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Critical care

Safety thermometer data was displayed on the units for staff and patients to see. This included information on falls, catheter associated urinary tract infections and pressure ulcers.

Staff used safety thermometer data to further improve services which included appointing champions to specific areas of clinical practice such as a pressure ulcer prevention. These champions attended trust wide meetings, gathered the most up to date evidence-based practice and helped to educate and support staff within the department.

National reporting of safety thermometer data was stopped nationally in January 2020 due to the COVID-19 pandemic.

Is the service effective?

Requires Improvement 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, managers did not always check to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included an enhanced care policy and an observation policy. Venous thromboembolism (VTE) was managed by following national guidance such as the National Institute for Health and Care Excellence quality standard 201 which stated that patients assessed to be at risk of venous thromboembolism are offered prophylaxis (measures to prevent) within 14 hours of admission. We looked at 10 records and saw that the sepsis screening process was in place on the general and cardiac critical care unit. The sepsis screening occurred on admission and routinely twice weekly on a Monday and Thursday in addition to if a patient deteriorated.

The department made sure that important standards such as the Intensive Care Society standards and recommendations were monitored but did not always implement actions to improve compliance. The guidelines for the provision of intensive care services V2 (GPICS) was a set of standards and recommendations for the planning and delivery of UK adult intensive care services. We were sent data to show compliance to GPICS, both general and cardiac critical care unit use the Red-Amber-Green (RAG) ratings to show the progress to meeting the standard or recommendation;

- Red – uncompliant
- Amber – in progress
- Green – compliant

Out of the 54 chapters within the GPICS standards and recommendations, the general critical care unit provided a random sample of three chapters and their compliance rates for August 2021. They were only fully compliant with one of the three chapters supplied. Therefore, the department could not be assured they were working towards the most up to date evidence-based practice.

The trust's two units, general intensive care and cardiac intensive care contributed separately to the Intensive Care National Audit Research Centre (ICNARC). Participation in ICNARC meant that outcomes of care delivered, and patient

mortality could be benchmarked against similar units nationwide. Both critical care units were within the expected ranges in the last ICNARC data published. The last report for ICNARC was published for the period 01 April 2018 to 31 March 2019; no more recent reports have been published by ICNARC and the trust did not monitor its own performance against the ICNARC information whilst the audits had been paused.

From information provided by the trust, patients were not always screened daily for delirium on general critical care unit which was not in line with the Guidelines for the Provision of Intensive Care Services V2 (GPIC). General critical care unit scored this as in progress and noted that the intensive care delirium screening checklist worksheet (TUFT's Scoring) and the PINCHESME checklist, a mnemonic for the review of possible causes of delirium, was not routinely completed on all patients. The General critical care unit had implemented a sticker for the notes to highlight the delirium screening and PINCHESME checklist. We requested but did not receive evidence of daily delirium screening for the cardiac intensive care unit. However, whilst on inspection we saw delirium screening was completed in all patient records that we reviewed.

The department provided an annual report for 2019 on the compliance of local safety standard for invasive procedures (LocSSIP) and national safety standards for invasive procedures (NatSSIP) for all the critical care units. The departments told us that the audit was paused due to COVID-19, general critical care and the high dependency unit were due to be audited in November 2021 and cardiac critical care unit in February 2022.

Nutrition and hydration

Patients were not always given enough food and drink to meet their needs or improve their health. However, staff used special feeding and hydration techniques when necessary.

Specialist support from staff such as dietitians were not always available for patients who needed it. Patients did not always receive enough food and drink to meet their needs and improve their health. On two occasions in 2021 the department reported that a dietitian was not available due to annual leave for at least seven days. This resulted in two patients not receiving adequate nutrition or nutritional assessment. Guidelines for the provision of intensive care services standards v2 (GPIC) says that "critical care units must have access to a dietitian five days a week during working hours". Whilst the general critical care unit met the GPIC standard for the number of WTE dieticians, there was not enough cover for staff leave.

However, we saw during our inspection that patients were weighed daily, and staff fully and accurately completed patient's fluid and nutrition charts where needed. Staff made sure patients had support with nutrition and hydration to meet their needs. Patients we spoke with in the general intensive care unit told us they had been well supported with nutrition and hydration. A nutrition noticeboard which displayed information for patients and relatives was hanging on the wall of the cardiac intensive care corridor.

A malnutrition universal scoring tool was used to monitor patients at risk of malnutrition.

Pain relief

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

Critical care

Patients received pain relief soon after it was identified they needed it, or they requested it. During our inspection we viewed local audit data for pain score documentation in August 2021 this showed 92% compliance with documentation completion.

Staff prescribed, administered and recorded pain relief accurately.

Staff assessed patients' pain using the Abbey pain chart, which is a recognised tool. This took into account behavioural changes, body language and physiological changes and was designed to support the identification of pain in patients who may not be able to communicate it. Pain relief was given in line with individual needs and best practice.

Patient outcomes

Staff did not effectively monitor care and treatment provided within critical care. They could not always demonstrate they used the findings to make improvements and could not always demonstrate achieving good outcomes for patients.

The service participated in national clinical audits. The cardiac intensive care unit participated in the National Cardiac Benchmarking Collaborative and both cardiac and general intensive care units contributed to the Intensive Care National Audit Research Centre (ICNARC) until this was paused in March 2019 due to COVID-19.

Nationally, audits were suspended during the COVID-19 pandemic however, managers and staff carried out some repeat audits to check improvement over time. An example of this was an audit against NICE 83 Rehabilitation after Critical Illness Quality Standards 158 showed an increase in compliance from 25% in October 2019 to March 2020 to 83% in January to June 2021.

During our inspection we saw that local audit data assessed some areas of clinical practice on a monthly basis such as bowel documentation, ventilator acquired pneumonia prevention bundle compliance, frequency of pain scores and pressure area care detection. The staff also told us that no sepsis audits were undertaken. We requested but did not receive the local audits for pain, prescribing and medical audit schedules; however the trust informed us that critical care did not have their own audit schedule. This meant we could not be fully assured that staff were monitoring and improving practice in relevant key areas through audit.

Managers shared and made sure staff understood information from the audits, a local audit board was displayed on the general intensive care unit and workstream teams had been created in place of champion roles so that staff could be involved in the improvement of patient outcomes. The board contained compliance rates for August 2021 and demonstrated that peripheral intravenous cannula care compliance was 96% and central venous catheter bundle compliance was 100%.

The general intensive care unit did not have any readmissions between August and October 2021. Leaders told us that the cardiac intensive care unit monitored readmission rates and reviewed them at a bimonthly clinical governance meeting. The data provided by the cardiac intensive care unit demonstrated that between April and September 2021, May 2021 had the greatest percentage of readmissions at 5% and June 2021 the lowest at 2% however no other figures were provided and so the statistical relevance could not be determined.

Competent staff

Critical care

The service made sure staff were competent for their roles. However, managers did not appraise all staff's work performance although they held supervision meetings with them to provide support and development.

Staff were experienced and had the right qualifications, skills and knowledge to meet the needs of patients. On the cardiac critical care unit, 52% of staff had undertaken the post registration certificate critical care course. On general critical care 45% of staff had completed the post registration certificate critical care course. This figure was due to increase to 52% in March 2022 when the current cohort completed their training. GPICS standards stated that a minimum of 50% of registered nursing staff must be in possession of a post-registration academic programme in critical care nursing.

Managers gave all new staff a full induction tailored to their role before they started work and an eight-week supernumerary period which could be extended if required.

The clinical educators supported the learning and development needs of staff. Practice development managers supported staff and worked alongside them within the units to support training and development. There was also a dedicated practice development manager for medical devises. During the pandemic staff supporting the intensive care unit were provided with training in care such as mouthcare, turning patients and checking for pressure wounds.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with confirmed they were given dedicated time to complete training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve. Managers worked with the practice development manager to support staff and increase competency, where any issues were identified. There was also a buddy system to support staff out of core working hours.

Managers made sure staff received any specialist training for their role. Examples of this included, cardiac output studies, renal replacement therapies and safety in transport of the critically ill patient.

Managers did not always support nursing staff to develop through yearly, constructive appraisals of their work. In critical care core service, the trust provided annual staff appraisal rate data which demonstrated that 53% of registered nursing staff for the general intensive care unit and 68% of registered nursing staff for the cardiac intensive care unit had received an appraisal. We requested but did not receive evidence of the medical staff appraisal rates within critical care services. However, the appraisal cycle was an annual one, which ran until the end of March 2022 therefore managers told us they expected compliance to increase.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All long stay patients and those with complex needs were discussed each morning. During our inspection we attended a multidisciplinary team (MDT) meeting on the general intensive care unit and found there was good attendance, appropriate discussion was undertaken of patients and information was shared appropriately.

Critical care

The critical care outreach service supported rehabilitation after critical illness. The critical care outreach service visited critical care step down patients with a goal of seeing them within 36 hours from discharge from the unit.

The critical care outreach service worked with the MDT by attending daily critical care handover and participated in the multidisciplinary team ward rounds that explored complex discharges. They worked across health care disciplines and with other agencies when required to care for patients. Both units worked as part of the local critical care network.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

The trust provided information regarding how it was meeting NHS England's seven-day services priority standards around such areas as outreach and access to therapists.

Staff on wards could call for support from the critical care outreach team five days a week between the hours of 7.30am to 4.30pm. An acute response team were available out of hours to support the medical workforce with clinical taskings and responding to acute deterioration. The acute response team and critical care outreach team corroborated and discussed patients with clinical concern at 7.30am and 4pm.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Occupational therapists were available five days a week on the general critical care unit as per GPICS standards. The cardiac critical care unit was not in line with GPICS standards as there were no dedicated occupational therapists on the unit, referrals were made at the point of discharge.

Both the cardiac critical care unit and the general critical care unit had their own dedicated physiotherapists who were available seven days a week, which was in line with the GPICS standards.

Speech and language therapists (SLT) and dietitians were mostly available five days a week on the general critical care unit. This was in line with the GPICS standards. The cardiac critical care unit did not have dedicated speech and language therapists and dietetic support but used the SLT from the general medical and surgical team. Cover was only provided by the general critical care team during periods of annual leave. The critical care unit was in line with the GPICS standard to have access to dietitians, however they did not have the recommended whole-time equivalent staff for SLT and dietitian. The leaders told us they had recognised that the seven day model needed to be strengthened. However, we did not see a plan of how this was going to be achieved.

Pharmacists were available on the cardiac intensive care unit, general critical care and high dependency unit for five days a week. In addition, a pharmacist attended the ward round on the critical care unit daily. This was line with the GPICS standards.

Both critical care units were supported on the telephone by a consultant microbiologist five days a week as required.

There was dedicated psychology support for patients on the general critical care unit. There was no dedicated psychology support on the cardiac critical care unit and referrals were made when required through the mental health liaison service.

Critical care

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the units.

Staff assessed each patient's health during admission to the units and provided support for any individual who needed to live a healthier lifestyle. Staff could refer patients to the drug and alcohol liaison team and nicotine replacement patches were utilised as required. Staff told us often patients continued with them when they were discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not follow national guidance to gain patients' consent. Some staff did not know how to support patients who lacked capacity to make their own decisions.

Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Some staff we spoke with were unable to give examples of when they would need to assess a patient's capacity and some staff told us they felt they needed additional training in this area.

Staff did not clearly record consent in the patients' records. Consent from patients for their care and treatment was not recorded in the patient records we looked at during our inspection.

When patients could not give consent, we were not assured due to lack of the appropriate documentation that staff made decisions in the best interest.

The service provided information which showed 84% of nurses and 72% of medical staff had received mental capacity act training against a trust target of 95%. However, this was for the whole division and not specific to critical care. The Trust then submitted training figures for critical care staff. This showed that the target for training was 85% as set out in service specification. For Critical Nursing MCA compliance at 04 October 2021 was 87.14%.

The department had a sedation policy, this included suggested drug and radiological regimes.

Is the service caring?

Good ➔➔

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

Compassionate Care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Critical care

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients we spoke with during our inspection confirmed that staff were compassionate and supportive. We also observed interactions between staff and patients in both units and found staff to be respectful, thoughtful and caring.

Patients said staff treated them well and with kindness especially during the difficult time where visiting was at a minimum due to the COVID-19 pandemic.

Staff followed policy to keep patient care and treatment confidential. We observed staff talking remotely via telephone to relatives of patients. Staff were discreet and made sure that others in the area were unable to hear the discussions.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs or complex needs, we observed this during a safety huddle when a patient with complex needs was discussed, professional judgement was used and concerns highlights and acted upon.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff we spoke with during our inspection told us this had been particularly difficult due to visiting being restricted. Staff made sure they were in regular contact with patients loved ones and where possible used face to face communication devises so that patients and relatives could see and hear one another. We heard of examples where staff had used their own communication devises to make this possible when the pandemic was at its height. We saw that staff explained to patients about their conditions and what they were experiencing and follow up clinics provided an opportunity for patients to access further emotional support if required. Staff also signposted patients to support groups for intensive care survivors which enabled patients to access support from others who had lived similar experiences.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. During our inspection we witnessed a patient who became distressed and saw that staff quickly and efficiently supported them in a respectful and kind manner. This reassured and settled the patient. Staff we spoke to were very aware of the emotional and psychological impact an admission to intensive care could have upon a patient.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A dedicated organ donation nurse was also in post and would work closely with any family members of patients that may have been suitable for organ donation. An end of life noticeboard was on the wall within the units and had lots of information for family members including signposting to where they could access further support.

A patient diary was completed during their stay in the unit which contained important stages of their journey and experience of care. This was an aide memoir for patients when they recovered because often, they would have little if any memory of their time in their unit and experienced large gaps in their timescales of memory. These diaries were either passed to the patient or destroyed depending upon their wishes or if the patient had died passed to their family.

Understanding and involvement of patients and those close to them

Critical care

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

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our inspection understood their treatment plans and were involved in decision making about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. Thank you cards were on display in both units from patients and their families.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. Managers attended daily network meetings to co-ordinate critical care capacity both in the service and across the region.

Managers knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Any breach or delayed discharge was reported through the incident reporting system and escalated to the matron and duty manager and was then monitored through the clinical information system. Same sex breaches were also reported to the local critical care network.

Facilities and premises were not appropriate for the services being delivered. This was because they did not meet the Guidelines for the Provision of Intensive Care Services standards. However, the service had clear plans to address this with a new build to be completed in September 2022.

Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems, learning disabilities and dementia from the psychiatric liaison team. However, staff told us they did not always make referrals due to a known lack of capacity within psychiatric liaison.

Meeting people's individual needs

Critical care

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service had trained staff to be champions for specific areas such learning disability, autism and delirium. Staff could access additional support for patients with these needs from the champions. A rehabilitation co-ordinator acted as a link between patients with learning disabilities and their families/carers. supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw get to know me boards at each bed space for patients living with dementia and learning disabilities. There were information boards covering a variety of topics such as end of life, falls awareness and dementia throughout the unit for use by staff, patients and visitors.

Staff understood and applied the policy on meeting the information and communication needs of patients living with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Staff used picture charts to facilitate communication with tracheostomy patients' or those unable to read.

Managers made sure staff, patients, and those close to them could get help from interpreters or signers when needed. Staff had access to a telephone-based interpretation service.

There was a 24 hour on call chaplaincy service which covered multiple faith groups. We saw this was always offered to patients and their families.

A clinical psychologist contacted all patients once they had been discharged from the general intensive care unit to offer additional support including access to a follow up clinic.

However, we did not see information leaflets available in languages spoken by the patients and local community.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

Managers made sure patients could access services when needed. The service had identified a bed upon the cardiac intensive care unit which was reviewed daily and ringfenced for patients who had out of hospital cardiac arrests and required intensive care treatment. Managers adjusted bed bookings in line with patient acuity daily in the cardiac intensive care unit. They liaised with surgical colleagues to ensure theatre lists were adjusted according to bed availability.

Between March 2020 and October 2021, the service reported a bed occupancy rate above 85% for 151 days out of 577. Of this, 32 days were at 95% and above, 22 days at 100% or above.

Between November 2020 and September 2021, the average bed occupancy within the cardiac intensive care was 78%.

Critical care

Managers and staff worked to make sure patients did not stay longer than they needed to. Managers told us that since the beginning of the COVID-19 pandemic length of stay and acuity had increased. The department had introduced a number of measures to support this including a flexible COVID-19 area, access to specialist beds for patients requiring longer weaning from oxygen and a four-bed thoracic high dependency unit to support longer stay cardiac intensive care patients.

Staff told us the service moved patients only when there was a clear medical reason or in their best interest. The unit had been reconfigured so staff could care for level two and three in all areas negating the need for patient moves.

Staff told us they did not move patients between wards at night. Managers told us patients were rarely moved unless in an emergency.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs with the support of a rehabilitation co-ordinator.

Managers told us they monitored the number of delayed discharges and took action to prevent them. Managers reported any delayed discharges through the incident management system, and these were escalated to duty managers as required.

Staff supported patients when they were referred or transferred between services. Critical care staff outreached onto wards to facilitate the transfer of patients into the unit.

Managers monitored patient transfers and followed national standards. We saw all relevant equipment was in place for transfers and staff received specific training on its use in line with guidelines for the provision of intensive care services.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern on a notice board in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to handle complaints and concerns.

Managers investigated complaints and identified themes. The management of complaints was reviewed in the governance, quality and risk committee meeting. The service had a dedicated quality manager and part of their role was to identify themes and trends from complaints and share any learning with staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The general intensive care unit received three formal complaints in the 12 months prior to our inspection. We reviewed complaint response letters sent to patients and saw all areas of complaints were fully investigated and were signposted to investigatory bodies if dissatisfied with the outcome of the complaint. Of the three complaints received by the division, two were responded within the trust target.

Critical care

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers gave feedback to staff directly involved. Staff and practice educators supported staff where appropriate. Key issues or messages were shared in safety huddles and these were stored in a correspondence folder for staff who were not on shift to review.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

The new leadership team had the skills and abilities to run the service. They understood and were starting to manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leadership within both the general and cardiac intensive care units had recently undertaken multiple changes. In April 2021 the general intensive care unit had moved into the scheduled surgical critical care, anaesthetic and theatre (SCCAT) division whilst the cardiac intensive care unit had moved into the tertiary division. Both services had new divisional leadership teams and the general intensive care unit had seen new appointments to matron and ward manager posts also within the twelve months prior to our inspection.

A lead allied health professional for SCCAT had also been in post twelve months.

A new divisional director of nursing role had been created within the SCCAT division to help support its governance and a quality manager role in both general and cardiac intensive care had been created.

The general and cardiac intensive care units ran as two separate entities, general intensive care by intensivists and cardiac intensive care by cardiac anaesthetists and surgeons.

Both departments had supernumerary clinical coordinators in place 24 hours a day in line with Guidelines for the Provision of Intensive Care Services (GPICS) standards based on the number of beds.

Leaders that we spoke with during and after the inspection recognised the challenges faced in terms of quality and sustainability. The COVID-19 pandemic had placed increased pressure upon the departments and the unique challenges they had faced meant that the team were exploring new ways of working. An example of this was the alteration from the traditional intensive therapy unit (ITU)/high dependency unit (HDU) model into an area which could be flexibly altered dependent on needs. Nurse staffing uplifts and changes to incident management supported improvements in quality and wellbeing of staff.

Leaders were both visible and approachable within the department and staff we spoke with largely said they felt supported in carrying out their role.

Succession planning was in place within the departments. During our inspection we spoke with staff members who told us that band 5 registered nurses who had taken on additional responsibilities during the pandemic were supported to develop to enable them to progress to first line band 6 managers. Additional band 5 registered nurses were then recruited into the unit.

Medical staff were working to develop their own staff to enable natural progression from within.

Vision and Strategy

The service had a one-year strategy in place which was focused on sustainability of services. Leaders understood and knew how to apply the strategy and monitor progress. However, staff were not always clear of what the strategy for the department was.

Following the expiry of the trust's previous five-year strategy in April 2021 the board had agreed a short term one-year strategy for the trust based around the restore and reset principles.

Staff we spoke with during the inspection were not always clear about the current strategy and objectives of the department. Staff and leaders told us about the challenges they had faced over the last 18 months due to the COVID-19 pandemic, this had meant a greater focus of staff upon wellbeing and peer support within the department during this period. Leaders told us it was their intention to create a five-year strategy with the involvement of all relevant stakeholders and had undertaken engagement meetings with staff to inform their future vision and strategy.

Following the realignment of the divisions and new leadership team, the service developed a surgical enhanced recovery area to support critical care. They developed contingency plans for future waves of the pandemic which was in line with the NHS sustainable development plan. There were clear and measurable timescales for achieving the objectives and resource and funding requirements were also listed. Progress was monitored at divisional board which meant that actions and timescales could be adhered to.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care and provided opportunities for career development. The services were working towards an open culture where patients, their families and staff could raise concerns without fear. However, the service did not promote equality and diversity in daily work.

During our interview with the division of SACCT, leaders told us they did not feel they fully understood the culture of the division and this was in part due to the restructuring. Staff surveys had not been completed following the trust restructure, so the existing ones did not reflect the views of staff in the newly formed divisions.

Staff within the cardiac intensive care unit commented that they felt uncomfortable to challenge leaders and raised concerns about learning from incidents.

Other staff we spoke with felt supported and valued and staff told us there was an open and positive culture. We found staff in both units were all dedicated and passionate about providing patient centred care and treatment.

Critical care

Staff we spoke with gave examples of leaders implementing changes which improved their working conditions such as wellbeing boards which were put up within the general intensive care unit. The whole team including administrative and housekeeping staff were included within the daily staffing board figures and staff reported this gave them a sense of belonging and teamwork.

Following feedback, leaders implemented a system which enabled patients' acuity to be easily identified by staff caring for them. Staff we spoke with reported this had a positive impact on effective working, communication and wellbeing.

A positive post box was in place in the staff room of the general intensive care unit. This was where staff wrote on slips of paper explaining how someone had made their day better. These slips were then emailed to that staff member and used as part of their revalidation.

The service and leaders were focused on supporting staff. A dedicated psychologist supported staff in the general intensive care unit throughout the pandemic in group and individual sessions. These sessions focused on relevant topics staff found particularly challenging and offered them an opportunity to discuss their feelings and thoughts. A staff resilience hub was implemented during the pandemic. This hub was a confidential self-referral service where any staff member could access support from, 24 hours a day. New staff had supportive one to one meetings, with ward managers, to ensure they were coping with the pressures faced within the department.

However, equality and diversity were not promoted effectively throughout the services. Leaders and staff were unable to describe how services had been considered or developed in a way that met needs of those with a protected characteristic.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Whilst staff and leaders had opportunities to meet and discuss the performance of the service there was limited evidence of how effective this was. However, staff at all levels were clear about their roles and accountabilities.

There were various meetings at all levels in both units to discuss divisional performance, service quality and governance procedures, including monthly departmental meetings, a bi-monthly clinical effectiveness meeting, bi-monthly governance, quality and risk committee meeting and six weekly divisional board meetings. The key functions of the divisional board meeting were to review finance, human resource, clinical and operation function within the division. Minutes from this meeting were fed back to department meetings. The governance structure within the departments consisted of weekly ward manager phone calls with the deputy director of nursing, daily catch up calls between the matrons and deputy director of nursing and tri-weekly with the head of service. Staff at all levels were clear about their role.

The SACCT triumvirate was supported by a quality manager to support the division's governance processes.

However, the trust provided us with clinical effectiveness and quality and governance meeting minutes for both areas. We reviewed these and found limited evidence of sufficient scrutiny and challenge around quality, performance and risk management for critical care services. We also found that meetings were not held regularly and with minimal evidence of attendance of relevant staff and leaders from critical care services.

Managers did not make sure all staff attended team meetings. However, they had recognised this and introduced other methods for staff to receive the information from team meetings such as information boards and folders, safety huddles and closed social media groups.

Following our inspection, the trust provided us with a trust commissioned external review and report of the effectiveness of the trust's divisional governance systems and processes. As a part of the external review each divisional leadership team had completed a reflective self-assessment using a governance maturity matrix to assess performance across a range of indicators of good governance. Maturity matrix self-assessment indicators were each scored from one to four, with four being the highest rated maturity index score of good governance. The divisional leadership team had self-identified improvements that were required across a number of governance indicators. The divisional leadership team for the division of SACCT had assigned a self-assessed score of three for implementing best practice, care quality commission implementation, patient and carer feedback and improvement implementation and lessons learnt, and a self-assessed score of two for risk management, patient safety and managing incidents, clinical audit and mortality.

The divisional leadership team for the division of tertiary services had assigned a self-assessed score of four for implementing best practice, risk management, patient safety and managing incidents, and a self-assessed score of three for care quality commission implementation, improvement implementation and lessons learnt, a self-assessed score between three and two for patient and carer feedback and a self-assessed score of two for clinical audit and mortality. Each divisional leadership team had developed an improvement action plan, however we found that deadlines and timeframes were not set for the completion of all identified improvement actions, and limited evidence of the continuous monitoring and recording of progress against actions.

The trust had also introduced a quality assessment system known as the Collaborative organisational accreditation system for teams (COAST). It was the trust's ambition to implement COAST throughout all hospital areas, wards and units, with the aim and objective of continually monitoring and improving services. The COAST used the CQC's key lines of enquiry (KLOEs) as the basis for evaluation. Accreditation was ranked from gold, silver or bronze, and each area had an action plan for improvement that was the responsibility of the manager for the area to implement. Areas were reaccredited at set intervals based upon the received accreditation rank.

The cardiac intensive treatment unit had been assessed and had achieved a gold accreditation in October 2021 and had a date for a reassessment booked. We did not find evidence during inspection that this activity had been formalised into actions for improvement however we were informed that they had submitted an action plan in November 2021. The intensive care unit and high dependency unit had not been assessed and there were no dates identified for the initial assessment of the units as they were unannounced.

Management of risk, issues and performance

Leaders and teams had identified and escalated relevant risks; however, they did not identify actions to reduce their impact in a timely manner or effectively manage those risks. Leaders and teams did not effectively use systems to manage performance. They had plans to cope with unexpected events. Leaders contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders told us they attended a monthly trust risk assurance meeting where risk registers were challenged and scrutinised and that risk registers were discussed in divisional and department meetings.

Leaders we spoke with acknowledged that risk registers held risks which were historic and overdue a review; therefore, they did not have the assurance that all risks were being appropriately and effectively managed. We reviewed the risk

registers and found that numerous entries had remained on the register since 2017, with limited evidence of appropriate and timely review taken and with no resolution. We also saw that not all risks had target dates for completion of identified necessary actions or controls and responsibility of actions had not been clearly assigned to relevant staff. Therefore, the service could not be assured that risks and issues were appropriately managed.

The service took part in some national and local audits however these were limited and did not include key areas such as sepsis. There were monthly divisional meetings to discuss, monitor and identify improvement actions based upon completed audit findings. There was a newly appointed quality manager dedicated to improving quality and performance.

The critical care services had provided care and treatment to patients affected by the COVID-19 virus during the pandemic. This had significant impact upon the service. As a result, staff, clinicians and leaders worked together to increase the provision of the services to meet this unexpected increase in demand.

Information Management

The service did not always collect reliable data and analyse it. Staff did not always have access to the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were not always integrated. Data or notifications were consistently submitted to external organisations as required.

Leaders did not always have access to service quality and operational information to make effective decisions about quality and sustainability of care and treatment. Data was not routinely collected or monitored in key areas such as documentation compliance, sepsis management and mixed sex accommodation within both units and ICNARC data supplied by the trust was not the most up to date information available. This meant that performance could not be analysed, and relevant improvement measures implemented.

During our inspection we saw that patient information was difficult to access in the cardiac critical care unit. Paper based records meant patient records could not be reviewed in their entirety unless all records were together which we saw was not always the case within cardiac intensive care. This meant there was a risk that staff may not have the appropriate information to care for patients safely. However, staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.

Staff completed information governance and data security training as part of their mandatory training. The training compliance rate amongst doctors for the completion of information governance mandatory training, was 100% for doctors within the general critical care unit and 63% nursing staff. The training compliance rate amongst doctors for the completion of information governance mandatory training, was 85% for doctors within the cardiac critical care unit and 89% nursing staff. Information governance training was not always in line with the trust compliance rate of 85%.

Staff understood their requirements regarding notifications to external bodies.

Engagement

Leaders and staff did not always actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.

Critical care

The service did not take a full and diverse range of stakeholder's views. They worked well with external partners, however, did not routinely actively engage with staff or patients. We spoke with divisional leaders and staff and they told us there were no staff or patient group meetings to shape services and culture. Divisional leaders and staff we spoke with during our inspection could not provide any examples of how the service engaged or collaborated with patients, equality groups, the public or local organisations to plan and manage the services provided.

The trust told us that there had been a noted reduction in attendees at the patient focus groups; specifically, the patient influence panel recent attendees were between eight and 10. The poorer uptake was a result of the COVID-19 pandemic. The trust had contacted the local clinical commissioning group to develop a wider Fylde Coast patient influence panel to enable patient engagement; the first joint patient influence panel meeting was held in January 2020. This was an example of how the trust had engaged with patients and listened to the patient voice during the challenging pandemic circumstances.

The critical care outreach service supported hospital ward engagement by delivering training in post-critical care issues through group sessions and face to face.

Learning, continuous improvement and innovation

There was a developing focus on continuous learning and improvement. There was some knowledge of improvement methods and the skills to use them.

There was an increasing focus on continuous improvement throughout the critical care services, including through internal quality accreditation and a critical care improvement plan (CCIP). The CCIP was overseen by the operational delivery network (ODN) and had identified improvement workstreams; staff at all levels participated in the improvement workstreams. However, more broadly the approach was underdeveloped and there was no evidence of quality improvement methods being implemented. We saw risks which had been on the risk register since 2017, limited auditing and monitoring of performance and areas for improvement which had been previously identified at the last inspection.

Regular mortality meetings were undertaken by both units and each death was discussed. We saw that an action and learning report was completed. However, from what we saw, the progress with action or learning points section detailing who was responsible for the action and an update on its progress was not completed. An example of this was in the August 2021 report where no update was included despite actions and learning points being identified in the July 2021 report.

Surgery

Requires Improvement ● →←

Is the service safe?

Requires Improvement ● →←

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

Mandatory training

The service did not provide mandatory training in key skills to all staff. The mandatory training compliance rate did not meet the trust's target in all modules. However, the service had systems in place to make sure everyone completed it

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was a mixture of face to face training and e-learning modules. Managers and staff told us that due to the COVID-19 virus pandemic that this had impacted the ability to complete mandatory training modules that could only be delivered via face to face training. We were told by managers that they used an electronic system to monitor and record staff mandatory training module compliance rates and they alerted staff when training module compliance had lapsed or when training was due, and they proactively booked training modules and assigned time for staff to complete mandatory training.

The trust set a mandatory training compliance rate target of 95% for all modules. Following our inspection, we requested twice from the trust the mandatory training compliance rates for surgical services over the last 12 months. The surgical services staff had achieved the trust's mandatory training completion target of 95% or above for health, safety and welfare training. However, the surgical services staff had not achieved the trust's mandatory training compliance target of 95% in a number of modules including; equality, diversity and human rights (93%), fire safety (93%, information governance and data security (93%), moving and handling level one (93%), conflict resolution (92%), basic preventing radicalisation awareness (92%), infection prevention and control level one and level two (91%), resuscitation level one (82%), moving and handling level two (79%), resuscitation paediatric basic life support (77%), resuscitation adult basic life support (76%) and preventing radicalisation prevent awareness (70%).

The trust did not provide mandatory training compliance rates for eligible surgical service staff in immediate life support (ILS) training or advanced life support (ALS) training modules. The trust could not demonstrate their assurance that all relevant surgical services staff had received an appropriate level of training in resuscitation and had the necessary skills and knowledge to help someone in a life threating situation such as a cardiac arrest.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff told us they had completed training in caring for patients with a complex need.

Safeguarding

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

The trust set a training compliance rate target of 95% for all safeguarding vulnerable adults and children modules. Following our inspection, the trust provided us with safeguarding vulnerable adults and children training module compliance rates for surgical services staff over the last 12 months. The surgical services staff had achieved the trust's target of 95% or above for safeguarding children level three training. However, the percentage of staff that had completed safeguarding adults level one (92%), safeguarding adults level two (89%), safeguarding children level one (85%), safeguarding children level two (81%) and safeguarding adults level three (73%) were below the trust target of 95%.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During our inspection we saw that the trust had safeguarding policies which staff accessed via the trust's intranet to support staff to raise safeguarding concerns. We reviewed 11 patient care records and we found that safeguarding concerns were present in four patient care records and evidence that staff had raised these safeguarding concerns in line with the trust's policy.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke to were aware of the trust's named lead for safeguarding adults and children and provided examples of when they had made a safeguarding referral to raise concerns.

Cleanliness, infection control and hygiene

The service did not always take action to prevent surgical site infections, however they used systems to identify them. The service controlled infection risk well on wards and theatres. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff did not work effectively to prevent, identify and treat surgical site infections. The trust monitored and submitted mandated orthopaedic surgical site infection (SSI) data for surveillance quarterly to the national surgical site infection surveillance service (SSISS) at Public Health England (PHE), the trust did not submit data for other surgical categories as participation remains voluntary. Surveillance data submitted by the orthopaedic surgical service between October 2019 and June 2021 demonstrated the following number of patients that developed an SSI following an operation: six patients that underwent a hip replacement operation, three patients that underwent a knee replacement operation and four patients that underwent a repair of neck of femur operation. Following our inspection the service provided us with an action plan that demonstrated the service had identified in August 2020 and is documented on the SACCT divisional governance action log, that the service had a higher than average SSI rate for elective and emergency orthopaedic surgeries. We found minimal evidence of actions that had been taken within the orthopaedic surgical service to continually monitor and improve SSI rates.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed ward staff and housekeepers undertaking daily and weekly cleaning tasks of ward environments and equipment. Cleaning records were in place for staff to document the cleaning of the environment and equipment and completion of these records were monitored by the service. The cleaning records we reviewed on the wards and theatres we visited demonstrated that staff cleaned the environment and equipment consistently. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that staff used the "I'm clean" sticker system on wards which indicated when equipment had last been cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). As part of the trust's response to the COVID-19 pandemic the service had environment risk assessed each ward to ensure the appropriate social distancing guidance for staff and patients was in place to prevent potential transmission of the COVID-19 virus. On

each ward we visited we saw that all rooms had been COVID-19 environment risk assessed for maximum occupancy and this was clearly displayed on room doors. The areas we visited had adequate supplies of PPE and there was information displayed at ward entrances about appropriate PPE usage. We also observed that staff followed the trust's COVID-19 social distancing and PPE policies.

We saw there were enough hand washing sinks and alcohol gel hand rub in all areas we visited, and we observed that staff washed their hands and followed the world health organization's five moments for hand hygiene guidance. We saw hand hygiene audit results displayed in ward areas we visited which demonstrated good rates of hand hygiene compliance.

The service had a service level agreement in place with an external contractor for the decontamination of reusable surgical equipment in theatres.

Staff we spoke to were aware of current infection prevention and control guidelines, including the process for screening patients for COVID-19, Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile prior to and during an admission to wards and theatres. Staff told us that patients identified as having a current or previous infection were isolated in side-rooms and we saw that appropriate signage was used to indicate the potential for infection in order to protect staff and patients. At the time of our inspection there had been increased medical inpatient admissions at the hospital, in response to this, surgical areas were identified by the trust to be used to care for medical patients. Medical patients that receive care or treatment in a surgical area are known as medical outliers. Medical patients do not ordinarily undergo screening for certain microbes on admission to the hospital, however staff told us that processes were in place to reduce the risk of transmission of microbes or infections between medical outlier patients and surgical patients. For example on ward 35 staff told us that medical outliers were isolated in side rooms and on the day surgery unit staff told us that two out of four of the bay areas were used to care for medical outlier patients to ensure that they were kept isolated from surgical patients.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. Patients we spoke to told us that staff were attentive and responded to call bells and requests for assistance.

The environment and equipment on the wards we visited were well maintained. We saw that recent building works were made on some wards to create more storage areas.

We raised this with managers who told us that an area on one ward had been identified as a main storage area for all wards to address this, but more storage space was required.

Staff carried out daily safety checks of specialist equipment. During our inspection we saw that there was a sealed and tagged resuscitation trolley available in all the areas we inspected that contained emergency equipment and medicine. All disposable equipment on the trolley was sealed and all required equipment was present. There was an electronic system in place for the recording of resuscitation trolley equipment checks staff performed. We saw that resuscitation trolley equipment was checked and recorded consistently by staff.

Surgery

The service had enough suitable equipment to help them to safely care for patients. We saw that there was adequate stock and a process of regular review was in place on wards and theatres to ensure that patient consumable equipment was within their expiry date.

Staff disposed of clinical waste safely. The wards and theatres we visited had arrangements in place for the handling, storage and disposal of domestic and clinical waste and sharps. We saw that clinical and non-clinical waste was segregated into colour coded bags and sharp objects were deposited in sharps bins, all waste and sharps were safely disposed of by the estates staff. All wards we visited had access to a dirty utility room with a macerator to dispose of human waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

We reviewed 11 patient care records and saw that staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We saw that risk assessments were conducted for venous thromboembolism (VTE), pressure ulcers, nutritional and hydration needs, risk of falls and infection control risks. During our inspection we also saw that staff conducted intentional rounding to continually assess patients as indicated by condition and need and to identify any issues promptly that may need to be escalated. Staff knew about and dealt with specific risk issues such as sepsis, VTE, falls and pressure ulcers.

In our review of patient care records we also found that the staff used the national early warning score system (NEWS2), which is a nationally recognised tool to identify deteriorating patients that require escalation of their condition. We found that staff recorded and monitored patients NEWS2 score consistently in the patient paper record and escalated patients that had deteriorated in-line with the trust's policy.

We observed three theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist and found that the theatre staff completed safety checks before, during and after surgery.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self harm or suicide. During our inspection we saw that staff arranged psychosocial assessments with the psychiatry team for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed two morning ward handovers, two ward safety huddles and one morning theatre team brief and saw that all key information was shared in these meetings.

Nurse staffing

The service mostly had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment in most areas. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Surgery

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust adjusted staffing levels daily according to the needs of patients. Managers advised us that the safe staffing levels of all areas were reviewed twice daily in a trust wide safe staffing meeting. These meetings were chaired by a divisional director of nursing or the corporate associate director of nursing and were in attendance by senior management and ward managers and staffing levels were reviewed in each area for safety and could be challenged if staff felt that any area was unsafe.

There was an electronic system in place across the hospital that took into account staff skill and competency mix alongside the acuity and dependency needs of patients when allocating and adjusting staffing levels throughout the service, managers told us that this gave them assurance that their staffing levels in areas was safe. Staff told us there were often shortfalls in staffing due to staff sickness or a COVID-19 virus related reason. Staff shortages were responded to quickly and the trust used bank and agency to fill shifts, managers told us that they used bank and agency staff whom were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

We reviewed staffing rotas for wards we visited and found they mostly had enough nursing and support staff to keep patients safe and the number of nurses and healthcare assistants matched the planned numbers. However during our inspection, we found during the night shifts on the Lancashire suite ward there was only one registered nurse and one health care assistant allocated to care for patients. Staff we spoke to told us this was the nursing staff model establishment for this ward and shift. We raised this concern with the trust at the time of our inspection and in response the trust increased the staffing to two registered nurses on a night shift on this ward.

The theatre staff at this hospital were overseen by a matron for theatres within each division. We reviewed a sample of theatre staffing rotas and saw that operating theatres had sufficient numbers of staff, in line with national guidelines, such as the association of perioperative practice (AfPP).

The service had reducing vacancy rates for nursing staff. The SLTs were aware of the recruitment issues posed by the trust's geography and the presence of larger trusts and hospitals in nearby cities. However, the trust had a workforce recruitment and retention strategy in place to address the workforce issues and they had recently undertaken a large overseas recruitment drive. The trust had recruited a number of international nurses on the surgical wards at this hospital. As of August 2021, the service had nine registered nurse vacancies. The SLTs told us that the service was actively recruiting to these vacancies.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The wards and theatre areas we inspected had sufficient numbers of medical staff with a good skill mix on each shift to ensure that patients were safe. The service always had a consultant on call during evenings and weekends. We reviewed a sample of medical staffing rotas and saw that the service always had a consultant, junior doctor and middle grade doctor for each surgical specialty 24 hours per day, including a separate 24 hour on call rota for evenings and weekends.

At the time of our inspection the surgical services had five consultant surgeon vacancies and three middle grade doctor vacancies. The SLTs told us they had attempted to recruit to these positions. The service was using locum doctors to cover these positions.

Surgery

The surgical services had identified and planned for the increased pressures of winter and had secured funding for and recruited four middle-grade non-consultant substantive posts to reduce the pressure on the surgical services during the winter period.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them. The service used a mixture of electronic patient and paper records. During our inspection of the surgical wards and theatres we looked at a total of 17 patient records, and we found that records were completed comprehensively by staff. When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us that all patient records were easily accessible.

Records were stored securely. At the last inspection we told the trust it must ensure records are stored securely, at this inspection we found that this had improved. We saw in all areas we visited that paper patient records were stored securely in keypad access cupboards. We also observed that staff logged out of systems and computer terminals when no longer in use or before leaving an area to maintain the security of electronic patient records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The hospital used a paper prescription chart to prescribe medicines for patients. We found all 16 patient prescription charts we reviewed had the patient's allergy status recorded and the patient's weight recorded when required for a medication to be prescribed by weight. However, we found some critical medicines including antibiotics had not been administered in a timely manner and it was not always clear of what actions nursing staff had taken when a medicine was not available to be given on the ward. Medicines not given included medicines for mental health conditions and medicines to treat dementia.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We found evidence in patient care records we reviewed that information to make informed decisions had been given to patients by ward or pharmacy staff. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Medicines were stored securely. We found a controlled drug incident had been escalated to the chief pharmacist who was the controlled drugs accountable officer (CDAO) in a timely manner. The CDAO was able to explain all actions taken. We found staff reported to the pharmacy team when medicines were stored outside the recommended temperature range and the actions taken by pharmacy were clear. Controlled drugs were stored in line with national guidance. Controlled Drug balance checks were carried out daily on all controlled drugs.

Incidents

Surgery

The service did not manage patient safety incidents well. Staff did not recognise and report all incidents and near misses. The service did not consistently share lessons learned with the whole team and the wider service. When things went wrong staff had not always apologised and gave patients honest information and suitable support in a timely manner. However, managers investigated incidents and ensured that actions from patient safety alerts were implemented and monitored.

Staff did not consistently raise concerns and report incidents and near misses in line with trust policy. We reviewed incidents that occurred within surgical services between August 2020 and September 2021 and found that there were significant delays in staff reporting incidents. This meant that the service was unable to be assured that they had taken all appropriate action to mitigate or reduce risk in a timely manner. Staff we spoke to also told us they had not reported some concerns and incidents due to lack of action and sustained improvement by managers. Staff gave examples of concerns they had raised previously that had not been fully addressed such as; inappropriate patient moves between wards overnight that had impacted upon patients' care. Staff also shared that patients awaiting admission to a surgical area from the emergency department who had breached the four hour target were being left to wait for long periods of time, whilst patients who had not breached the urgent and emergency care four hour wait target were moved to more appropriate areas to provide care and treatment. We found staff had reported two examples of these concerns, however staff told us that this was an on-going concern and these concerns had been raised through divisional governance meetings. Staff told us they had raised these concerns before; however they felt the concerns had not been addressed by managers. At the time of our inspection we visited the emergency department and did not find that patients awaiting admission had waited for long periods of time. Following our inspection, we requested documented minutes of divisional governance meetings and could not find evidence that these concerns had been raised.

The service had reported two never events within the surgical services over the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The two never events had occurred in the ophthalmology surgical unit, the two never events were the placement of the wrong implant. The service had investigated the never events and developed a joint action plan and commissioned an external review by the Royal College of Surgeons. We saw that managers shared learning about never events with staff within the unit but had not shared learning with staff across the trust. The action plan identified that staff required training in the World Health Organization (WHO) prosthetic pause checklist and training to enable staff to understand the correct calculation of lens implant. We asked the trust to provide evidence that staff had been trained, the trust provided evidence that eligible staff had been trained in the calculation of lens implants, however the trust did not provide evidence that eligible staff had completed training in the WHO prosthetic pause checklist. The trust could not demonstrate their assurance that all identified necessary actions to mitigate risks to the health and safety of patient's receiving care and treatment had been completed.

Managers did not share learning about never events with their staff and across the trust and managers did not share learning with their staff about never events that happened elsewhere. We spoke to staff and managers within the service and they were unaware of the never events that had occurred within the service and across the trust and were unable to describe any learning that had been shared.

Staff did not understand the duty of candour and they were not open and transparent and did not give patients and families a full explanation if and when things went wrong in a timely manner. The service did not meet the trust's target timeframe for applying the duty of candour. We found that there were significant delays in the trust notifying patients and their relatives of an incident and in providing an apology or support that may had been required.

Surgery

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke to told us that they received feedback from managers in writing and feedback was also shared in staff safety huddles. Staff met to discuss the feedback and look at improvements to patient care. During our inspection we saw that staff in team briefings and safety huddles discussed feedback and improvements to patient care. We also found patient safety incidents and actions taken displayed in the ophthalmology surgical unit staff, however we did not find this in other surgical areas, wards or units.

Staff knew what incidents to report and how to report them. The trust had an electronic incident reporting system in place and staff we spoke to were aware of their responsibilities to report incidents, near misses and raise concerns.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. During our inspection we saw in areas we visited that information relating to patient safety, including pressure ulcers, hospital acquired infections, falls, staff PPE compliance and hand hygiene compliance was displayed on notice boards.

Staff used the safety thermometer data to further improve services. Staff we spoke to on the trauma and orthopaedic wards told us that the cohort of patients were deemed at high risk of falls on the ward and that they had seen an increased level of falls. To improve the safety of patients at an increased risk of falls on this ward they had introduced sensor mats that were placed at the sides of patients' beds which were used to alert staff to a patient at a risk of a fall that had attempted to stand. The ward had also introduced bay tagging which ensured that a member of staff was also present to support a patient to mobilise and help to reduce the risk of a patient falling.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. During our inspection we reviewed policies and clinical pathways and found that these were based on best practice guidance such as from the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE). Staff accessed policies through the trust's intranet, and we saw that these were within their review date and easily accessible.

Nutrition and hydration

Surgery

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. However, the service made limited adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We observed mealtimes on the wards and saw that patients who required additional support with their eating and drinking were assisted appropriately by staff and that staff were aware of patients that required assistance or an altered diet.

We reviewed 11 paper care records for patients and saw that staff fully and accurately completed patients' fluid and nutrition charts where needed and saw that staff used the Malnutrition Universal Screening Tool (MUST) tool, which is a nationally recognised screening tool to identify and monitor patients at risk of malnutrition. Staff told us that specialist support from staff such as dietitians was available for patients who needed it and we saw evidence of dietitians involved in patients' care where appropriate through our review of patient care records.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff were aware of systems that were in place that followed current best practice guidelines to identify patients that were required to fast before surgery.

Patients and staff told us the food and drink available did not provide adequate choice for patients' with cultural or religious needs or a dietary requirement. Patients and their relatives frequently sourced their own alternative food and drink due to the limited options that were available. This is covered further in the meeting people's individual needs subheading in the responsive section of our report.

Pain relief

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

Patients received pain relief soon after requesting it. All patients that we spoke to during our inspection told us they received pain relief when they requested it or were due pain relief, and that staff checked pain relief had been effective.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We reviewed 11 patient care records and found that staff consistently monitored and recorded patient pain symptoms on patients' paper records at regular intervals.

We reviewed 16 patient prescription charts and found staff consistently prescribed, administered and recorded pain relief accurately and inline with the trust's policies.

Patient outcomes

Staff monitored the effectiveness of care and treatment and achieved good outcomes for most patients. However, they had not used the findings to make improvements. Most clinical audit outcomes were comparable to expected national standards, although the service performed worse than expected for some national audit indicators.

Surgery

Hospital episode statistics (HES) data between March 2020 and February 2021 showed that all patients at this hospital had a lower than expected risk of readmission for elective admissions when compared to the England average. Between the same period urology patients at this hospital had a lower than expected risk of readmission for elective admissions when compared to the England average. However, general surgery patients and ophthalmology patients had a higher than expected risk of readmission for elective admissions when compared to the England average.

Hospital episode statistics (HES) data between March 2020 and February 2021 showed that all patients at this hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average. Between the same period general surgery patients had a lower than expected risk of readmission for non-elective admissions when compared to the England average. However, urology patients and trauma and orthopaedic patients had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The SLT for the division of SACCT told us they did not have any specific concerns in relation to patient readmissions rates and the higher than expected risks of readmission was due to complexities in patient cohorts.

The service participated in relevant national clinical audits. The surgical services participated in both national and local clinical audits. The surgical specialties at this hospital were involved in 19 national audits and 51 local audits during the past 12 months.

The national emergency laparotomy audit (NELA) report of 2018 showed this hospital achieved the national standard of above 85% in all five indicators and performed within the expected range for risk adjusted 30-day mortality.

The national oesophago-gastric cancer audit report of 2020 showed the hospital performed within the expected range for all audit indicators.

The national bowel cancer audit report of 2019 showed that the hospital performed within the expected range for the audit indicators relating to risk-adjusted 90-day post-operative mortality rate and risk-adjusted 30-day unplanned readmission rate. However, the hospital was a negative outlier for risk-adjusted two year post-operative mortality rate and the hospital performed worse than the expected national average for risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection. We raised this with the SLT for the division of SACCT and they told us that the service had investigated this and when the complexity of patient condition was accounted for they were assured that the hospital was not a negative outlier.

The national hip fracture audit report 2020 showed that this hospital performed worse than the England and Wales average for four out of six indicators and was a negative outlier for crude perioperative medical assessment within 72 hours and crude overall length of stay. We raised the hospitals worse than the national average performance measure and negative outlier in this audit with the SLT for the division of SACCT, however they were not aware that the hospital was identified as a negative outlier for this audit.

Managers and staff had not investigated outliers or audit outcomes and implemented local changes to improve care and monitored the improvement over time. The SLTs told us that outcomes were reviewed, and improvement actions were discussed at the divisional clinical effectiveness committee meetings which were attended by each surgical speciality. Following our inspection, we requested the minutes from the clinical effectiveness committee meetings and audit improvement plans, however the trust did not provide the audit improvement plans. We reviewed the minutes and found that there was limited focus on national audits and improvements were not discussed. The trust could not demonstrate how they were assured that audit outcomes had been appropriately reviewed and that actions required to improve services and patients' outcomes had been identified and implemented.

Surgery

Competent staff

Managers had not appraised staff's work performance and had not held supervision meetings with them to provide support and development. However, the service made sure staff were competent for their roles.

Managers had not supported staff to develop through yearly, constructive appraisals of their work. Managers we spoke to told us the trust had recently changed the staff appraisal system and this was the reason for low staff appraisal compliance rates. They told us that the trust had introduced a new system but had not provided sufficient training in the system for managers to effectively use it.

Following our inspection the trust provided annual staff appraisal rate data that demonstrated as of November 2021, 67.94% of medical staff, 23.13% of registered nursing staff and 13.3% of allied health professionals within the division of SACCT had an appraisal within the 12 months prior to our inspection, and 76.62% of medical staff, 37.88% of registered nursing staff and 7.69% of allied health professionals within the division of tertiary services SACCT had an appraisal within the 12 months prior to our inspection .

Staff were not all experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke to on inspection within the theatre areas told us that due to the retirement of experienced staff and the recruitment of newly qualified registered nurses and overseas registered nurses that not all staff had the required specialist skills and competence to meet the needs of patients within theatres. We were told this made safely staffing shifts complex, however plans were in place to improve the competency of staff. We were told that staff who had retired worked bank shifts to support the safe staffing of the shifts and that shifts were over established with one extra registered nurse to ensure the safety of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that they had received a full induction before they commenced their role. We saw that some staff working in areas were supernumerary until they were deemed competent.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us the service utilised encrypted social media messaging applications to provide team updates to all staff and share learning. Staff told us team updates were ad hoc but they felt informed about any important changes. Managers told us they held regular weekly meetings which were documented and displayed in staff areas.

Multidisciplinary working

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

Staff we spoke to were positive about working with and supporting other disciplines to provide care and treatment and we saw evidence in patient care records that staff took a multi-disciplinary approach to caring for patients. However we found, in the ward areas we visited, that staff did not hold multidisciplinary meetings to discuss patients and improve their care.

Seven-day services

Key services were not all available seven days a week to support timely patient care.

Surgery

Consultants led daily ward rounds on all wards excluding weekends. Staff we spoke to told us that the medical staffing workforce were pressured due to the increase of medical admissions, short staffing and the COVID-19 virus pandemic. We were told that consultants or a member of the medical team did not have the capacity to review all patients over the weekend and that this resulted in delayed patient discharges.

Staff could call for support from doctors and other disciplines, including mental health services 24 hours a day, seven days a week, however they were unable to access key diagnostic tests out of hours. Staff told us they did not have access to magnetic resonance imaging (MRI) out of hours and this impacted staff's ability to provide timely care and treatment to patients.

The clinical pharmacy team were known by all members of staff who we spoke to. Staff told us the clinical pharmacy team were present on the wards Monday to Friday and a full dispensary led service and minimal ward service was available on Saturdays and Sundays. The pharmacy team had found that medicines reconciliation carried out within 24 hours was 19% for patients admitted over the weekend.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff we spoke to in the pre-operative assessment unit told us they assessed patient's health and needs prior to surgery and could provide further support, information or make referrals to other teams such as the smoking cessation team. The pre-op assessment team also used the audit-c tool to assess the potential alcohol dependency of patients and where appropriate make a referral to the alcohol liaison team who gave advice to patients and supported care staff to provide a plan of care that addressed potential alcohol withdrawal whilst patients were being treated as inpatients.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters displayed throughout the hospital and within ward, theatre and unit areas giving advice on reducing alcohol consumption.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Not all staff followed national guidance to gain patients' consent or knew how to support patients who lacked capacity to make their own decisions and not all staff used agreed personalised measures that limit patients' liberty. However, staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who were experiencing mental ill health.

Not all staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care and not all staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed 17 mental capacity assessment forms across all areas within surgical services and we found that five forms were not completed in line with the Mental Capacity Act. We found in these five forms that staff's assessment of a patient's mental capacity to consent to care and treatment were not decision specific, and staff had completed generic mental capacity assessments based on a patient having a diagnosis of a dementia or a patient's capacity to understand factors irrelevant to consenting to care and treatment. All five forms were completed by nursing staff on ward 35, we reviewed six forms in total on ward 35. We raised our concerns at the time of our inspection with managers. We spoke to staff on ward 35 and they did not all understand how and when to assess whether a patient had the capacity to make decisions about their care. However, we did not find this was the case in other areas of the service.

Surgery

Following our inspection, we asked the trust to provide us with outcomes from patient consent audits and any associated action plans formulated to take identified improvement actions, however the trust informed us that they do not undertake any consent audits within the service. The trust could not demonstrate how they were assured through continual monitoring and evaluation that staff sought to gain patient consent in line with all relevant legal acts and guidance.

Staff could describe and knew how to access the policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke to told us they could access support from the trust wide safeguarding team.

Staff clearly recorded consent in the patients' records. We did find that patient consent to surgical procedures was recorded in all patient records we reviewed where a procedure was planned or had been carried out.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act training and Deprivation of Liberty Safeguards training was included for clinical staff in the adult safeguarding level three training module and for all other staff in Mental Capacity Act awareness was included in the adult safeguarding level two training module. The training module compliance rates for these modules are reported under the safeguarding subheading in the safe section of our report.

Staff also had access to weekly bitesize learning sessions covering Mental Capacity Act and Deprivation of Liberty Safeguards which were held via teleconference.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During our inspection we observed that care and treatment provided by staff was done in a kind and compassionate manner. Patients we spoke with told us that when staff spoke about their care with them, they used language they could understand, and that staff maintained patients' privacy and dignity.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff shared examples of how they adapted care to meet patients' individual needs.

The division of SACCT took part in the NHS Friends and Family Test (FFT). The NHS FFT is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The NHS FFT test demonstrated that the majority of patients were positive about recommending the surgical services to friends and family.

Surgery

We saw evidence on some wards that staff had access to further resources from the trust to support staff understanding of different cultural, social and religious needs of patients and how to meet these.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The hospital had a chaplaincy service and a bereavement service which staff could access to provide support to patients and their relatives. understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us that each area had a dementia champion, a champion was a staff member who had undergone further training in caring for a patient living with dementia and could offer support to other staff if required. Staff told us that this improved their ability to care for patients living with dementia.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care. Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us that staff spoke to them in language that was easy to understand and they were given the opportunity to ask questions. Staff had access to interpreter services for non-English speaking patients. Patients we spoke to told us they felt involved in their care and understood their treatment plan. We reviewed patient care records and saw that patients and relative voice was sought by staff and recorded in care plans.

Patients gave positive feedback about the service. Patients we spoke to were complimentary about the care and treatment they had received.

Is the service responsive?

Inadequate ↓

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

Service delivery to meet the needs of local people

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

Surgery

Managers planned and organised services, so they met the needs of the local population. The SLTs told us that the trust's one-year strategy aligned with the needs of the local population and wider health economy. At the time of our inspection the trust had commenced new surgical pathways in a same day emergency care (SDEC) unit, which provided same day surgical treatment to patients. It had a capacity for eight surgical patients.

The SLT for the division of tertiary services told us they were involved in the cardiac network in Lancashire and South Cumbria and worked with other providers within the integrated care system (ICS).

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff we spoke to told us there had not been any mixed sexed breaches within the services. Staff told us they would escalate to their managers if there was a potential breach.

At the time of our inspection the surgical wards operated low, medium or high risk COVID-19 designations, all surgical wards at this hospital were assigned as medium risk COVID-19 wards. Due to the COVID-19 pandemic and increased medical inpatient admissions some of the surgical wards and units at this hospital were used to care for medical outliers.

However, we found at the time of our inspection that two bays within the day surgery unit were being used by the trust as an escalation area, one male bay and one female bay and each bay had capacity for four patients in total. We observed the environment and facilities and identified that there was only one shower room between the two bays. We questioned how patients who looked after their own personal care needs could do this with dignity with the facilities. Staff told us that they recognised this as a concern and a limitation of the environment and that male patients were provided with bowls to clean themselves in the bathroom and that they could attempt to arrange a patient using a ward shower room, however this was complicated due to COVID-19 restrictions. We spoke to patients being cared for in this area and they expressed that they would prefer to use shower facilities during their stay on the ward, and that staff had not offered them the choice to use shower facilities on another ward. We raised this with senior management at the time of our inspection and were informed that patients would be facilitated to bathe in a way that respected patient choice and dignity.

Meeting people's individual needs

Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However the service was not inclusive and did not take account of patients' individual needs and preferences.

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. We saw in our review of patients care records that patients living with a complex need, dementia or mental health conditions were supported by staff and that social services, psychiatry and the safeguarding team were involved in individuals care when required.

Staff told us the trust's safeguarding team and the lead nurse for dementia care could be accessed for advice and support for how to meet the needs of patients with complex needs.

The wards we visited did not all have day rooms that patients or relatives could use and we also found that wards were not designed to meet the needs of patients living with dementia. However we saw there were areas outside the wards where patients who were living with a dementia could visit and partake in activities.

The service had information leaflets available, and these were available in larger fonts, we were also told staff could access information leaflets in other languages through the patient advice and liaison service (PALS). Staff also had access to interpreter services if required.

Patients were not given a diverse choice of food and drink to meet their cultural and religious preferences or individual needs. Staff and patients we spoke to told us that food options for patients that required adjustments to meet their needs, such as patients' that required halal food were limited to one option at mealtimes. Staff and patients also told us that the accuracy of meals delivered by the kitchen to the wards was a concern and provided examples when food and drink that was not patient choice arrived from the kitchen to the ward and needed to be returned if a patient had a dietary need. Staff told us they had raised this concern and that this was due to COVID-19 social distancing restrictions in the kitchen which affected the variety and choice of food kitchen staff were able to prepare, however the patient menus had not been updated to reflect the restrictions. Staff and patients told us that alternative food and drink would be sought to ensure patients had enough food and drink and that staff allowed patient's relatives to bring in food for patients during the COVID-19 restrictions.

Access and flow

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

Patients could be admitted through a number of routes, including a GP referral, an elective pre-planned day surgery or through the accident and emergency department.

At the time of our inspection the surgical activity at the trust had been affected by the increased medical inpatient admissions the trust was experiencing compounded by the COVID-19 virus pandemic, this had put increased pressure on the hospital and had resulted in a higher surgery cancellation rate.

Staff told us that the single point of discharge (SPOD) team had improved the discharge process of patients and resulted in shorter inpatient admissions. The trust held two discharge meetings each day which identified patients fit for discharge.

We found that the trust did not have an effective system to clinically prioritise and to assess and monitor the risk to surgical patients waiting over the standard referral to treatment (RTT) waiting time of 18 weeks which included some patients waiting 100 weeks. All staff we spoke with were unaware of any clinical harm review process that was in place to assess the potential risk of harm patients were at whilst they were waiting for this long period on the treatment. We found that there was no clear system or process in place at the time of our inspection for staff to follow to appropriately prioritise and review patient harm.

We raised with the divisional SLTs that there was not an effective system in place to clinically prioritise long waiting patients awaiting surgery and a process to review patient harm. We were told by the SLTs that a harm review would be enacted for patients that had waited over 100 weeks. The SLT identified that this was much longer than appropriate, however they told us staffing pressures prevented the service from completing the harm assessments earlier.

Following our inspection the trust provided a sample of three completed harm reviews for patients that had waited over 100 weeks, all harm reviews identified low harm, however we found no evidence the clinician that completed the harm

review had included the patient in the assessment. Following our inspection, we requested from the trust the clinical harm review process, the trust provided us with an unapproved draft version of a clinical harm review process. We asked leaders how they were assured that harm reviews were completed and that the harm was reviewed appropriately. Leaders told us they did not have oversight of harm reviews and that they were not assured.

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2020 to December 2020 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. Since December 2020 the trust performance had shown a steady trend of decline. In the latest month of March 2021, the trust RTT for admitted pathways for surgery was 62.3% which was better than the England average (58.7%).

Referral to treatment - 104 weeks and over performance

In May 2021 the trust had 24 patients waiting 104 weeks and over. The number of patients waiting 104 weeks and over increased to 50 patients in July 2021. The trust's comparative performance was in the bottom 25% of all national trusts' performance from May 2021 to August 2021. However, the number of patients waiting 104 weeks and over reduced to 40 patients in September 2021, the trust's comparative performance in September 2021 was in the middle 50% of all national trusts' performance.

Average length of stay

The average length of stay for patients having non-elective urology surgery at Blackpool Victoria Hospital was 2.7 days. The average for England was 2.3 days.

Blackpool Victoria Hospital - elective patients

From April 2020 to March 2021 the average length of stay for patients having elective all surgery at Blackpool Victoria Hospital was 4.8 days. The average for England was 4.0 days.

Some specialities were better than the national average for the average length of stay for patients having elective care; urology surgery at Blackpool Victoria Hospital was 1.8 days. The average for England was 2.4 days. The average length of stay for patients having elective trauma and orthopaedics surgery at was 2.9 days. The average for England was 3.3 days. The average length of stay for patients having elective cardiac surgery at Blackpool Victoria Hospital was 8.7 days. The average for England was 9.1 days.

Blackpool Victoria Hospital - non-elective patients

From April 2020 to March 2021 the average length of stay for patients having non-elective surgery at Blackpool Victoria Hospital was 5.2 days. The average for England was 4.2 days.

The average length of stay for patients having non-elective general surgery at Blackpool Victoria Hospital was 3.7 days. The average for England was 3.3 days.

The average length of stay for patients having non-elective trauma and orthopaedics surgery at Blackpool Victoria Hospital was 8.8 days. The average for England was 7.2 days.

Surgery

Cancer waiting times - Two week wait performance

From May 2020 to March 2021 the hospital's two week wait performance had been above the England average and 95% national standard. Trust performance declined in April 2021 (85.1%) to below the national standard and was similar to the England average (85.4%).

Cancer waiting times - 31 day wait performance

From June 2020 to May 2021 the hospital's 31 day wait performance met the national standard (95%) and remained above the England average.

Cancer waiting times - 62 day wait performance

From September 2020 to May 2021 the hospital's 62 day wait performance was below the national standard (95%).

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

From quarter three 2018/19 to quarter one 2019/20 the percentage of cancelled operations at the trust showed a performance decline to worse than the England average. However, the trust performance of percentage of cancellations had improved in the latest two quarters, in quarter three 2019/20, the trust cancelled 4%. Although, the number of cancelled surgeries (234 cancellations weren't treated within 28 days) had shown an increase, indicated there was an increased demand for surgeries.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. The service clearly displayed information about how to raise a concern in patient areas. We saw in the ward and theatre areas information leaflets displayed for patients detailing how to raise a complaint with staff and Patient Advice and Liaison Service (PALS) leaflets were also available for patients should they wish to make a formal complaint to the trust. The patients, relatives and carers we spoke to knew how to complain or raise concerns.

Staff we spoke with understood the policy on complaints and knew how to handle an informal or formal complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that information about complaints was shared in team meetings, safety huddles and ward handovers. Managers and staff also told us that they used encrypted social media messaging applications to share any learning.

Surgery

The trust complaints policy stated that complaints would be responded to within 25 working days, however they may take up to 40 working days when investigating complex complaints that may have involved multiple services or external organisations. Following our inspection the trust provided us with data that demonstrated from October 2020 to September 2021 there were 66 complaints about the surgical services at this hospital and the trust reported 53 of these were responded to within the specified timescales.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. Leaders understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However leaders were not all visible and approachable in the service for patients and staff.

The surgical services were managed by the division of SACCT and the division of tertiary services. The two divisions were formed by the trust in April 2021 and both divisions had a separate senior leadership team (SLT). Each SLT was made up of a clinical director, a director of operations and a director of nursing. The SLTs had a clear understanding of the risks to the surgical services and how to address these.

The two SLTs told us they had struggled to recruit medical staff to consultant vacancies within the surgical services.

In response to this, the SLTs had actively recruited overseas medical staff and supported these staff to apply for a Certificate of Eligibility for Specialist Registration **(**CESR) from the General Medical Council (GMC). In order to be eligible to apply for an NHS consultant post, doctors must be on the Specialist Register of the GMC. The CESR allows doctors who have not completed a UK specialist training programme and have a combination of qualifications, training and experience gained elsewhere in the world to be evaluated as part of an application for entry to the GMC's Specialist Register. The SLT told us that these medical staff were given additional support and protected time within their working hours to submit the required applications.

The SLT for the division of tertiary services told us they had put workforce plans in place to provide career development opportunities for staff and to ensure the cardiothoracic service had an appropriately skilled workforce to meet future service expansion and demand and adopting a model of Surgical Care Practitioner (SCP) led care. SCPs work independently, pre-operatively assessing patients, perioperatively in theatre and post-operatively on intensive treatment units, wards and clinic environments, assessing patients and managing post-operative complications. The division had identified a gap of two SCP roles and had recruited to these positions and put plans in place to support their qualification in a course accredited by the Royal College of Surgeons.

During our inspection staff we spoke with were not all positive about the leadership and organisation structure. Leaders told us that they made themselves visible and approachable to staff and patients and would often visit areas within the service. Staff we spoke with that worked on the wards and theatres told us that they felt supported by their local

leaders, including unit managers and matrons. However, staff we spoke to that worked on the wards and in theatres told us that that they did not know who their divisional leaders and executive leaders were, and that they were not visible, supportive or approachable. Surgical consultants we spoke with told us that the two divisional clinical directors were visible, supportive and approachable.

The SLTs felt executive directors were visible, approachable and supportive.

Vision and Strategy

The service had a one year vision for what it wanted to achieve and a strategy to turn it into action, however this was not developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The trust's five-year strategy ended in April 2021 and due to the pandemic the trust had postponed the development of a longer-term strategy until 2021/22 and had put in place a one-year vision and strategy that supported restoration and recovery following the COVID-19 pandemic. The trust launched this one-year strategy in April 2021 and the key themes of this was people restoration, no wait, no waste, zero harm and building fundamentals. Following our inspection, the trust provided us with the vision and strategy for the division of SACCT and division of tertiary services. These aligned with the trust's vision and values and to wider health and social care economy and planned to meet the needs of the population. We also saw evidence that leaders understood and knew how to apply them and monitor progress.

Divisional leaders told us staff had been involved in the development of the trust strategy, however staff we spoke told us they were unaware of their divisional vision and strategy and trust vision and strategy, and that they were not engaged in the development of these. Leaders told us that divisional visions and strategies had not been developed through structured planning processes in collaboration with people who use the service and external stakeholders due to the pandemic.

Culture

Staff did not all feel respected, supported and valued. The service did not promote equality and diversity in daily work. However, staff were focused on the needs of patients receiving care. The service provided opportunities for career development. The trust was working towards an open culture where patients, their families and staff could raise concerns without fear, however, this was not yet embedded.

The satisfaction of staff was mixed. Staff told us there was an open and positive culture on wards and in theatre areas and we found that staff were all dedicated to providing patient centred care and were passionate about the care and treatment they provided. However, staff did not feel engaged, supported or empowered by leaders. Staff were not aware of the trust's vision and values.

During our interview with the division of SACCT, leaders told us that they did not feel they fully understood the culture of the division and this was in part due to the restructuring and staff surveys being completed prior to the trust restructure and not reflecting the newly formed divisions. Leaders told us that improving the culture was a priority and shared that staff surveys and big conversation meetings had been held over the previous 12 months and that action plans were in development.

Staff told us that they felt confident to raise concerns with their managers. However, during our inspection, we found that staff did not always raise concerns or incidents as they did not feel they were always appropriately addressed by leaders. Staff we spoke to were not aware of who the trust's freedom to speak up guardian was or how they could be accessed.

Equality and diversity were not promoted throughout the services. Leaders and staff were unable to describe how services had been considered or developed in a way that met needs of those with a protected equality characteristic. Staff we spoke with gave examples of how they had not been appropriately supported by managers and leaders when they had been treated poorly by people who use services due to a protected equality characteristic they held.

Governance

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

We found that governance structures and performance management processes were not all operated effectively. These were new in place due to the trust restructure of the divisions in April 2021. However, staff we spoke with were clear about their roles, what they were accountable for and to whom. We were told that each divisional SLT had a governance quality manager to support the divisions governance processes. There were monthly divisional board meetings and bimonthly clinical effectiveness committee meetings to discuss governance and risk. We reviewed the meeting minutes of divisional board and committees' minutes and a lack of systemic performance management in addressing and improving services risks, outliers and performance.

We asked the trust to provide evidence of the service continually monitoring and evaluating through audit surgical services compliance with recognising and responding to deterioration in acutely ill patients and their own relevant trust policies and improvement actions identified and implemented. However, the trust provided us with the results of a retrospective note audit of patients that was completed by the critical care outreach team in June 2021 across the services in the critical care and the unscheduled care division. This was now a defunct division and critical care did not provide surgical services. The trust provided minimal relevant audit outcomes in relation to monitoring sepsis metric performance. The trust provided sepsis metric performance across the hospital for a sample of 44 patients in July 2021 and no evidence of actions taken to improve the outcomes and therefore could not demonstrate their assurance that staff in surgical services were consistently recognising and responding appropriately to patients that had deteriorated and that appropriate actions were identified and implemented to improve the quality and safety of the service.

Following our inspection, we asked the trust to provide us with evidence of the service continually monitoring and evaluating staff compliance with the safer surgery WHO checklist across the surgical theatre areas through audit and improvement actions identified and implemented. However the trust provided limited evidence and could not demonstrate their assurance that staff involved in surgical procedures followed all relevant trust policies and the 'five steps to safer surgery' checklist to ensure that surgical procedures were conducted accurately and safely and that appropriate actions were identified and implemented to improve the quality and safety of the service.

We noted in the September 2021 clinical effectiveness committee meeting minutes that the committee had identified that there was a need to review audit processes and assurance frameworks to identify improvements that were

required. There was recognition in the meeting that both national and internal audits were being completed but that the assurance framework needed to be strengthened. Following our inspection, the trust told us that they had recruited an associate medical director for mortality, governance and clinical audit. The trust anticipated this role would support improvement in audit assurance and processes.

We found during our inspection that leaders did not have clear oversight of all issues and risks within the service. Following our inspection, the trust provided us with a trust commissioned external review and report of the effectiveness of the trust's divisional governance systems and processes. As a part of the external review each divisional SLT had completed a reflective self-assessment using a governance maturity matrix to assess performance across a range of indicators of good governance. Maturity matrix self-assessment indicators were each scored from one to four, with four being the highest rated maturity index score of good governance. The divisional SLTs had self-identified improvements were required across a number of governance indicators. The SLT for the division of SACCT had assigned a self-assessed score of three for implementing best practice, care quality commission implementation, patient and carer feedback and improvement implementation and lessons learnt, and a self-assessed score of two for risk management, patient safety and managing incidents, clinical audit and mortality. The SLT for the division of tertiary services had assigned a self-assessed score of four for implementing best practice, risk management, patient safety and managing incidents, and a self-assessed score of three for care quality commission implementation, improvement implementation and lessons learnt, a self-assessed score between three and two for patient and carer feedback and a self-assessed score of two for clinical audit and mortality. Each divisional SLT had developed an improvement action plan, however we found that deadlines and timeframes were not set for the completion of all identified improvement actions, and limited evidence of the continuous monitoring and recording of progress against actions.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At the last inspection we told the trust that it must improve how it monitors, acts, and records the steps it has taken to reduce and mitigate risks. At this inspection we found that risks held on the divisional risk registers had remained on the register for some time, with no resolution and limited evidence of appropriate and timely review taken, we also saw that not all risks had clear actions or controls in place to reduce and mitigate risks and therefore the service could not be assured that these actions and controls had been effective.

We reviewed divisional risk registers and found the risks rated between 20 and 16 and were red rated did not appear to be escalated to the executive directors and did not appear on the corporate risk register or board assurance framework.

During our interview with leaders within the trust and the division of SACCT and division tertiary service, we were told they there were not assured that all the risk registers reflected current risks, we were told that risk registers were outdated and held historical risks that had not been de-escalated.

During our interview with the divisional SLTs we raised that staff we spoke with during our inspection were unaware of shared learning from significant patient safety incidents and never events that had occurred within the surgical services and the wider trust. The SLTs told us that there were multiple systems in place to disseminate learning, however they had acknowledged that learning could had been communicated and shared with staff outside of teams and divisions.

The SLTs for the divisions informed us of waiting list initiatives to improve access to surgical services, for example the service had secured funding to outsource breast surgery to an external provider. The service had ambitions and plans in place to increase surgical activity to 120% of their capacity in comparison to the previous year to address the surgical waiting list backlog. The SLTs had been worked with an external consultancy to undertake transformational work.

Information Management

The service did not collect reliable data and analyse it. Staff could not find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not integrated. Data or notifications were not consistently submitted to external organisations as required. However, the information systems were secure.

IT systems used for information management and governance were outdated and did not always enable staff and leaders to perform their roles effectively. The trust did not have a reliable system for monitoring patients on the surgical waiting list. We were told that the electronic patient tracking list system had errors and resulted in staff having to micromanage waiting lists as the patient assigned waiting list priority code was not always correct.

The service did not consistently report incidents externally in a timely manner. We reviewed incidents that occurred within surgical services between August 2020 and September 2021 and found that there were significant delays in staff reporting incidents.

Staff files and other records, such as training files were held electronically.

Staff completed information governance and data security training as part of their mandatory training. The surgical services had not achieved the trust target of 95% of staff to have completed this training, the compliance rate for this module was 93%.

We saw that all staff had access to computers throughout the wards and theatre areas and staff access was password protected.

The service had access to oversight dashboard that allowed staff to identify patients awaiting discharge.

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

Engagement

Leaders and staff did not consistently engage with patients, staff, equality groups, the public and local organisations to plan and manage services. However, they did collaborate with partner organisations to help improve services for patients.

We found there was inconsistent attention paid to engaging with people who use services, staff, the public or external partners and with those who possess protected equality characteristics. Divisional leaders and staff we spoke with during our inspection could not provide any examples of how the service engaged or collaborated with patients,

equality groups, the public or local organisations to plan and manage the services provided, or how the service sought to share information or gain the views of staff, people who use services or stakeholders. Leaders told us patient engagement groups had ceased meeting due to the COVID-19 virus pandemic because of work pressures and social distancing restrictions preventing face-to-face meetings being held.

Following our inspection the trust told us that the trust held a quarterly patient and carer involvement meeting which were attended by patient representatives and health and social care charities, and trust clinical improvement leads for the division of SACCT. The trust also told us the division of tertiary services had plans in place to commence engaging with people who use services or stakeholders.

Following our inspection the trust told us that the surgical service worked with East Lancashire NHS Foundation Trust for the management of surgical enhanced care pathways, and that the trust was a member of a joint provider collaborative which oversaw the planning and performance of surgical services within the local area.

Learning, continuous improvement and innovation

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

There was an increasing focus on continuous improvement throughout the service, including through internal quality accreditation and participation in research. The trust had introduced a quality assessment system known as the Collaborative Organisational Accreditation System for Teams (COAST). It was the trust's ambition to implement COAST throughout all hospital areas, wards and units, with the aim and objective of continually monitoring and improving services. The COAST used the CQC's Key Lines of Enquiry (KLOEs) as the basis for evaluation. Accreditation was ranked from gold, silver or bronze, and each area had an action plan for improvement that was the responsibility of the manager for the area to implement. We saw evidence during inspection of progression with these action plans. Areas were reaccredited at set intervals based upon the received accreditation rank. Within the division of SACCT, eight out of 18 surgical areas, wards and units had been accredited. Out of the areas that had been accredited, three had achieved gold, four had achieved silver and one had achieved bronze. All of the accredited areas had a date for reassessment booked. The remaining areas had not been assessed. Within the division of tertiary services, five out of 12 surgical areas, wards and units had been accredited, two had achieved gold, two had achieved silver and one had achieved bronze. The remaining one area had not been assessed. The trust told us that assessment visits were unannounced. Staff told us they welcomed the implementation of the accreditation system and that it gave them a sense of pride to continually improve and receive an accreditation quality rating. Leaders told us that it was their intention for all areas to be accredited, however at the time of our inspection COAST was recently implemented within the trust.

Staff in the cardiac surgical services through their research had pioneered a cardiac catheter lab technique called ultralow contrast percutaneous coronary intervention (PCI) that reduced the risk to patients living with severe kidney disease that required an angioplasty to insert a stent. The technique allowed for less contrast dye to be used during the procedure, which could be harmful to patients with severe kidney disease and has improved the prognosis of this patient group. Leaders were proud of this research innovation and had nominated the staff and their innovation for the Health Service Journal (HSJ) 2021 acute sector innovation of the year.

Urgent and emergency services

Inadequate ↓

Is the service safe?

Inadequate ↓

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

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. Managers monitored mandatory training but did not always make sure everyone completed it.

We reviewed the trust mandatory training completion rates. The overall mandatory training compliance rate for medical staff was 63%. This was below the trust target of 95%.

The overall mandatory training compliance rate for nursing and emergency department assistant (EDA) staff in the main department was 90%. This was below the trust target of 95%.

Mandatory training compliance had been discussed at the departmental governance meeting and paediatric department meeting in August 2021 however, we did not see that any robust plans had been made to improve compliance.

In the main emergency department, 93% of staff were in date for basic life support training and paediatric life support training. One hundred percentage of the band 7 nurses and 96% of the band 6 nurses within the main emergency department had completed advance life support training.

Mandatory training compliance rates for medical staff were overall much lower than the trust target of 95%. The medical staff compliance rate for basic life support training was 54% and for paediatric basic life support it was 36%. The trust did not consider intermediate life support training or advanced life support training to be mandatory for medical staff.

All nursing staff working in the paediatric department had completed paediatric immediate life support (PILS) training. All band 6 nurses in the paediatric department had attended European paediatric advanced life support (EPALS) or advanced paediatric life support (APLS) training. We were told that all band 5 nurses were booked onto this training in the month following our inspection.

The department had a dedicated practice development nurse who monitored the mandatory training compliance and alerted staff when they needed to update their training. The practice development nurse booked nursing and EDA staff directly onto courses and this was factored into the department staffing rota. Staff told us they were provided with time to complete the training requirements.

Staff and leaders told us the pandemic had affected their ability to deliver face to face training, and they were working to improve the medical staff mandatory training compliance figures to 90% by November 2021.

Staff we spoke with told us that the mandatory training met their needs.

Staff told us they completed training on recognising and responding to patients with mental health needs. However, they did not receive training on learning disabilities, autism and dementia.

Compliance rates for face to face conflict resolution training were 34% for nursing and EDA staff. Staff told us this course was delivered by the trust security staff and they had only been offered 20 places on this course since May 2021. However, staff had completed an online conflict resolution course and the compliance rate for nursing and EDA staff was 91%.

Safeguarding

Safeguarding training rates were positive however, not all staff had training or understood how to protect patients from abuse.

During our inspection, one patient had been in the department for over 12 hours without a safeguarding referral being completed. Staff we spoke with were unsure of the referral process for this patient due to their age. Staff reported the referral process was long and complicated and support was not always available from the trust safeguarding team.

The consistency in care audit completed by the trust in August 2021 showed that safeguarding issues had not been highlighted or escalated appropriately, or that safeguarding trigger tools had not been completed for more than 60% of patients. Staff were not able to tell us what had been done to improve this.

Staff told us that the department had a meeting to discuss patients who frequently attended. However, senior staff that we spoke with were not aware of any plans put in place to manage patients who regularly attended the service who may be vulnerable.

We reviewed the safeguarding training completion rates for staff in the emergency department. For medical staff the completion rate for safeguarding children and young people level 1 was 100%, no medical staff had completed level two and only 32% had completed level three. No medical staff had completed safeguarding adults' level two training and only 47% had completed safeguarding adults level three.

For nurses and EDAs in the main department, completion of safeguarding of children and young people level three was 91% and for safeguarding adults' level three the completion rate was 95%. For nurses in the paediatric department, completion of safeguarding of children and young people level three was 90% and for EDAs it was 80%.

Some staff who required training had been scheduled time to complete the training and that this was factored into the staffing rota for the department.

Staff completed a safeguarding trigger tool for all children attending the paediatric emergency department. Information collected included: details of the child, if they were known to a social worker and information about who accompanied the child to the department. During our inspection this had been completed for young persons who also attended the main emergency department. All of this information was sent to the trust safeguarding team.

There was a separate waiting area for children's ED with secured doors, this meant that staff could control who had access to the children's area.

Cleanliness, infection control and hygiene

Urgent and emergency services

The service did not control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

During our inspection, there was a COVID-19 positive patient in the department however not all staff were aware. The cubicle door was also open and isolation signage was not in use. Inspectors highlighted this as an infection control issue on site. Staff acted quickly to put the necessary precautions in place. We also saw that throughout the department social distancing was not always possible due to the number of patients within the department and the number of staff working at workstations.

All areas had suitable furnishings but were not always clean. A storage trolley in the department had a dated sticker which showed it had not been cleaned for over a month and the trolley was visibly dusty. Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly. We observed one patient being moved out of a cubicle, and then another patient being moved into that cubicle without the environment or trolley being cleaned.

Environmental cleaning audits had not been regularly completed for three weeks prior to our inspection and had consistent gaps. Staff we spoke with told us environmental audits were not completed as they were not fit for purpose. Senior staff told us they were aware that environmental audits were not consistently completed and were unable to tell us how they were assured the department was clean. Divisional managers told us they knew the processes were not robust and they were working to improve this. We saw that environmental cleaning audits had been updated to suit the needs of the department, but we were not told about any actions being taken to improve staff compliance with cleaning requirements.

An internal accreditation audit called Collaborative Organisational Accreditation System for Teams (COAST) carried out by the service in February 2021 highlighted several issues with the cleanliness of the department. The staff who completed the audit recorded that they were not very confident that the environment in the department supported good care. Staff in some areas reported to feeling proud of the silver rating, whereas this equated to requires improvement status. This demonstrated a potential disconnect between staff's understanding of where their ward was at and gave them a false sense of security in terms of compliance. However, it did ensure that staff felt positive in their ward or departments improvement journey within the accreditation scheme.

Although there were plentiful supplies of personal protective equipment (PPE), we observed that staff did not always follow infection control principles including the use of PPE. We observed one staff member attending to a patient in triage without any PPE.

Although infection prevention and control training was included in the trust mandatory training requirements, only 67% of medical staff had completed it, which was much lower than the trust target of 95%. However, 96% of nurses and EDAs had completed the training.

There were handwashing sinks and hand hygiene stations throughout the department, and we observed staff following guidance on handwashing. The department achieved 100% on the trust hand hygiene audit for April to June 2021.

Chairs, beds and trolleys were made of wipeable material for them to be easily cleaned. Chairs in the waiting area were cordoned off to allow social distancing.

Urgent and emergency services

We observed reception staff asking COVID-19 screening questions when patients self-presented to the department. Patients received a COVID-19 test as part of their triage in line with the trust policy for COVID-19 Management of Elective and Emergency Patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. However, staff were trained to use equipment and they managed clinical waste well.

The department had three entrances, one for walk in patients, one for ambulance drop off and one for ambulance drop off into the isolation area.

Walk-in patients were triaged from a reception desk in the main reception area. There was a seating area adjacent to this for patients to wait. The patients waiting in this area could be observed by the staff working in assessment area B.

The triage area consisted of two ambulance cubicles for the transfer of patients from ambulance stretchers onto hospital trolleys and one walk in cubicle. The resus area had four assessment bays which were used to resuscitate and stabilise acutely unwell patients. The cubicles were equipped with monitoring equipment and defibrillators. One cubicle was suitable for accepting paediatric emergencies. Assessment A was used for patients who were acutely unwell but not requiring resuscitation. There were 13 cubicles in this area including side rooms which could be used to isolate patients.

The isolation area consisted of one triage cubicle and four assessment rooms. This area had a separate access point for both walk in and ambulance conveyances. The cubicles were equipped with continual monitoring and defibrillators.

In the rapid assessment and treatment (RAT) area there were five cubicles to enable the nursing and medical teams to complete rapid assessment and treatment including diagnostics. The cubicles were open plan and were not suitable to care for an infectious patient. Assessment B was located across from the main waiting area and was part of the emergency village development. It had seven assessment cubicles including one which could be used to assess and treat patients with ophthalmic (eye) illness or injury. The paediatric emergency department had two triage cubicles, five treatment cubicles and a waiting area. Paediatric patients were booked into the ED at reception and directed straight to the paediatric waiting room. The department had a separate internal entrance with an intercom to control entry.

Access throughout the department was challenging and not all areas could be accessed by trolleys or wheelchairs. During our inspection, the department was overcrowded due to a high level of demand and a lack of flow through the hospital. The design and use of the department resulted in patients not being appropriately distanced from each other. This meant it was also not always possible to maintain patient's privacy and dignity.

The overcrowding in the department had resulted in access to some areas becoming blocked or restricted. For example, access to the emergency equipment in one area was restricted by trolleys and one of the doors to the mental health triage room was blocked with equipment. This meant that in an emergency, equipment was not easily accessible. Staff told us that if the mental health triage room was needed, access would be cleared, however, there was a risk that this would not happen due to the demand on the department.

The main department had a mental health triage area, however at the time of the inspection, this room was not being used for this purpose and patients with challenging mental health conditions that put them or others at risk were placed in inappropriate areas. These areas were not ligature free and did not meet the Royal College of Psychiatrists Psychiatric Liaison Accreditation Network (PLAN) standards for facilities for conducting high risk assessments within the emergency department. Staff told us that patients were placed in these areas due to the demand on the department.

The risk of not having an appropriate assessment area was on the departmental risk register. We asked for risk assessments of the areas which were being used for patients presenting with mental health conditions, but the trust was not able to provide them.

The service had facilities to meet the needs of patients' families. However, during the inspection this was being used as an additional assessment area for patients due to the numbers of patients in the department This meant that relatives in the department were not able to access family rooms if needed.

The department had signs to find your way around the department. High level fire exit signs were present and fire extinguishers were in date.

Staff carried out daily safety checks of specialist equipment. Each area within the department had adequate access to emergency equipment. Resuscitation trolleys in the department were checked daily and this information was recorded. When trolleys had been opened or used, additional checks took place to restock and restore the trolleys. We checked equipment on the trolleys and found it to be in date and clean.

During the inspection, all equipment we checked was in date for portable appliance testing (PAT).

The service had enough suitable equipment to help them to safely care for patients. Staff received training in the use of medical equipment, and this was reviewed annually. In an audit of Medical Device Training throughout 2020, the department was 100% compliant.

Staff disposed of clinical waste safely. Waste bins were available throughout the department and waste was segregated appropriately. Sharps bins were available throughout the department. They were dated, not overfilled and the temporary closure mechanism was in use.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient swiftly. There was a risk that staff did not always recognise or respond appropriately to signs of deteriorating health or medical emergencies.

During the inspection period 18 patients were managed by ambulance crews in the back of ambulances as there was no room in the department. There were four patients who presented with chest pain and experienced a delay in triage by trust staff. One patient with chest pain was not triaged until more than four hours after they arrived at the department by ambulance. We also saw a patient with possible sepsis who was not triaged until more than one hour and 30 minutes after they arrived at the department by ambulance. This meant, patients were at risk of not receiving treatment in a timely way or in line with national guidance.

Patients were also being cared for by ambulance crews on a corridor in the department. Delays in ambulance handover meant that there was an increased risk to patients in the local community who were waiting for an emergency ambulance. On 14 September 2021, one patient had been waiting on the corridor with an ambulance crew for three hours and 30 minutes.

During our return visit on the 11 and 12 October 2021, we saw that the trust had re-instated corridor care for up to 10 patients when the department was busy and that they had allocated staff to observe patients in this area. At this time, we did not see any patients waiting in ambulances outside of the department.

The department completed a 'consistency in care' audit monthly, this included auditing of the use of a nationally recognised tool to identify deteriorating patients. In August 2021, more than 70% of patients did not have a full set of observations recorded on arrival to the department, more than 60% of national early warning score system (NEWS2) scores had been calculated incorrectly and more than 70% of patients did not have an ECG within 15 minutes of arrival. This audit showed little or no improvement since the July 2021 audit. Staff were not able to tell us what actions were being taken to improve this.

During our inspection, a patient who required 15-minute observations, following sedation was not monitored in line with trust policy or national guidance and staff had not recognised or responded to the patient's deterioration. However, in five sets of records we reviewed we found the NEWS2 was accurately recorded and escalated.

Patient risk assessments were not always acted upon or reviewed in a timely manner. Some patients had been in the department for more than 10 hours and had been identified as very high risk of pressure damage. However, we saw no evidence that action had been taken by staff to reduce this risk.

The inspection team also escalated a second patient who was identified as having difficulty swallowing but had not been cared for appropriately and staff had not taken the necessary action to assess and mitigate this risk. In addition, there were no staff in the department trained to perform swallowing assessments and no access to specialist support from dietitians and speech and language therapists out of hours.

We also identified that Clinical Institute Withdrawal Assessment for Alcohol (CIWA-AR) scores were not always being completed correctly and staff were not always monitoring patients withdrawing from alcohol in line with trust policy. Therefore, staff were not always responding appropriately. When this was discussed with the trust alcohol team, they acknowledged that they were aware of the poor recording and that it was a consistent issue within the emergency department. Staff and leaders were not able to tell us what actions were being taken to improve this.

Staff did not always share key information to keep patients safe when handing over their care to others. Staff in the ambulatory emergency care unit told us about one incident where a patient was not handed over effectively and incorrect information was given. A review of incidents reported showed this was not an isolated incident.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw one patient whose risk assessment had not been reviewed within the appropriate timeframe. We also saw another patient who attended the department with mental health concerns and no risk assessment had been completed. Patients were also not always observed in line with their mental health assessment needs.

Not all staff that we spoke with understood the trust's mental health protocol and risk assessment and their

responsibilities. However, the service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff told us that the mental health liaison team were very responsive. The mental health team were present in the department throughout the inspection.

In the paediatric emergency department, an audit of triage times in 140 random cases had been completed in April 2021. There was 97% compliance with the 15-minute standard from the Royal College of Paediatrics and Child Health that an initial clinical assessment of the child occurs within 15 minutes of arrival in the department. This is an improvement from our findings in our last inspection.

Staff in the paediatric department completed a 'safe and seen' form for all paediatric mental health presentations.

Staff within the paediatric emergency department could explain the red flags for recognising a sick child and how to respond appropriately. We also observed staff responding quickly to an emergency. Shift changes and handovers included most key information to keep people safe. We observed two nursing handovers within the department. Regular safety huddles were also held with key staff members in the department where patients were discussed.

We observed that the handover of patients from ambulance crews to triage staff was of good clinical quality.

Nurse staffing

During our inspection the number of nursing staff on duty did not correlate with the establishment. There were more registered nurses on duty than the planned baseline and the department was below the planned baseline for EDA's. However, given the demand on the service there was still not enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers told us they regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

Staff we spoke with told us the service did not have enough staff to meet the needs of the numbers of patients within the department and they felt the department was not always safe.

We reviewed staffing numbers in the emergency department over a one-month period. We found 78% of shifts were staffed with less emergency department assistants (EDA) than planned. On some days, EDA staffing was less than half of what was planned. However, we found 81% of shifts were staffed with more nurses than planned. Agency staff were used on 96% of shifts. Senior staff in the department were unclear about how many staff should have been on duty.

During the inspection the main department only had four EDAs on shift. Leaders told us there should have been ten EDAs on shift. This has been escalated at the trust clinical command meeting that morning, but staff told us managers did not always take action to resolve staffing issues.

During the inspection the resus area had five patients and was staffed with two qualified nurses. Staff told us this was normal. This was not in line with the Royal College of Emergency Medicine (RCEM)/Royal College of Nursing (RCN) nursing workforce standards. We escalated our concerns to senior staff and were told the department had four resuscitation areas and the fifth area was used as an ambulance receiving room. However, during our inspection all five areas were being used for resuscitation patients. Following the inspection, the trust confirmed this was correct. We also observed a period where the resuscitation area had no nursing staff present and patients were not being adequately monitored.

We reviewed the department staffing rates and found that the department was overstaffed with nurses by 13.3%, and EDAs by 10% when compared to the current establishment figures. Managers told us that the staffing numbers were currently under review due to the new emergency care village development and that this would be assessed in accordance with national guidance. Despite being overstaffed when compared to the establishment, nurse staffing had been on the department risk register since March 2019.

The trust reported that the turnover rate for nursing staff was zero. However, during our interview with the divisional leadership team we were told that a number of staff had recently left the department or developed into alterative roles, for example advanced care practitioners.

The service had high rates of bank and agency nurses. Managers told us that they requested staff familiar with the service. Senior nurses in the department told us that bank and agency staff received an induction to the department. An emergency department pocket guide had also been developed which included important information about the department and clinical prompts and tools.

In May 2021, the overall sickness rate for the trust was 5.3% This was worse than the England average 4.3%. Information provided by the trust showed that nursing and EDA sickness rates for urgent and emergency care had recently risen to 7.42% in September 2021.

We reviewed staffing numbers in the paediatric emergency department over a one-month period. We found that the department was fully staffed with nurses throughout the month. However, the EDA staffing was lower than planned each day, 36% of days having no EDA staff at all. Staff told us this was due to a shortage of EDAs.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. Consultant staffing was below RCEM guidance for the department and the trust was not meeting the requirement for a consultant presence in the department for 16 hours per day. Department leaders were able to tell us about recruitment plans but in the interim, the medical staffing in the department was not in line with RCEM guidance and staff told us they felt the department was unsafe.

In addition, on review of medical staffing we found the speciality trainee (year four) staffing was below planned for 24 out of 28 days. Speciality trainee (year three) staffing was below planned for 13 days out of 28 days. Junior doctor staffing was below planned for 23 out of 28 days. Middle grade medical vacancies had been on the departmental risk register since June 2019, however we did not see that medical staffing shortages were being adequately mitigated to keep people safe.

In addition, the planned numbers of medical staff were lower at the weekend which did not correlate with the attendance numbers and potentially left the department with unsafe staffing numbers. We asked department leaders how they decided how many medical staff are required in the department, but they did not provide information about how this is calculated.

Urgent and emergency services

At the last inspection, one of the actions for the trust was to recruit a paediatric emergency medicine (PEM) consultant. The trust had not successfully recruited a suitable candidate. However, the department had access to the speciality inpatient paediatric team 24 hours a day, seven days a week. Staff that we spoke to told us that the paediatric team were very supportive and responsive.

The department had 12.75 whole time equivalent (wte) medical staff vacancies and had recently been allocated additional funding to recruit more consultants.

The trust reported that the turnover rate for medical staff was zero.

Records

Staff kept detailed records of patients' care and treatment. Records were clear and up-to-date. However, they were not easily accessible for all staff and not always kept securely.

Patient notes were comprehensive however, not all staff could access them easily. The department used electronic computer systems which could not be accessed by agency staff. This meant that agency staff had to use paper records. Staff told us that these were not always scanned onto the patient's electronic record in a timely manner. Having both electronic and paper systems could lead to a risk that patient deterioration is not identified, or treatments missed.

Records were not always stored securely. Computer screens were not always locked when not in use.

When patients transferred to a new team, there were no delays in staff accessing their records.

Within the department, the record keeping training compliance rate for nursing staff was 93%. When we asked the trust for mandatory training compliance data for medical staff, record keeping was not listed as a mandatory course for medical staff.

Medicines

The service used systems and processes to safely prescribe, record and store medicines. However, patients did not always receive critical medications in a timely way and important information was not always shared with other stakeholders on discharge.

Staff followed systems and processes when safely prescribing, recording, and storing medicines. Patients receiving medicines in the department were started on a paper prescription chart, which would transfer with the patient between wards. Having one prescription chart made it clear when a medication had been given to prevent it from being given again.

Medical, pharmacy and nursing staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

The pharmacy service in the emergency department included a pharmacist and a pharmacy technician from Monday to Friday. The team were embedded within the department and nursing staff said the service had made a big difference to

the department. The pharmacy team spent a lot of time walking back and forth to the pharmacy department to dispense medications needed; a business case had been put in for a pharmacy assistant to support the team to allow the pharmacist and pharmacy technician to prioritise high risk patients and to extend the service to seven days in the future.

Medicines were stored securely. Access to the medicine rooms was restricted to staff with a swipe card. The fluid storeroom was clean, tidy and uncluttered, which was an improvement from the last inspection.

The pharmacy team started the medicines reconciliation process by looking at patients' summary care records; this allowed the team to prioritise high-risk patients to assure time critical medicines were given to patients within the department. However, we found some critical medicines including antibiotics had not been administered in a timely manner. The consistency in care audit completed by the department in August 2021 showed that more than 60% of patients who required critical medications had not been prescribed the medication they required. In addition, from April to July 2021 there were 458 medication incidents across accident and emergency and the medical admissions unit. The trust told us that 74 of these incidents took place in the emergency department. We discussed this with department leaders who told us that the themes were missed or delayed medications. They told us they had embedded a pharmacist in the department to provide education and learning from events. We were also told the nurse in charge conducts spot checks of medicines management.

During inspection, staff on the ambulatory care unit told us there was a backlog of more than 500 discharge letters which had not been sent to patients' GP's after patients had left the unit. We followed this up and witnessed a room containing the backlog of notes. This meant that GPs would not know about changes to a patient's medical care or medication and may continue medication that had been stopped. We were told staff had been designated to address the backlog. Managers were unclear how long this would take. When we discussed this with department leaders, they were not able to tell us how they had managed the risk of this.

Safety alerts were discussed in the ED consultants monthly meeting and the departmental governance meeting.

Within the department, the medicines management training compliance rate for nursing staff was 95%. When we asked the trust for mandatory training compliance data for medical staff, medicines management was not listed as a mandatory course for medical staff.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers did not always investigate incidents in a timely way and lessons were not always effectively shared with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. During the inspection, staff were able to identify incidents and that they reported them in line with trust guidance. However, some staff we spoke with told us the incident reporting system was not always easy to access and use. We did not see evidence that staff received training in incident reporting.

There was evidence some changes had been made as a result of feedback, however these changes were not always fully implemented.

Urgent and emergency services

Prior to our inspection a serious incident occurred whereby a patient with a long wait left the department, suffered a cardiac arrest and died. We asked leaders about the management of patients who left the department without being seen. We were told a new process had been implemented. However, they told us they were aware this process was not yet embedded, and this may not have always been followed.

Staff we spoke with were aware of a never event that had recently happened in the department regarding assessments of patient with eye problems. Changes had been made and one of the cubicles in assessment B had been stocked with ophthalmology equipment. However, during the inspection, one patient who had an issue with their eye had not been assessed properly which resulted in a delay in treatment.

Senior staff in the department told us there was a backlog of more than 140 incidents waiting to be reviewed but this was not possible due to clinical workload. They told us managers were not supportive with this. When we raised this with department leaders, they told us all outstanding incidents were reviewed daily and those which were considered serious were prioritised. After our inspection, we looked at the trust incident data and found that the division had 530 outstanding incidents. One incident where echocardiogram (ECG) findings were not followed up and a patient was inappropriately discharged had been open for 89 days however due to the delay in reporting this was 674 days since the incident. The harm from this incident was also not correctly graded.

Staff received feedback from investigation of incidents, both internal and external to the service. Some staff met to discuss the feedback and look at improvements to patient care. Staff received a trust wide email which shared incidents and lessons learned from across the trust. However, not all staff we spoke with were able to tell us about incidents that had happened, or any lessons learned. Staff told us learning from incidents was also shared in department safety huddles and learning was displayed on noticeboards throughout the department. Incidents that took place in ED were shared at the departmental governance meeting. However, attendance at these meetings was limited.

Staff who we spoke with understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong.

Safety performance

The service did not always use monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety data was displayed on noticeboards within the department for patients and staff to see. There had been five patient falls in the department in June 2021. There had been two pressure ulcers acquired in the emergency department in June 2021. However, staff were not able to tell us how this data was used to improve patient safety.

Is the service effective?

Requires Improvement  

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

Evidence-based care and treatment

Urgent and emergency services

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

There were clinical guidelines available on the trust intranet and staff told us these were easily accessible. Pathways and policies were based on guidance and standard set by organisations such as National Institute of Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM). There were guidelines to manage common emergency presentation and all guidelines were up to date and had planned revision dates. However, staff did not always follow the trust policies. During our inspection we saw that the trust policies in relation to the use of control and restraint and delay to transfer into the emergency department were not always followed. We did not see leaders were monitoring this.

New or updated national guidelines were discussed at departmental governance meetings. However, attendance at these meetings was limited.

The paediatric emergency department had toolkits available for staff to follow in the event of emergency situations. These were laminated and within easy reach in the event of an emergency. For example, during the inspection a patient had a seizure within the department and staff utilised the seizure toolkit and responded quickly and appropriately.

Staff protected the rights of patients subject to the Mental Health Act but did not always carry out mental health assessments in a timely way to ensure that the right level of care was put in place.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. However, they did not always identify additional needs or risks and make adjustments to support patients.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We observed staff carrying out comfort rounds and patients being offered food and drink. We also saw that when the department was busy, extra housekeeping staff attended the department to support with comfort rounds. Patients who we spoke with told us they felt they had good access to food and drink.

Staff we spoke with were able to tell us about the options available for patients with special dietary needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, staff did not always fully and accurately complete patients' fluid and nutrition charts where needed.

We reviewed six sets of notes and found three patients had not had a nutritional risk assessment.

The consistency in care audit completed by the trust in August 2021 showed fluid balance charts were not in place for more than 60% of patients who required them. Although this audit was on display in the department, staff were not able to tell us what actions had been taken to improve practice.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after it was identified they needed it or they requested it.

All of the patient records we reviewed had completed pain assessment tools. All of the patients we spoke with told us their pain was well managed. However, the consistency in care audit completed by the department in August 2021 showed that more than 50% of patients did not have a pain score recorded on arrival to the department. Although this audit was on display in the department, staff were not able to tell us what actions had been taken to improve practice.

Patient outcomes

Staff could not always demonstrate that they monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for patients.

The service participated in relevant national clinical audits. However, we did not see any evidence that managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Where national clinical audits had been placed on hold during the pandemic, the trust did not always continue to monitor their performance. Department leaders were unable to tell us how they were monitoring performance, specifically in relation to the RCEM audits results that were reported on following our last inspection and how they were assured that performance had been maintained or improved.

An audit had been completed to review the management of adults with asthma. This audit did show some improvement in practice when measured against the RCEM standards. However, this audit was last completed in 2020 and we did not see evidence that standards in care had been maintained or improved since this audit.

Not all staff who we spoke with were aware of any audit activity which was taking place. Some senior nurses in the department were not able to tell us how patient outcomes and performance was being monitored.

It was not clear if managers and staff had a comprehensive programme of repeated audits to check improvement over time.

We saw that a planned re-audit for July 2021 of the care of patients who fractured their hip had not been completed. We were told departmental audits had been placed on hold in the main department due to the new intake of junior doctors who were responsible for the completion of these audits.

However, staff in the paediatric department were completing audits and results were shared and discussed in the paediatric monthly team meeting, and clear plans for re-audit were identified.

Managers shared and made sure staff understood information from the audits. Audit information was shared at the departmental governance meetings, however attendance at these meetings was limited.

Some audit data was displayed on notice boards within the department for staff and patients to see. Safety thermometer data was displayed on wards for staff and patients to see. This included hand hygiene audits and consistency in care audits. However, it was not always clear how this data had been used to improve services.

Competent staff

Urgent and emergency services

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, however this was not always done in a timely way.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff told us the simulation suite within the trust was used to maintain staff competence and support new staff during induction and training.

The department had a consultant clinical educator who worked in the department three days per week. Staff told us this was to support multidisciplinary simulation training and work based clinical assessments.

Managers gave all new staff a full induction tailored to their role before they started work. The department had a dedicated practice development nurse who had tailored the department induction programme to meet the needs of the staff.

Staff also told us the paediatric department had a tailored induction programme for staff.

Managers supported staff to develop through yearly, constructive appraisals of their work, however not everyone had an appraisal. Data provided by the trust showed that 43% of nurses, 43% of admin staff and 75% of medical staff had an appraisal in the last year. Staff we spoke with told us appraisals were meaningful and they felt supported.

The clinical educators supported the learning and development needs of staff. The department had an induction programme for adaptation nurses who had been recruited from overseas. This included a twelve-week supernumerary rotation covering all the areas of the department. The adaptation nurses were also supported with practice and learning in preparation for the Objective Structured Clinical Examination (OSCE) that they were required to pass before performing clinical tasks independently.

Staff told us they were not always invited to attend team meetings or had access to meeting minutes when they could not attend. However, following the inspection, the trust provided evidence of meeting minutes being shared with staff by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with told us the opportunity for additional training had recently improved. Additional funding had been made available and nurses were receiving financial support to complete courses they had an interest in.

Medical staff in the department were allocated a supervisor to support them with maintaining clinical competency and professional registration. Staff told us junior staff were provided with regular half day study time and they also ran a journal club to share best practice and learning.

We were told senior nurses allocated staff to areas within the department according to the individual staff skill set. However, we did not see how they had oversight of this. Following our inspection, the trust told us that nurses who work in triage are provided with in house training. However, during our inspection, staff were not able to tell us if they had received any additional training for working in triage.

Multidisciplinary working

Urgent and emergency services

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

Staff held regular safety huddles to discuss patients and improve their care.

We observed instances of the multi-disciplinary team working and supporting each other to provide good care for patients within the department.

Inspectors observed physiotherapy staff working well with nursing staff to review patients within the department. Staff we spoke with told us the physiotherapy staff were very supportive and responsive.

Staff worked across health care disciplines and with other agencies when required to care for patients. Speciality teams were regularly in the department reviewing patients who needed to be admitted. Staff told us they worked well with the speciality teams.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. However, we did see that some patients experienced delays in mental health assessments.

Staff we spoke with told us they were not aware if the trust had a dementia lead nurse and, although a new lead learning disabilities nurse had recently been appointed, staff said they had not yet been present in the department.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

A business case had been submitted and approved to extend the opening hours of the minor injuries department within the urgent treatment centre to aid the flow in the emergency department.

X-ray and computerised tomography (CT) scans were available 24 hours a day, seven days a week.

Health Promotion

Staff did not always give patients practical support and advice to lead healthier lives.

Staff did not always assess each patient's health when attending the department and provide support for any individual needs to live a healthier lifestyle. We reviewed five sets of patient records and found no assessment had taken place or advice given.

The service had relevant information promoting healthy lifestyles and support on the unit. A variety of information was available in the paediatric department including a monthly themed health promotion notice board.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Urgent and emergency services

Staff did not always understand and follow process to support patients who lacked capacity to make decisions about their own care. However, staff followed national guidance to gain patients' consent.

During our inspection two patients were held in the department without consideration of the trust's legal right to do so. Therefore, we were not assured all staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The trust completed a monthly divisional audit of mental capacity act and Deprivation of Liberty Safeguards (DoLS). The audit showed that staff awareness of the statutory principles of providing care under the Mental Capacity Act was between 66% and 79%. Staff were not able to tell us if any actions were identified following this audit to change or improve practice, and no recommendations were listed within the audit.

When we asked department leaders about how they monitor how staff obtain and record consent, they told us a consent audit was completed within the trust. However, they were unable to provide a copy of this audit when we asked. Following the inspection, the trust confirmed that they did not audit consent.

When we asked the trust for mandatory training compliance data for medical staff, Mental Capacity Act training was not listed as a mandatory course for medical staff. Ninety five percent of the nurses and EDAs had completed training in the Mental Capacity Act. We did not see that staff received training in Deprivation of Liberty Safeguards (DoLS).

Not all staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. We spoke with two members of nursing staff who were not aware of Gillick Competence and Fraser guidelines.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and this was clearly recorded in the patient records. All the patient records we reviewed had consent recorded for treatment.

Staff made sure patients consented to treatment based on all the information available. Patients we spoke with told us they felt included in decision making about their care.

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs. Patients were not always supported to maintain their privacy and dignity.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

When patients were being cared for on the corridor, staff worked to maintain the privacy and dignity of those patients. If examinations were required, staff would move patients into cubicles to complete this.

Patients we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The privacy and dignity of patients was not always maintained. We saw patients being assessed and receiving treatment in the waiting area in view of other patients who were waiting.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Despite the COVID-19 restrictions, relatives and carers were encouraged to stay with patients if this was in the interest of the patient.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were relatives' rooms and family's rooms in the department for use by service users, families and carers in time of distress. The paediatric department had adapted a triage cubicle into a sensory room for children who may become distressed in the waiting area. Staff told us this room was also used as a private space for breastfeeding mums.

Training on breaking bad news was not included in the mandatory training requirements. Staff in the paediatric emergency department had received training in sudden infant death syndrome. Staff told us they have a good relationship with the local children's hospice.

Staff understood the emotional and social impact a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The department had noticeboards displaying feedback from patients and families.

Urgent and emergency services

Staff supported patients to make informed decisions about their care. Patients and relatives who we spoke with told us staff involved them in decision making.

The feedback from the emergency department survey test was positive. The paediatric department had received 135 responses to their survey between April and June 2021 and they were all positive.

Staff made sure patients and those close to them understood their care and treatment. We observed staff interacting well with patients and relatives. However, we did observe one member of staff who did not recognise and respond appropriately to a relative who was in distress.

Is the service responsive?

Inadequate 

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

Service delivery to meet the needs of local people

The service planned care in a way that met the needs of local people and the communities served. However, the care was not always provided in a way to meet these identified needs.

Managers planned and organised services, so they met the needs of the local population. When we spoke with staff and leaders, they were able to tell us about the needs of the local population and how they adapted services to meet this need.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. However, at the time of the inspection, the department was very busy, and women and men were on trolleys side by side in the corridor and in the rapid assessment and treatment (RAT) area.

Not all facilities and premises were appropriate for the services being delivered and the service was not always making the best use of the facilities available.

Meeting people's individual needs

The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff did not always make reasonable adjustments to help patients access services.

Patients could reach call bells however; staff did not always respond quickly when called. During the inspection, the department was very busy and we observed that call bells were not always answered quickly. One call bell was ringing for more than ten minutes before staff responded. However, patients we spoke with told us they had all been responded to quickly.

Urgent and emergency services

Staff did not always understand how to meet communication needs of patients with a disability or sensory loss. Hearing loops were available in reception but not in other areas of the department. When we discussed this with leaders, they told us that they had not recognised this or considered the impact of this on patients. A patient who we spoke with told us information provided by the trust in braille could not always be understood. During April and September 2021, the division received two complaint about how staff managed and communicated with patients with learning disabilities. It was not clear if staff had access to communication aids to help patients become partners in their care and treatment.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. However, staff often told us family members were regularly used as interpreters which could pose an unnecessary risk to vulnerable patients.

The service had the facility to translate information into languages spoken by the patients and local community. However, not all staff were aware of this facility or how to access it.

Staff supported patients living with dementia and learning disabilities by using 'paint me a picture' documents and patient passports. Staff that we spoke with were familiar with patient passports and understood the importance of them. However, the trust was not auditing compliance. Pathways and documentation for patients living with dementia or learning disabilities was included on the trust COAST audit tool. However, in the June 2021 audit, no learning disability passports had been reviewed and it was not recorded if the trusts 'paint me a picture' document had been implemented for patients living with dementia.

The trust dementia strategy was dated from 2016 to 2019, and staff were not able to tell us about this when we asked.

Access and flow

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

Ineffective processes in relation to access and flow of patients into and through the trust were creating and contributing to significant delays in admitting patients onto wards, from the emergency department, to enable them to receive timely and appropriate care and treatment.

Whilst on inspection we saw the department was under significant pressure. One patient was waiting in the department for over 73 hours. On 15 September 2021 at 9.50am the average triage time for that day was twelve minutes, the average time to see a doctor was 108 minutes and the average time in the department was 7.9 hours. In August 2021, the national median average total time in A&E was 2 hours 58 minutes. There were 60 patients in the department, there had been six ambulance arrivals and 11 ED arrivals in the last hour. There had been three four-hour breaches in the last hour, and there were four 12-hour decision to admit breaches in the department.

Staff told us there were often long waits for triage due to capacity issues within the department. Data from 1 to 30 September 2021 showed average waiting times for triage of 38 minutes which was not meeting the national standard of 15 minutes. Within the emergency department, total time from arrival to seeing a clinician was an average of 114 minutes over the month of September 2021.

Urgent and emergency services

In August 2021, Blackpool Victoria Hospital ED had an average daily ambulance attendance of 92.8. In the same month, 77 ambulance handovers took over one hour and the local ambulance trust lost 337 hours to delayed handovers and 47 hours to delayed admissions at Blackpool Victoria Hospital, with the longest delayed admission being 149 minutes.

When we discussed access and flow with department leaders, they were able to tell us about plans for the future but were not able to tell us how they were managing the immediate issues with flow and how they were assured people were safe.

We did not see that staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs and that patients were always discharged safely.

Staff told us not all patient moves were made for a medical reason or in their best interest. Staff in the ambulatory emergency care unit (AECU) told us inappropriate patient transfers were a regular occurrence and they were overridden by leaders if they challenged a move. Staff told us inappropriate moves were often made to prevent breaches rather than in order of clinical need and that this sometimes impacted on the safety of patients. Staff told us that this patient pathway was changing the week following our inspection, AECU was due to close and patients would be transferred to a same day emergency care (SDEC) unit which would be located outside of the main emergency department. Staff and leaders anticipated that this would reduce the number of inappropriate patient transfers.

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them but did not always share lessons learned with all staff.

The service did not clearly display information about how to raise a concern in patient areas. We did not see information about how to complain or raise a concern. However, patients and relatives we spoke with told us they knew how to raise a complaint or concern.

Staff understood the policy on complaints and knew how to handle them.

From March to September 2021, the emergency department received 20 complaints from patients and relatives. The top themes of complaints in the division were issues with treatment and communication. There was also a complaint which related to the alleged unsafe discharges of a patient. Following our inspection, we also received information of concern about another patient who was not safely discharged from ED back to a care home.

Managers investigated complaints and identified themes and shared feedback with individual staff, but we did not see if learning was used to improve the service. Staff we spoke with told us complaints were fed back to those involved but were not always shared more widely.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with individual staff, but we did not see if learning was used to improve the service. Staff we spoke with told us complaints were fed back to those involved but were not always shared more widely.

Urgent and emergency services

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills and abilities to run the service. Triumvirate leaders were not always visible in the department and did not always have a clear understanding of the risks, issues and challenges in the service. They did not always act in a timely manner to address them.

The emergency department was part of the division of Integrated Medicine and Patient Flow. There was a triumvirate leadership team for the division, which included an interim divisional medical director, divisional director of operations and divisional director of nursing.

We observed the department when it was busy, and had concerns there was a lack of senior leadership. At times the department felt chaotic and we had concerns about the lack of oversight the leadership team had of the risks. We did not see the triumvirate leadership team in the department throughout our inspection.

The lack of oversight and monitoring of the access and flow in the department was particularly concerning. Senior leaders did not always have oversight of the patients waiting in ambulances and the associated risk.

The leaders were able to tell us about the main risks within the department and long-term plans for change. However, we did not see how these risks were being effectively managed and mitigated in the immediate short term.

Some staff told us the leadership team was not visible in the department and when issues were escalated, they did not always see action was taken to manage risks and support staff.

Staff were allocated areas of responsibility for each shift. Challenges occurred when the department was short staffed or became busy and staff had to support other areas in the department.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. However, staff did not always know about the strategy and vision for the division and trust and we did not see that the care being delivered was always in line with the trust strategy.

The trust launched a one-year strategy in April 2021. Divisional leaders told us the five-year strategy had been put on hold due to the pandemic. They told us the key message of the new strategy was ‘no wait, no waste, zero harm’ and the plans for the emergency care village were aligned to this. However, staff were not able to tell us if there was a divisional vision or strategy that aligned with the trust strategy.

Urgent and emergency services

Divisional leaders told us staff had been involved in the development of the trust strategy, however, staff we spoke with were not able to tell us if the division or trust had a vision or strategy and had not been involved in the development. The care being delivered was not always in line with the trust's ambition of zero harm and no waits.

Culture

Staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care. The service did not always consider equality and diversity in daily work. The service had an open culture where patients and their families could raise concerns without fear.

Staff felt proud of their work and the care they provided to patients and relatives. Staff were concerned about how the demand on the department was impacting the care they would like to provide, but we saw they worked as a team and supported each other during busy periods with limited resources.

We saw staff working extremely hard, in challenging situations to help the service manage the pressure. Staff told us debriefs were held following distressing cases to offer support to staff. They also told us the trust wellness team offered support when needed.

Staff were supported in development and were provided with opportunities to access learning to support career development.

Patients and relatives, we spoke with told us they felt able to raise concerns if they needed to.

Staff of all levels felt supported by their colleagues within the department but some staff felt they were not supported by other teams within the trust and the emergency department was the only area which was expected to manage the increase in demand on services.

We were told managers were not always visible in the department to assist when it was busy. Staff also told us they had reported staff 'burnout' and exhaustion following the pandemic. Although the trust had introduced some wellbeing workstreams, staff told us that the support that was offered was not always helpful.

The trust did not have staff network groups and equality and diversity was not always considered.

Staff we spoke with were not able to tell us who the freedom to speak up champions were or who the Freedom to speak up guardian was, but they felt able to speak up if they had issues or concerns within the department or trust.

Governance

Leaders did not operate effective governance processes through the service. Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

The division held departmental governance meetings; however, not all staff had access to the meetings or minutes.

Information and learning were displayed on noticeboards throughout the department; however, staff were not always aware of audits, incidents and any identified learning.

We saw that learning from significant incidents was not embedded and changes were not always fully implemented to mitigate risks to patients. When we discussed this with department leaders, they were aware that some processes were not yet fully embedded but were unable to tell us how they were keeping people safe.

We saw that performance was not always monitored and audit activity was not always completed as planned. The trust audit of the management of patients who had fractured their hip which showed that the trust was not meeting the RCEM standards was due to be repeated in July 2021. This was not repeated as planned and staff were not able to tell us what actions were being taken to improve this.

Following our last inspection in January 2021, the trust told us they planned to audit the new process for patients waiting in ambulances in May and June 2021. These audits were not completed. When we asked the trust for copies of the planned audits, we were told these had not been completed as the process was under review.

Whilst staff were generally aware of their individual roles and responsibilities, there was a risk that the high numbers of agency staff may negatively impact on clear alignment of roles and responsibilities and these staff may not always be aware of the trust policies and processes.

The trust dementia strategy was dated 2016 to 2019 and had not been updated.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and but actions to reduce their impact were not always effective. They had plans to cope with unexpected events.

Staff told us staffing issues had been escalated at 8am on 14 September. Although two housekeepers were asked to help in the department, we saw no other action was taken. When the inspection team escalated the concerns about staffing, theatre staff and nurse specialists were redirected to the department.

We discussed the top risks for the service with the leadership team. They were able to tell us the top risks and that these were captured on the divisional and trust risk registers and discussed during divisional governance meetings. From our observations of the department, it was clear that plans and mitigating actions to address all these risks were not always robust.

The mandatory training figures for medical staff were lower than the trust target for 16 out of the 18 required courses. Although trust leaders told us that they recognised that this was an area of concern, they had not yet put a plan in place to improve the position.

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

Although the consistency in care audit was on display in the department, staff were not able to tell us what actions had been taken to improve practice in areas that were not compliant.

Leaders had not taken appropriate action to monitor or improve performance following poor performance in national audits.

Urgent and emergency services

There was limited assurance as to whether leaders were aware of the safety of the department for patients during busy times. Staff consistently told us they thought the department was not always safe, however we were not assured leaders were sighted on this.

We were told by staff and leaders that the trust was experiencing unprecedented pressures. However, the trust was on Operational Pressures Escalation Level (OPEL) three which given issues with demand, capacity and safety in the department, did not seem appropriate. The trust patient flow policy outlined when the trust OPEL level four should be triggered. One of the criteria was ambulance turnaround times being over one hour. During the week commencing 13 September 2021, the trust had 84 ambulance handovers over one hour, with six being over three hours and the longest turnaround time being four hours and 20 minutes.

Since the last inspection in January 2021, the trust had worked with the local NHS ambulance trust to develop guidance for staff on managing patients waiting in ambulances. However, we found that the guidance was not robust and the risk to patients was not being managed adequately. The trust had not completed planned audits of this new guidance.

The department had a major incident plan and major incident lead. Staff told us how the plan was practised annually to ensure staff were familiar with the process.

Information Management

The service did not always collect reliable data and analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated and were not always secure.

Staff accessed information relating to policies and guidance electronically. The system was easy to navigate. However, there was agency staff working in the department who did not have access to all electronic systems. The department was using both electronic and paper records, which posed a risk to patient safety.

Staff received training in information governance. The compliance rate for nursing and EDA staff was 93% and 74% for medical staff. This was lower than the trust target of 95%.

IT systems used for information management and governance were outdated and did not always enable staff and leaders to perform their roles.

Engagement

Leaders and staff did not always openly engage with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, staff did not always feel listened to.

Some staff told us they didn't always feel listened too and when they escalated concerns, leaders did not always act.

During our inspection, staff and leaders were not able to tell us if the service collaborated with partner organisations other than the local ambulance trust to improve services for patients. However, following our inspection, the trust provided information about how they worked within the local integrated care system and with stakeholders to plan and develop services.

Urgent and emergency services

The department participated in the friends and family test and CQC surveys but had not carried out any local surveys in relation to the quality of the service. In 2020, CQC carried out a survey to find out about the experiences of people who receive care and treatment in emergency departments. Responses were received from 332 people at Blackpool Teaching Hospitals NHS Foundation Trust. When compared to other trusts, this trust scored about the same in all aspects of the survey.

Department leaders told us they engaged with front line staff through meetings, newsletters and closed social media groups.

In the 2020 NHS staff survey, the trust scored slightly better on staff engagement than the average score when compared to other trusts. When staff were asked about their involvement in changes in their work area, the trust was above average when compared to other trusts.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation but did not always effectively share learning.

Staff had worked on a quality improvement project in May 2021 to improve the care and management of patients who had fractured their hip. The planned re-audit had not been completed so it was not clear if any improvement had been made. Following our inspection, the trust provided information about they had begun a programme on 24 September 2021 to work with eight local care homes with the aim to reduce the number of fractured hips by 70%.

Staff were also working on a quality improvement project around triage within the emergency department. When we spoke with staff about this, they were passionate about improvement and were keen to trial and measure the impact from changes despite the department being extremely busy. Staff told us how proud they were of this work. This work was in the early stages so we did not see any results at the time of the inspection.

Shared learning was not always demonstrated to inspectors when we spoke with staff and leaders.

Medical care (including older people's care)

Requires Improvement ↑

Is the service safe?

Requires Improvement →←

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

Mandatory Training

The service provided mandatory training in key skills to staff, however the overall compliance rate for completion of all mandatory training was low.

Overall compliance with mandatory training was 72.4% for nursing staff against a target of 95%. Nursing staff told us they received and mostly were up to date with their mandatory training however trust data showed this not to be the case. Staff informed us that completing training was now easier as this was available online, however despite this we found overall compliance was low.

Staff also told us that the completion of mandatory training in conflict resolution had been low due to the face to face training being stopped due to COVID-19.

Clinical staff told us they also completed training on mental health needs, learning disabilities, autism and dementia.

Ward managers and/or matrons told us that they monitored mandatory training and alerted staff when they needed to update their training. Matrons told us they would try to ensure staff were given time away from clinical duties to complete mandatory training when they were behind in its completion, however we could not corroborate this. There was an electronic tracker used by the matron to review mandatory training compliance.

Staff said they had received training in sepsis management and management of a deteriorating patient and National Early Warning Scores (NEWS2) and were able to describe the process for escalation of a deteriorating patient, dependent upon their NEWS2 score.

We spoke with a practice development nurse who explained that they were responsible for ensuring staff completed and understood their mandatory training. They told us they would also work with staff to provide development opportunities to help prepare band 5 nurses for band 6 posts.

We saw that the trust's risk register had identified that the low compliance rates for the completion of mandatory training was a risk and they told us that actions were being implemented to improve compliance.

The trust told us that due to some of the training provided being routinely delivered face to face this had impacted on staff being able to complete some of the required training during COVID-19 restrictions. The trust also told us that in line with national guidelines and guidance published by NHS England and Improvement, only certain topics were required to be continued to be delivered and achieved as compliance competencies, they had focused on those required areas, which were:

- Health, safety and welfare
- Fire safety
- Infection prevention and control – level 2
- Resuscitation – level 2

We were told by medical staff that they were usually given time to undertake their mandatory training, however, when there were additional service pressures this time was often filled with clinical duties instead. Overall compliance with mandatory training for medical staff was 65.7% against the same target of 95%.

The trust told us that they had had a significant number of new foundation year one (FY1) doctors who had commenced employment with the trust at the beginning of August 2021 and that they were working their way through the mandatory training modules. In addition, there had been several foundation year two (FY2) doctors who had started at the trust in August who were also working through the modules. The trust explained that their foundation programme team were monitoring the FY1 and FY2 completion rates with the expectation that those staff have completed all the required mandatory training (not requiring face to face completion) by the end of October, with full compliance by the end of December 2021. They also told us that the heads of department were to be contacted by the Interim divisional medical director to advise that it is the division's expectation that overall compliance should be at 80% by the end of October and 90% by November 2021.

Safeguarding

Staff told us they understood how to protect patients from abuse and that the service worked well with other agencies to do so. Staff told us they had training on how to recognise and report abuse and that they knew how to apply it. Completion of mandatory safeguarding training, amongst medical staff, was low across the directorate.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us they received training in safeguarding adults and children and knew how to report any concerns. Data provided by the trust highlighted that the completion of mandatory safeguarding training was low overall for medical staff.

For medical staff the overall compliance with training, against a trust target of 95%, was as below:

- Level 2 safeguarding adults training was 66.2% in the IMPF division and 74.3% in the tertiary services division.
- Compliance with safeguarding adults' level 3 was 64.6% in IMPF and 60.4% in tertiary services.
- Level 1 safeguarding children training compliance was 22.2% in IMPF and 71.7% in tertiary services.
- Level 2 safeguarding children training compliance was 73.9% in IMPF and 54% in tertiary services.
- Level 3 safeguarding children training compliance was 21.6% in IMPF. Figures for level 3 training in tertiary services were not provided by the trust.

The trust explained that safeguarding adults' level 3 training had been provided face to face until the end of October 2020 when this had been stopped due to COVID-19 restrictions. The training was then held virtually from November 2020 and had continued to be offered remotely. The trust told us that between November 2020 and October 2021 the

safeguarding team had delivered 48 virtual sessions. Levels 1 and 2 and 3 for safeguarding children and levels 1 and 2 safeguarding adults was available to complete electronically via the electronic staff record system. We were told that all clinical staff were required to complete level 3 safeguarding adult training and level 2 or 3 safeguarding children training, dependent on their clinical role and in line with current guidance.

Staff spoken with knew how to make a safeguarding referral and who to inform if they had concerns and how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We were given an example of a recent safeguarding concern raised by staff, who were worried about a recently admitted patient. This was raised via the ward matron and the safeguarding team in line with the trust's safeguarding process.

At a staff focus group staff reported the introduction of safety huddles had brought safeguarding to the forefront of patient safety. Staff told us the trust safeguarding team was highly visible and accessible, and provided support and feedback where required.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well and displayed clear signage to indicate COVID 19 risk areas. Infection control measures were mostly in place and staff used equipment to protect themselves and others from infection and they kept equipment and most of the premises visibly clean.

The trust's risk register had identified in August 2020, that adherence to IPC processes was a risk and action plans were initiated to make improvements in this area. This risk was due to be reviewed in October 2021.

Signage to indicate areas where there were COVID-19 positive patients was suitable. We saw evidence of signage at the entrance to the wards we visited, to inform staff or visitors of the COVID status of the area.

Staff rooms and office spaces stated the maximum number of people that could be inside at any one time to enable social distancing.

We observed the side rooms where patients were being treated for an infection, or were at risk of infection, had doors which could be closed. All doors were closed during the time of our inspection.

There was clear signage outside of these rooms to indicate the risk of infection and the need to wear appropriate personal protective equipment (PPE). Entrances and exits to the wards had stations which contained hand sanitiser and there were 'donning and doffing' stations outside bays and side rooms, with additional PPE as required for patients with infectious illnesses.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and tidy. Staff kept equipment clean and we saw 'I am clean' stickers used to indicate when it had been cleaned.

We saw that nursing staff used barrier techniques appropriately, to stop the spread of infection, where patients had contagious conditions, however, not all patients were nursed in isolation in line with national guidance. Where patients are diagnosed with infections, such as Methicillin-resistant Staphylococcus aureus (MRSA), clinical guidance states that

patients should be nursed in single bed side rooms. We saw one case where this guidance was not followed and the patient remained in an open bay, as a result of a shortage of isolation space. The trust, however, stated that as the patient had received a full course of decolonisation treatment prior to being moved to the open bay, and had continued to be barrier nursed, had presented minimal risk to others as they were no longer colonised with MRSA.

The trust's infection prevention and control team conducted audits to monitor compliance with infection prevention controls which included observational assessments of staff washing their hands, feedback was provided to the ward managers regarding findings.

The service generally performed well for cleanliness. Ward matrons monitored environmental and equipment cleaning and staff adherence to the use of personal protective equipment and hand hygiene. Data relating to the hand hygiene audits was available on quality notice boards within the wards and indicated a high compliance rate across the wards.

In data provided by the trust we saw that in their commode audit, where the cleanliness of commodes and use of seals were monitored, the division had achieved an overall compliance rate of 90.9% for the month of August 2021, compared with 88.3% in July 2021. The report stated that for areas which achieved less than 95% extra support and training was offered to those wards by the infection prevention and control team.

For hand hygiene (which included covert patient reporting) the results showed an overall score of 92.2% and for PPE compliance, 97.5%. A cleaning audit across all wards showed a range of results from 94.7% on ward 25 to 100% on wards 2, 8, 12.

The trust told us that they carried out an environment audit for each area once a quarter and an audit of 30 clinical observations of hand hygiene (per ward/unit) per quarter.

Audits of aseptic non touching techniques (ANTT) and saving lives data were submitted quarterly. The data from August 2021 was not yet available.

Audits of the use of personal protective equipment (PPE) were submitted weekly, with 10 observations per week being undertaken by each ward/unit.

We observed staff using personal protective equipment (masks, aprons and gloves) and saw they adhered to 'bare arms below the elbow' guidance. We saw PPE was used when providing patient care and when cleaning the ward environment.

Each bay contained facilities for staff to wash their hands and we saw staff washing their hands and using hand gel before and after contact with patients.

We were told that the hospital's IPC team had sight of the daily COVID-19 swab tracker to ensure all patients received swab testing for COVID-19 and hospital acquired infections (HAI) All patients were swabbed in the emergency department, and once admitted a repeat COVID-19 swab was taken every three days.

Data showed that as of 24 September 2021, there were 31 beds occupied by COVID-19 positive patients across the trust. This equated to 5.2% of their total beds.

Environment and equipment

Medical care (including older people's care)

In most areas inspected the design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The medical care service at Blackpool Teaching Hospitals NHS Foundation Trust provides care and treatment for:

- General medicine
- Care of the older person
- Diabetes and endocrinology
- Infectious diseases
- Gastroenterology
- Stroke and tertiary haematology

There are 443 medical inpatient beds located at Blackpool Victoria Hospital across 21 wards or units. The division has an ambulatory emergency care unit (AECU) and a short stay unit with the primary aim that patients admitted to these areas can be typically discharged within 72 hours. The trust had also opened a new same day emergency care (SDEC) unit during our inspection period.

On AMU we saw that a record of fridge temperatures for the 'food pantry fridge' was available, with the maximum permitted temperature of the fridge stated as being 8 degrees. Whilst all entries showed that temperatures remained within safe limits, it was noted that there were some days where recordings had not been documented.

On Ward C, we found that the ward kitchen had been condemned due to IPC concerns several months prior to our inspection. This put patients at potential risk of harm because staff had continued to use this facility as there was no other kitchen for them to use.

On Ward 37 we found that a patient side room was temporarily being used as a storeroom for equipment and that there was no lock on the door to prevent patients entering the room. This was a potential risk to patient safety. We found that no risk assessment had been undertaken regarding this matter. We were later informed by the ward that a risk assessment had been undertaken on the day that we highlighted the issue and that a request had been made for a lock to be fitted to the door as a matter of urgency. We were told the issue would remain on the risk register until resolved.

From the trust's environmental audit, which monitored the quality of the patient care environment and IPC within the environment, we saw noted that the overall divisional compliance for April to June 2021 was 96.1%.

On some wards it was noted that the layout of bays and location of side rooms made it difficult for patients to be viewed from the nurse's station. To reduce the risk to patients we saw staff had been either allocated to 'tag' a bay (this is where a member of staff stays within a particular bay at all times) or smaller nursing stations had been located within a bay. We were told that, should a patient be high risk then one to one care and supervision would be provided.

We viewed logs and verified that daily safety checks of specialist equipment such as resuscitation trolleys and medicines fridges were completed.

We found equipment that was faulty was clearly labelled with 'do not use' stickers.

We saw that staff disposed of clinical waste appropriately and safely.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks in most cases, however assessments were not always completed at the required intervals. Staff identified and mostly acted quickly upon patients at risk of deterioration.

Staff completed risk assessments for each patient on admission or arrival. We were told by staff that these were generally completed by band 6 nurses, whilst on some wards band 5 nurses were being trained to undertake the risk assessments. We saw in one patient record (out of 22) that there had been a gap in completion of weekly risk assessments. This should have been completed weekly, however, there had been one occasion where this had not been completed for two weeks. This meant there was a risk of patient changes not being acted upon.

On two wards we found examples of where patients had been given rapid tranquilisation, also known as emergency sedation, however those patients were not monitored in line with trust policy and NICE guidance (NG10 2015) following administration of the medication. Rapid tranquilisation can cause adverse changes in respiratory and heart rate and therefore the trust policy and national guidance stated that 'side effects must be monitored and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status'. We found that staff were either not aware of, or were not using any trust policies, that related to rapid tranquilisation. There was evidence the trust's Advice and Guidance in Relation to the Use of Control and Restraint within the trust policy was not adhered to in both cases.

We found that the trust's Advice and Guidance in Relation to the Use of Control and Restraint policy was not robust for the administration and management of patients requiring rapid tranquilisation and keeping them safe from harm. We raised these findings directly with the trust following the inspection, by issuing a formal letter.

Staff used a nationally recognised tool called the National early warning score (NEWS2) to identify deteriorating patients. We found in one of the 22 patient records reviewed that, whilst the patient had been escalated when their NEWS2 score deteriorated, a medical review had not been undertaken, in line with the trust policy or national guidance. We also found that no ceiling of care had been put in place for the patient which meant that appropriate treatment and/or investigations may not have been implemented. This matter was escalated to the trust and an appropriate review undertaken.

Matrons monitored the completion of NEWS2 as part of their monthly matron audits. They checked that patients were being appropriately managed and that the required action was documented in relation to the scores.

Trust audit data, dated 25 May 2021, identified some areas where compliance with national guidance, (NICE CG50 – Acutely Ill Patients in Hospital), fell well below the expected standards. An example of the compliance rates for some of those key areas are listed below (trust target rate was 100% compliance):

- Was there a clear written plan specifying observation frequency - 26%
- Patient has passed urine check- 38%
- In the event of a patient having an altered level on consciousness was the blood glucose monitored and recorded- 37.5%

The audit report noted, however, that there had been some improvement in certain areas since the previous audit and referred to the possible further improvement as a result of the deteriorating patient collaborative which had been introduced by the trust.

This was the most up to date data given to us, more recent data was not available.

We reviewed audit results relating to sepsis identification and management on wards 3 and 8. The trust identified that in 30 out of the 33 (90%) patient records reviewed, sepsis was recognised correctly. All patients had been prescribed antibiotics appropriately and oxygen levels had been monitored. An action plan was initiated to help improve the identification of sepsis.

On the acute medical assessment unit (AMU) we observed each bay had NEWS2 boards in place, which we were informed had been in place for around two months. This recorded each patient's current NEWS2 score, how often they should be checked, whether the latest score was better or worse than the last and when the next assessment was due. This allowed staff to see at a glance whether patients were at risk of deteriorating. We saw that all boards had been completed and updated appropriately.

In February 2021, the hospital had introduced a deteriorating patient collaborative, which focussed on improving the care of deteriorating patients and an enhanced care policy had been introduced by the trust in June 2021. Phase I of the collaborative included participants from a variety of backgrounds who worked as a team to help ensure improvements were made. Updates relating to the collaborative, training opportunities and related audits were shared via a monthly trust newsletter. In addition, presentations and videos, sharing information, guidance and learning opportunities, were available via a dedicated 'teams' page.

Staff told us they had access to a critical care outreach team 24 hours a day, seven days a week where they could escalate concerns and seek support for patients who were showing signs of deterioration.

As part of the deteriorating patient collaborative, the AMU had developed, and introduced into practice in July 2021, 'medical escalation' stickers for use in patient records to indicate when a staff member had escalated a deteriorating patient to medical staff. These were then rolled out for use in other wards. This was to help with record keeping and audit trails as it had been identified by the trust that due to the urgency of the actions, nursing staff could forget to record their actions at the time. They then could not prove what actions had been taken and when. The stickers were like those used for cardiac arrest recording. We saw evidence of the use of these stickers on AMU and ward 24, where patients had been escalated for assessment. The subsequent review by a medic was also recorded.

Staff on the AMU explained that if a patient had a NEWS score of above five then a trolley was put at the end of their bed, or outside their room so that the patient could have hourly observations recorded. We saw evidence of this on both bays.

We observed, on the wards' electronic patient tracker systems, that all patient risks were identified by a corresponding symbol flagged on their records, for example dementia, falls risk and venous thromboembolism (VTE).

For the records we reviewed, risk assessments for falls, nutrition and hydration, VTE and pressure care had been undertaken appropriately and recorded within the notes. However, we noted in September 2021 board papers that VTE was on the trust risk register and had been there since August 2020. In July 2021 VTE was audited in the IMPF division and it was found that on ward trackers only 13 out of 91 VTE assessments showed as completed. However, when case notes were reviewed on the same wards it showed that 29 out of 32 records were completed, showing approximately 91% compliance.

The service had access to mental health liaison and specialist mental health support when required. We saw in patient records that mental health assessments were undertaken out of hours when required urgently.

Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe. We observed, at handover and safety huddles, that key information was passed between teams. Information relating to a patient's psychological state was noted where applicable. We observed on ward 23 that a new handover sheet had been developed which used the acronym 'FORCES' to remind staff of the key information that should be relayed at handover. This was: Fluids, Observations, Risk assessment, Care, Escalation and Social.

Staff told us that AMU had a triage nurse who undertook patient baseline observations within 30 mins of arrival on the ward. They would also undertake any required interventions such as taking bloods, catheterisation etc.

A practice development nurse explained that they provided simulation training on AMU every two weeks, where they would simulate a clinical scenario and staff would receive guidance and feedback as required. She said she would use learning from incidents to decide on what additional training was needed for staff.

We were told by staff that patients would have hourly pressure area checks on admission, regardless of whether they were mobile or not, and this would be reassessed and adjusted after 48 hours. We saw evidence, in patient records, of pressure checks being undertaken regularly on all wards. Waterlow assessments (an approved tool for assessing a person's level of risk of developing a pressure ulcer) were noted as having been completed in all records that we reviewed.

Staffing

Nurse staffing

The service did not always have enough substantive registered and unregistered nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, bank and agency staff were utilised to fill gaps whenever possible. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough substantive registered and unregistered nursing staff on shift, the core service of medicine supplied a registered nursing staff dashboard which showed more staff actually employed than established. This was because the trust had recently completed a staff review which indicated an uplift in staffing levels. However, the fill rates for registered nursing staff within medicine varied significantly dependant on the ward. In August 2021, in the IMPF division fill rates varied as low as 68% on AMU but were 127% on ward 12. We were concerned there was a lack of consistency across all wards. We were told, however, that there were a number of registered nurses employed from overseas who were awaiting their UK registration and so remained supernumerary and therefore not counted in the data above.

The fill rates for unregistered nursing staff showed a similar position within medicine division. In August 2021, in the IMPF division fill rates varied as low as 65% (ward 32) but were 124% (ward 23). We did not receive the fill rates within the tertiary services.

Data supplied by the trust showed that across the medical division, in August 2021, 17% of registered and unregistered nursing staff shifts were undertaken by bank or agency staff. This meant there were potential risks to patients resulting from a lack of continuity, however the trust advised that they endeavour to use bank and agency staff who either already work for the trust or work regularly with the trust.

Sickness rates across the divisions ranged from 1% (ward 3) to 13% (ward 23) for registered nursing staff. Sickness rates for unregistered nursing staff ranged between 1% (ward 3) to 20% (ward 24).

Senior management told us they had a matron of the day and twice daily meetings where the staffing levels were checked for safety using the “safe care” system algorithm. One ward manager told us that the "safe care" system algorithm allowed for competencies and skill mix to be reviewed alongside numbers, patient acuity and dependency, which was useful where there were a lot of newly registered and junior nursing staff. The ward managers explained additional staff could be requested daily according to the needs of patients. We listened to four safer staffing calls, where the number of staff available on that day, any gaps in staffing, or risks were discussed. We saw reallocations of staff when risks were identified risk due to lack of staff.

However, from April to September 2021 there had been 61 incidents on the national reporting and learning system related to poor staffing. Staffing for the divisions was on the trust risk register. Some staff said that at times they felt there were not enough staff to keep patients safe as the acuity of the patients on the ward was not always considered. Staff were encouraged to raise any staffing concerns as an incident on the national reporting and learning system (NRLS). We were concerned about the potential risk to patient safety due to low staffing in such incidences. However, we were told that the trust adjusted staffing levels daily according to the needs of patients. We listened in to a safe staffing call and were advised that safe staffing levels in all areas were reviewed twice daily in a trust wide safe staffing meeting. We were told that staff would be reallocated, or agency/bank staff would be sourced, in order to cover any gaps where possible.

Registered and unregistered nursing staff for the division was not always in line with the national guidance. The acute stroke unit provided a thrombolysis service for patients with a diagnosed cerebral bleed and, whilst every action was taken to ensure patient safety, the recommended staffing levels for care of post thrombolysis patients was not met. This was recorded on the department’s risk register and plans were in place to recruit more staff to meet the required level of one nurse to two post thrombolysis patients.

Medical staffing

The service did not have enough substantive medical staff, managers regularly reviewed and adjusted staffing levels and skill mix.

We were told by senior leaders there was a 21% vacancy rate for medical staff across the medical division, the vacancy rate was not broken down by grade. The board reports from September 2021 showed medical staffing was noted as high risk across the divisions. Leaders told us the issue with recruiting doctors seemed to be the lack of preference to work in the Blackpool area, as opposed to larger cities. They told us they continued to try and recruit to these positions.

Whilst the service had some medical vacancies, partial mitigation of the risk was to use locum, bank and agency medics, who were utilised to fill gaps in rotas wherever possible. We saw from board papers that locum doctors had declined posts at short notice. This meant there was limited assurance around safe levels of medical staffing.

Trust data for August 2021 identified that 15% of medical staffing hours were filled via bank, locum, or agency staff.

We spoke with medical staff who said they felt supported in their roles and some felt the on-call system pattern was better at the trust compared with other hospitals.

Board papers indicated “large vacancy numbers” of middle grade doctors in AMU and ambulatory care areas. This meant that consultants had to cover some weekend and out of hours shifts.

Trust data identified that the vacancy rate for doctors in the IMPF division was 31.2 WTE and 10.3 WTE in tertiary services. All these vacancies were being covered by locums.

In September 2021, sickness rates amongst doctors ranged from 0% WTE, amongst the cardiothoracic medical staff, to 2% WTE amongst doctors within the stroke medicine teams.

Records

Staff mostly kept detailed records of patients’ care and treatment. Records were mostly clear, up to date, stored securely and easily available to all staff providing care. However, there was a variation in systems used and reliability of those systems, across the trust, which could cause a reduction in the accuracy, monitoring and reliability of record keeping.

Inadequate or incomplete documentation which comprised patient care was on the divisional risk register; it had been on there since 2015. There were actions in place for matrons to undertake monthly audits of records which were discussed at governance meetings.

Patient records we reviewed were comprehensive and all staff could access them easily, however the lack of electronic systems meant that only one member of staff could update a patient’s record at any one time and made it difficult to holistically review the care of a patient.

We were told by staff on AMU that the emergency department used electronic records and AMU used paper records, this could cause some issues when patients were initially transferred between the two areas. This meant there were potential risks if information about patients was not always readily available. Staff told us the trust was working towards a universal electronic patient record system across all areas, however there was no implementation date for this.

Records were stored securely in most cases, however on one ward we found that a locking drawer in a patient record trolley was broken and unable to be locked. On highlighting this to the ward manager those records were removed and placed in a secure location.

In some of the records reviewed, the name of the person completing the record was not always clearly legible and, on some occasions, did not have the name and designation of the person completing the entry clearly identified.

We noted that not all records contained patient identifiable details on every page of the records, in line with the Nursing and Midwifery Council guidance. This could potentially cause loose pages of records to be misfiled.

On some wards we noted that, to protect confidentiality, a sheet of laminated card had been placed on the top of the notes, where they were held on a clip board outside of side rooms, preventing the notes being visible to people walking past.

Medicines

Medical care (including older people's care)

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found there were some delays in provision of medication and that there were times when medications had not been provided where patients were withdrawing from drugs or alcohol use.

We found that staff followed systems and processes when prescribing, administering, recording, and storing medicines. We noted that the pharmacy provided a ward-based service for the trust from Monday to Friday, between 8.45am and 5pm, and a full dispensary service, covering the same hours, on Saturday and Sunday. We were advised that they were working towards a seven-day ward-based service, however the recruitment of pharmacy staff had made it difficult to progress with this to date as a significant number of new staff would be required.

We saw that some critical medicines including antibiotics had not been administered in a timely manner. This potentially put patients at risk of harm. Nursing staff reported in the patient's medical notes when a medicine had not been given as it was unavailable; it was not clear on the steps taken by nursing staff to try and obtain the medicine from another ward, from the pharmacy or from the on-call pharmacist.

We found patients who were withdrawing from alcohol did not always have their observations checked in accordance to the hospital policy; this may have put patients at risk of harm. We found in two cases that the Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) assessment had not been completed in line with the trust's policy. We found in one case that a CIWA-AR score had not been recorded until four days after admission and there was no reference in the patient's initial emergency department records which indicated that the patient may be withdrawing from alcohol. This meant there were potential risks to the wellbeing of patients.

We saw that the trust's Clinical Opiate Withdrawal Scale (COWS) chart did not guide staff on what to do when a patients COWS score was zero. The trust's policy stated, however, to give medication as required for symptoms.

Blood tests are needed to prevent side effects for the antibiotic Gentamicin; we saw that these blood tests took place as they should have done. However, we found in one case that the Gentamicin dose had not been given in accordance to the patient's weight, with the dose prescribed too low for that patient and doctors could not explain the rationale for giving a lower dose. We also noted that a dose of Gentamicin had not been given on one day meaning that the patient had missed a critical medicine. We saw in another three patient records incidences where an antibiotic or other medicine had been missed.

We saw that in one case an anti-depressant had been given incorrectly, being incorrectly prescribed as twice daily when it as should have been once daily. No harm had resulted from this error.

We saw that in one instance that a medicine used to treat portal hypertension (an increase in the pressure within the portal vein) had not been available to give as out of stock and although staff had recorded the reason for not administering the medicine, it was unclear of what the nurse did to try and obtain it. We saw in another two patient's records that medication had been missed or delayed due to it not being available on the ward.

There was a lack of clarity regarding the legal accountability for when medicines where transcribed for discharge.

Whilst visiting the discharge lounge we spoke with two patients who had not been provided with medication that was required during the time they were waiting. Board papers from September 2021 showed there was a high risk of delays

in supplying medicines to patients due to an out of date pharmacy dispensing robot, however, information provided by the trust identified plans to mitigate the risk should the pharmacy dispensing robot fail and confirmed that funding for a replacement system had been approved in September 2021. Data provided after the inspection showed that discharge medication turnaround times had been consistently below 90 minutes in the 18 months prior to the inspection.

On all wards visited we saw that medicines were stored securely and access to medicine rooms was restricted to staff with a swipe card.

Medical, pharmacy and nursing staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We looked at how the trust monitored medications with a narrow therapeutic window, which can cause harm if the levels are too high; the trust had a system in place and staff were aware of the process.

We saw that controlled drugs were checked daily and were adequately secured. Audits of controlled drugs were carried out regularly.

An audit of the overall adherence to the formulary choice of treatment antimicrobials in June 2021 showed a compliance rate of 97% within the IMPF division and 91% with the tertiary services division. Across the trust the compliance rate had increased since the previous audit.

Medicines reconciliation audits were undertaken monthly using the trust's electronic ward tracker data, which allowed a snapshot of one day's data across 37 areas within the trust. The audit document provided by the trust indicated the ward tracker provided a timestamp showing when a patient was admitted to a ward and that the pharmacy professional 'timestamped' on the tracker when each patient was seen by them and when the medicines reconciliation was completed.

Incidents

The service did not always manage the investigation of patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the team and the wider service, however, these were not always completed in a timely manner. When things went wrong, staff apologised and gave patients honest information and suitable support.

From August 2020 to July 2021 there were a total of 6,046 incidents, reported on the National Reporting and Leaning System (NRLS), which related to medical specialties.

Data supplied by the trust showed that across the IMPF and tertiary services divisions there was a total of 613 incident reports awaiting investigation. Of those the longest wait for investigation was one incident recorded in January 2021. This meant there was delayed learning from incidents which could impact on the safety of other patients.

Incidents relating to medication errors accounted for 96 of those reports, 158 related to skin damage/pressure ulcers, 34 related to issues around the care or treatment provided. Two reports related to a failure to escalate a deterioration in a patients NEWS2 score and 11 related to issues around IPC, mainly relating to COVID-19.

From August 2020 to July 2021 the trust reported 11 serious incidents (SIs) which met the reporting criteria set by NHS England. Of those pressure ulcers accounted for 36% of the incidents, sub-optimal care of a deteriorating patient 27%, delay in treatment 27% and slips/trips or falls 9% of the incidents reported. We were informed of specific collaboratives set up in order to reduce the number of incidents relating to managing deteriorating patients and reducing falls.

Managers told us they were confident their staff knew how to and regularly did report any incidents on the wards.

Staff spoken with on inspection understood what incidents to report and how to report them. We discussed examples of recent incident reports and how these would be investigated.

Staff raised concerns and reported incidents and near misses in line with trust policy. Trust level NRLS data indicated there was a good reporting culture.

Some staff spoken with said they received feedback from investigation of incidents. We were told learning would be shared at ward meetings and one to one where required and via the trust level bulletin. Staff met at monthly ward meetings and would discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Learning from a recent incident had led some wards to approach a local service to help provide staff with additional training in looking after end of life patients and their family/carers.

Safety Performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. Matrons told us the trust was focussing on reducing the number of hospital acquired pressure ulcers, improving the care of deteriorating patients and reducing the number of falls on wards. We saw information on ward notice boards relating to the number of days they had gone without any reports of such incidents.

We were told about a staff 'teams' page which was used to share learning and of a training register which identified gaps in knowledge after incident investigations.

The risk of pressure ulcers remained on the divisional risk register. The register identified there was limited assurance and the division had a higher than national prevalence. This was due to be reviewed at the beginning of October 2021 and had been on the risk register since August 2020.

From learning around the high prevalence of pressure ulcers the trust introduced an eliminating pressure ulcer collaborative. Data provided by the trust showed that whilst there appeared to be a correlation between an increase in pressure ulcers during the second COVID-19 peak, the work of the collaborative had resulted in a 65% reduction in grade two pressure ulcers, following the initiation of phase two of the collaborative (across all the trust's medical services). They also noted an improvement in the days without reports of grade three or four pressure ulcers from an average of 15 days to an average of 75 days. The data identified that the improvement had been sustained with the final data showing, in September 2021, that it had been 146 days since the last incident.

From data provided by the trust we found that there had been 95 falls with minimal harm, 63 falls with no harm, five near misses, one fall resulting in moderate harm to a patient between 19 June 2021 and 19 September 2021. All falls had been investigated and where appropriate, learning was shared and an action plan implemented to reduce the risk of recurrence.

Medical care (including older people's care)

We were told by ward managers that, where patients were at high risk of falls, sensors could be used to alert staff that the patient was attempting to stand. Alternatively, bay tagging or 1:1 care would be utilised.

One matron informed us that staff had been undertaking a lot of work to reduce the number of pressure ulcers and falls on the wards. They explained that falls assessments were undertaken within six hours of admission onto the ward and that body mapping for pressure care was part of the intentional rounding checks. We saw evidence of this in the patient records reviewed.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

The IMPF triumvirate said they had been undertaking work to ensure that national guidance such as the National Institute for Health and Care Excellence (NICE) guidelines were consistently being followed across the divisions.

We were shown a collection of files, prepared by a ward manager, containing national and local guidance relating to key roles and activities on the ward. The files were used to assist staff in remembering guidance and provided up to date information and relevant associated paperwork, for example Malnutrition Universal Screening Tool (MUST) assessments, and Mental Capacity Assessments.

We were told that the endoscopy unit was Joint Advisory Group for gastro-intestinal endoscopy (JAG) accredited. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

In line with national guidance, we saw that consultants on AMU worked block days to ensure continuity of care for patients admitted to the unit.

We were told by staff on the stroke unit that, as per national guidelines, all stroke admissions had their swallowing ability screened as soon as possible following admission. The unit had arranged for more nurses to be trained, by the speech and language team, to undertake swallowing assessments.

At handover meetings we noted that staff referred to the psychological and emotional needs of patients as well as their physical and clinical needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. We saw a small number of gaps in assessment records.

We witnessed staff providing patients with food and drinks and giving assistance to patients to eat and drink where this was required.

We reviewed patient records and found that staff had fully and accurately completed patients' nutrition charts where needed.

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. We saw that the Malnutrition Universal Screening Tool (MUST) was used to identify adults who were malnourished or at risk of malnutrition. Patients had their nutritional needs assessed and these were recorded in care plans.

Of the patient records reviewed we saw that, where applicable, most MUST risk assessments, food and rounding charts had been completed appropriately, however, there were occasional gaps in recording of observations identified in two patient records.

We saw that patients were referred for a speech and language therapy (SALT) assessment where difficulties in swallowing had been identified, however, we identified in one of the records reviewed that a delay in SALT assessment had meant that a patient had not received any nutritional intake for several days, as they had remained 'nil by mouth' with no alternative nutrition provided, whilst awaiting an assessment.

According to the trust's 2019/20 annual report they had developed a sustainable electronic learning package to raise awareness regarding patient risks of Acute Kidney Injury (AKI) and the importance of effective fluid balance monitoring. The trust noted that as a result of this there was an increased awareness of the risks and that this had helped to improve fluid balance monitoring of patients on the AKI pathway.

We witnessed staff using specialist equipment for patients who required assistance with eating and drinking.

Patients we spoke with told us they enjoyed the food they had been given in hospital.

Pain relief

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

Patients we spoke with told us they had received pain relief soon after requesting it.

We reviewed patient records and noted that pain scores had been recorded regularly and painkillers had been provided where required.

It was noted on ward notice boards they used the ABBEY Pain Scale tool, which is used to assess pain levels in patients unable to communicate their level of pain.

While the team were on AMU it was noted there had been a delay in provision of morphine for a patient who had pain. We were told the delay was due to there being no morphine on the unit.

Patient outcomes

Medical care (including older people's care)

Staff monitored the effectiveness of care and treatment to achieve good outcomes for patients.

Senior leaders said that the medicines core services continued to submit data to relevant national clinical audits, such as The Sentinel Stroke National Audit Programme (SSNAP), hip fracture, and encephalitis. A paper to the trust's quality and clinical effectiveness committee in April 2021 indicated that the service had participated in several national audits in 2020/21, including the Falls and Fragility Fractures Audit, National Audit of Care at End of Life, Getting It Right First Time (GIRFT) Thrombosis Audit as well as the National Audits of Inpatient Falls, Lung Cancer and Diabetes.

The senior leaders told us that learning from audits was used to improve patient care and outcomes. We were told that action plans resulting from the audit data were discussed and improvements monitored by the divisional clinical effectiveness team. We were told there was currently an advert out to recruit a clinical effectiveness lead for the medicines' division.

The SSNAP data showed that, overall Blackpool Victoria Hospital achieved grade C between April to June 2021 which was similar to audit performance since July 2019. SSNAP scores range from A (best) to E (worst). There had been deterioration in stroke unit, speech and language therapy, physiotherapy and discharge processes. Stroke unit and speech and language therapy were in the worst banding of E within the same time period. There were improvements in specialist assessments, which were in the highest banding. Improvements had also been seen in multi-disciplinary team (MDT) working and standards by discharge. Data subsequently provided by the trust, however, showed a continued improvement in overall score. The score between July and September 2021 was now at B overall.

We spoke with the SSNAP audit lead on the stroke unit who said that the SSNAP audit for April 2020 to March 2021 showed a standardised mortality ratio (SMR) of 1, meaning that the trust was within the average range. However, we saw on the risk register that a different measure (the summary hospital level mortality indicator (SHMI)) indicated the stroke mortality rate was above the national average, however this data includes patients who passed away within 30 days of discharge. This had been on the risk register since 2019 as it remains a risk for mortality. For April to June 2021 the SMR remained static. The audit lead outlined that areas scoring more poorly in the audit were due to issues around the effect of the COVID-19 pandemic and indicated they had seen an improvement in performance until the pandemic hit.

Board papers from September 2021 showed further investment and development was required in order to comply with some of the national stroke quality indicators.

We were told that the trust's stroke unit had recently been given Hyper Acute Stroke Unit accreditation and plans were underway to improve access to and outcomes from the service.

National data indicated that the trust was worse than the national aggregate for four out of five measures for chronic obstructive pulmonary disease (COPD) 2019 audit. Data provided by the trust showed an improving picture in this area with a SHMI score of 95 against a target of 100.

The trust was in the middle 50% for three out of four measures for the national audit of dementia and performance was in line with the 2018 audit. There had been improvement in the percentage of mental state assessments carried out during admission. They were in the bottom 25% of hospitals for MDT discharge discussion. The trust had not undertaken further audits in the care and treatment of patients with dementia as local and national audits had been suspended due to the COVID-19 pandemic.

Medical care (including older people's care)

The trust's clinical audit report identified there had been 278 local audits registered in 2020/21 and 50 audit proposals had been received during Quarter four (January to March) 2020/21. Some of these related to this service. For example, changes and additional training in the prescribing of some medications, the compulsory completion of the allergy status box on patient records and the use of printed stickers on prescription sheets.

National data available to the CQC showed, from March 2020 to February 2021, patients at the hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average. However, it also showed that gastroenterology patients had a higher than expected risk of readmission for elective admissions and cardiology patients had a higher than expected risk of readmission for non-elective admissions.

We saw that sepsis management was locally audited to ensure that it was in line with national guidance and that from an audit of two medical wards, over a three-week period, sepsis management had been correctly identified in 30 out of 33 patients. Following the audit, it was agreed that the sepsis pathway should be attached in patient's notes for staff guidance and staff were to be reminded of the importance of recognising sepsis and escalating in a timely manner.

It was noted that historically the trust had been an outlier for mortality in the Summary Hospital-level Mortality Indicator (SHMI), however, in recent months national data showed that the trust was now sitting within the 'as expected range'. Senior management explained they undertook a review of all mortalities that occurred within the division so that lessons learned could be shared with staff. We saw, from evidence supplied, that an associate medical director post for mortality governance (learning from deaths) and clinical audit was appointed in October 2021. They had also introduced a learning from deaths app and it was hoped that this would help assimilate all learning points in a standardised format.

Competent staff

The service mostly made sure staff were competent for their roles. Managers did not regularly appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff we spoke with on inspection were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Many had been supported by the trust to progress their careers and obtain promoted posts within the hospital.

We were told that managers supported staff to develop through yearly, constructive appraisals of their work, however, the data provided by the trust highlighted poor compliance in the completion of appraisals over the last 12 months. One ward had an appraisal compliance rate as low as 3.1%.

Managers told us they were keen to provide development opportunities for their staff. We were given examples of external training courses that staff had been supported to undertake. Matrons and ward managers told us all staff were encouraged to attend team meetings and minutes from the meetings were shared following the meetings so those who could not attend could review them.

We witnessed matrons identifying poor staff performance in relation to recording of observations, following a review of patient records, and staff were encouraged to make improvements in their recording.

Medical care (including older people's care)

We were told there was support in place for all junior doctors, with education supervisors, links with the medical education team and a structured induction programme in place. Doctors working towards their Certificate of Eligibility for Specialist Registration (CESR), told us they were given additional support and a job plan to give them time for revalidation.

Multidisciplinary working

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

Staff held multidisciplinary meetings to discuss patients and improve their care, with representatives from allied health professionals (AHP), and discharge teams.

We saw that staff had referred patients for mental health assessments when they showed signs of mental ill health.

Patients had their care pathway reviewed by relevant consultants and teams.

AHPs told us that in clinics staff were good at discussing patients with the whole team. They said they had close links to GP practices.

We were informed that the trust had initiated a large project in February 2021, linking occupational therapy and physiotherapy on care of elderly wards. Four new posts had been created. The AHPs told us they had started to provide exercise sessions each week on the care of the elderly wards.

We were told the wards worked closely with other organisations to assist in patient discharges, for example, NHS continuing healthcare teams would work with the staff to undertake a decision support tool in the ward (or via teams) to assess whether patients would be funded for NHS packages of care when discharged.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, including mental health services, 24 hours a day, seven days a week. We were told that there was a medical on call team, including senior medical staff, which was available out of hours and weekends.

We were told that AHP cover was available out of hours and at weekends via the bleep system.

On the stroke unit telemedicine was in place so that patients could be reviewed out of hours, additionally consultants could access patient scans remotely out of hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards and units. We viewed posters around the wards giving advice on alcohol consumption.

There was access to dietitian advice and we were told there were plans for patients who had been newly diagnosed as diabetic, to receive same day advice on how to manage their condition to reduce the need for them to be admitted whilst awaiting education and advice.

Patients admitted were assessed regarding lifestyle and we noted those patients thought to be suffering from alcohol addiction were referred to an alcohol withdrawal team where required.

We saw on the trust's website there were various patient advice leaflets relating to promotion of healthier lifestyles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment, however, these were not always decision specific. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health, however the documented reason for assessments were not always decision specific.

We found on examining patient records that staff did not always carry out an appropriate assessment of a patient's capacity to consent to specific decisions about their care and treatment. The staff mainly completed generic mental capacity assessments. This was not in line with the trust policy, national guidance or the Mental Capacity Act (MCA) and may have put patients at risk of harm. Out of the five mental capacity assessment documents we reviewed four were found to be non-decision specific.

The trust policy stated that the decision as to whether someone had or lacked capacity must be taken by the decisionmaker or person taking the action, and not the professional who is merely there to advise. However, in the case of DNACPR decisions completed by doctors, mental capacity assessments were not always recorded as having been undertaken by the person assessing capacity specifically relating to that decision.

Staff understood how to assess whether a patient had the capacity to make decisions about their care, however, they did not appear to know that the assessments should be specific to the decision being undertaken.

We saw four do not attempt cardiopulmonary resuscitation (DNACPR) forms, one was completed with patient choice, one recorded family involvement in the decision, one had no evidence of family involvement (where the patient lacked capacity) and one was a pre-existing community DNACPR. Two had non-decision specific mental capacity assessment, i.e. were not relating to the decision regarding resuscitation.

Where a patient had a DNACPR in place this was clearly visible in the patient's records and on the electronic tracker system. We also heard this information being passed on to staff during handovers.

Staff told us they had received training in deprivation of liberty, mental health, learning disabilities, dementia and mental capacity assessments.

Medical care (including older people's care)

Is the service caring?

Good 

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. During the inspection, on all wards, we witnessed staff interacting positively with patients.

Patients said staff treated them well and were extremely caring.

We saw, that when a patient was being examined or a clinical procedure was being undertaken, the curtains were drawn around the patient.

We saw staff interact with patients who were living with dementia in a calm and caring manner.

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

During the staff handover and throughout the day we witnessed staff communicate cheerfully and directly with patients.

The service had suitable facilities to meet the needs of patients' families. We were told by one matron that the ward had been provided with a sofa bed, which was placed within one of the side rooms, to allow family members or carers to stay with end of life patients.

We used 'talking mats' technology to enable us to gain the views of patients who were unable to communicate effectively verbally; all 11 patients we spoke with told us that they felt safe in the hospital. Nine of the 11 patients were happy with their treatment, one was unsure, and one patient was unhappy with their treatment.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We witnessed a student nurse providing support to a family member in order that they could carry out personal care activities for their relative.

Medical care (including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We witnessed staff dealing with a patient who was agitated while having a clinical intervention. They took time to explain what was happening and gave the patient reassurance throughout.

We were told of situations where support was provided to patients where they had experienced the loss of someone close whilst in hospital.

The wards had access to a 'Swan' team where required. The Swan model (sign, words, actions, needs) of end of life and bereavement care was introduced at the trust in 2019 and was used to support and guide the care of patients and their loved ones where they were being cared for at the end of life and after the patient has passed away.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw in patient records that staff had spoken with patients and/or their families/carers to provide information relating to their care.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw patient feedback boxes on wards, with comment cards available for patients, families or visitors to provide feedback.

Patients and carers spoken to on inspection gave positive feedback about the service and told us they had been given information relating to their care plans. They told us they knew who to approach should they have any questions and were happy to do so if required.

Throughout COVID-19 staff tried to keep families and carers updated by telephone on a daily basis as visiting was restricted. We saw evidence of the contact recorded in patient records. We were told that iPads and phones had been made available for patients to keep in contact with family and friends.

We were informed that the ward reception staff on AMU attended huddles and handovers to ensure they had relevant information to provide updates to families or carers making contact, rather than keeping them waiting while an update was gained from the nursing staff.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

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

The service did not always plan or provide care in a way that met the needs of local people and the communities served. It did not always work with others in the wider system and local organisations to plan care.

The tertiary service division senior leaders told us they had had conversations with the haematology network and were working closely with the Lancashire and South Cumbria Integrated Care System (ICS) looking at what the network should be and how they were provided in various other regional patches.

The tertiary service senior leadership team told us they were progressing plans for escalation and recovery, looking at ensuring they had the correct place, space and treatment to deal with the local population and ensuring they were providing services required by the ICS.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation.

Meeting people's individual needs

The service was mostly inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw patients with complex needs being provided enhanced levels of care to keep them safe.

Not all wards were designed to meet the needs of patients living with dementia. We were told by staff on AMU that they had plans to make the unit more dementia friendly, but it was not clear when this would happen.

Staff supported patients living with dementia and learning disabilities by using 'paint me a picture' documents and patient passports.

The trust's dementia lead told us that tier two training was available to all staff, however this had mainly been completed by staff who worked closely with people living with dementia. The lead person told us tier 1 training was to be made available, via an external party, for the trust's dementia friends group. They told us the aspiration was that everyone would complete the tier one training.

On the endoscopy unit we were told that special allowances had been put in place to allow patients living with learning disabilities or dementia to be accompanied by someone they knew, to ensure they were well supported throughout the procedure. The person accompanying the patient would be COVID-19 tested and fit tested for a mask, as the endoscopy unit was an aerosol generating environment.

The service had information leaflets available in languages spoken by the patients and local community. We saw that leaflets provided advice on accessing information in alternative formats and languages. We saw leaflets printed in larger fonts available on the wards.

Managers told us they ensured staff, patients, loved ones and carers could get help from interpreters or sign language interpreters when needed. (There was restricted visiting due to COVID-19, so there were small numbers of visitors in the hospital). The trust had a list of staff who could interpret for different language needs. In addition, staff had access to 'big word' or 'language line' systems for written, telephone or face to face translations.

Staff had access to communication aids to help patients become partners in their care and treatment. We were told that communication aids such as picture cards were available for patients unable to communicate verbally.

Access and flow

People could not always access the service when they needed it. There were issues with flow and the effects of COVID-19 on services, waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Following the inspection, we issued a section 29a warning notice, on 25 October 2021, in relation to how the trust was not effectively or appropriately assessing and managing the risks to patients who were waiting to receive care and treatment. The trust did not have effective systems to identify and reprioritise patients based on changes to their presenting risks.

The warning notice contained information that senior leaders told us there was assurance that all patients were reassessed and reprioritised whilst on the waiting lists between 18 and 100 weeks. We requested the patient tracking list (PTL) meeting minutes but these were not sent to us. However, we reviewed the PTL ongoing action plans. These did not evidence any reprioritisation of patients. We found that the ongoing action tracking document contained limited detail and lack of assurance.

The Patient Tracking List ongoing action tracking document identified there was an ongoing concern for P1 coding issues from the 06 September 2021, with no actions or reports produced. On 12 October 2021 there were actions stating the team were working on an electronic solution to review the P1 patients prior to this date. However, the focus was on the coding and the electronic issues rather than the harm to the patients. Furthermore, staff had raised concerns with us that patients were coming to harm whilst waiting significant lengths of time on the waiting list. They informed us that patients were not contacted or reassessed between 18 weeks and 100 weeks on the waiting list.

Trust data identified that there were, at the time of inspection, 647 patients who had been waiting between 39 and 79 weeks for treatment within the gastroenterology service. There was a total of 771 patients awaiting cardiology treatment. Of those 324 had been waiting over 18 weeks (this is the national target for non-urgent treatment); 52 people had waited over 52 weeks; seven people had waited over 80 weeks and one patient who had waited over 90 weeks. There was no evidence to give assurance that all these patients had been clinically reviewed and /or prioritised whilst awaiting treatment.

Trust papers showed targets relating to timeliness of treatment were not always met. The September 2021 board papers indicated trust wide overall referral to treatment (RTT) times were 73% against the 92% target. The six- week wait standard for diagnosis on the cancer pathway was 75% against the 99% target.

The service had not achieved the 62-day cancer waits since June 2021. We noted from board papers that 22 patients had waited over 104 days. This meant patients could be exposed to harm or poor outcomes as a result of having to wait longer.

In June 2021 the trust achieved the two-week cancer target at 97% except for upper gastrointestinal tumours. Treatment for breast cancers was achieved for June 2021 at 97%, this was an improvement from 50% in May 2021.

The main reasons for delays in care and treatment were backlogs in endoscopy, gastroenterology and colonoscopy services.

Information sent to us after the inspection showed other medical specialities had poor RTTs. For example, cardiology had a RTT of 73% and in rheumatology only 52% of patients started treatment within 18 weeks of referral. It was noted, however, that elderly medicine achieved 100% and thoracic medicine service achieved 92%.

Patients accessed medical services from various routes such as the accident and emergency department, referral from their GP and sometimes following outpatient appointments. All patients admitted through the accident and emergency department, who required inpatient care, were admitted through the acute medical unit (AMU) and the ambulatory care unit. Patients were not routinely admitted directly onto inpatient medical wards.

The AMU was open 24 hours, seven days a week and had access to medical cover. The purpose of the unit was to allow patients to be 'streamed' in a timely way from the emergency department and to help reduced admissions to the main wards. However, we found from inspecting the emergency department and attending the access and flow meeting that the trust experienced regular ongoing challenges in admitting patients in a timely manner to AMU. Large number of patients waited hours in emergency department to be admitted. Data we saw corroborated this.

Senior leaders told us patients sometimes stayed too long in AMU. However, trust data showed that the average number of hours that a patient had remained on AMU, over the past six months, was 20.9 hours. This was slightly better that the period between January to March 2021 when the average was 24.5 hours.

Patient flow meetings were held four times per day. We observed a teleconference trust bed meeting which covered aspects including; the review of actions from the previous day, updates for all speciality areas, patient flow within the trust, bed capacity position, emergency department position, update from the discharge team, community beds update, infection control update relevant to patient flow within the hospital and an ambulance update.

The trust used an electronic tool which tracked medical patients who were being cared for on the wards other than the required speciality. 'Outlier' lists were generated daily which identified where patients were, when the patient had last received a consultant review and a summary of their care plan. The 'manager of the day' had oversight of the medical allocation for these patients between the specialities. There were medical escalation teams who supported the review of these patients.

We were told, by a member of the medical outlier team, that there were two teams in the hospital who reviewed all patients that were medical outliers across the hospital. These were experienced staff of multiple specialisms. Each team had a FY1 or FY2 (first year one or two) or senior house officer, a registrar and a consultant. A staff member told us they worked well together and cross team working was described as effective. The team had been established for four years and the staff member felt that the process for review worked well and tied in well with the trust's other processes particularly with critical care outreach. The critical care outreach team also attended the hospital medical handover at 4.30pm where acutely unwell patients for escalation or awareness were discussed.

The senior leadership team told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care. There was some difficulty in accessing providers who could accept these patients. The trust utilised Clifton hospital site for some of these groups of patients. There were challenges for the trust when the Clifton hospital was full or closed to admissions due to infection outbreaks.

Delayed discharges were escalated to the ward manager and then to the matron in the morning staffing meetings, these were then raised with the bed management team.

Staff worked to make sure they started discharge planning as early as possible and we were told that on some wards a specific member of nursing staff took responsibility to gather all the relevant history to aid a patient's discharge more quickly.

We were told the hospital had a new transfer of care hub, which included the single point of discharge team. The hub lead explained they were currently in the process of recruiting 16 more discharge co-ordinators to work on the wards directly, with the hope that this would improve the discharge process and flow. It was not known when these posts would be filled.

For patients receiving end of life care there was a fast track discharge process in place. This meant discharge or transfer form hospital was prioritised.

Managers monitored the number of delayed transfers of care, knew which wards had the highest number and took action to prevent them. We listened into a flow meeting where patients ready for discharge across the trust were discussed.

Within the transfer of care hub, we viewed the patient tracker systems including the emergency department dashboard and their hospital dashboard for bed management and patient discharges.

NHS England data showed that from April 2020 to March 2021 the average length of stay for medical elective patients at Blackpool Victoria Hospital was 5.3 days, which was lower than England average of 6.5 days. For medical non-elective (urgent) patients, the average length of stay was 7.4 days, which was higher than England average of 5.7 days. At the time of the inspection we were told by staff that the average length of stay for a medical patient awaiting discharge to a care or nursing home was 4.5 days.

However, we saw that In September 2021, over 99% of patients who were waiting for a care home or nursing home placement were delayed in hospital by over 14 days or over 21 days. A senior leader at the trust told us around 20% of patients were medically optimised to leave hospital. The percentage of delayed discharges at the trust had increased from 52% of discharges in November 2020 to over 71% of all discharges being delayed in September 2021.

We were told by the senior leadership team within cardiology services, that the main reason for delays in elective admission of patients on waiting lists was due to cardiology beds being used for medical outlier patients. The divisional director of tertiary services told us that they had been working on the flow of outpatient cardiac patients and had set up 'hot' or rapid flow clinics to support patient flow. This had helped improve bed flow, with data in the first four months showing that the clinics had helped avoid approximately 40 admissions to hospital and had improved the use of bed base. Staff told us that some investment had improved the discharge of inpatients and was allowing better workflow. There was a cardiac consultant on call 24 hours with an approved pathway and protocol for screening and escalating to cardiac ward.

For the hospital's diagnostic waiting list and echocardiograms the tertiary services senior leaders told us that they had plans in place and had sourced a company to work weekends to conduct echocardiograms in order to support patient flow.

Learning from complaints and concerns

Medical care (including older people's care)

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

The trust's complaints policy stated they aimed to respond to formal complaints within 25 working days, however they may take up to 40 working days when investigating complex complaints or where the investigation involves multiple divisions, other organisations or NHS trusts. We were told by staff that any complaints received were reviewed by a member of the corporate governance team within 72 hours and on the wards, complaints were investigated by a nurse at band 6 or above.

Data provided by the trust told us that between March 2021 and July 2021 the trust received 69 complaints across the IMPF division and 16 across the tertiary services division. The main themes in complaints related to discharge issues, delays in medication, communication issues and staff attitude.

Staff told us they received information relating to complaints and lessons learned electronically via bulletins and at staff huddles. One matron told us they always asked staff to sign the documents shared to show they had read and understood the information supplied. Some staff we spoke with stated that they did not always receive feedback regarding the investigation of and lessons learned from incidents and complaints.

Information relating to raising concerns, giving feedback or making a complaint was available on the ward, with leaflets and posters available for public viewing. Patients we spoke with knew how to complain or raise concerns.

Staff we spoke with understood the policy on complaints and knew how to handle them.

Ward managers and matrons told us told us how they would investigate complaints and identified themes. One ward manager told us they had recently had a complaint about lack of communication, which was a theme especially during COVID-19, despite the fact they had tried to keep friends and family updated as much as possible.

A matron told us that if she could, she would speak to the person on the ward and try to resolve any issues without the need to escalate the complaint.

We noted one example where patient feedback regarding excessive noise at night had led to the staff ensuring that all doors to bays were closed at night.

Friends and family test data was displayed on ward notice boards and whilst the number of responses tended to be low the feedback was positive in most cases.

Is the service well-led?

Inadequate 

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Medical care (including older people's care)

Leaders had the skills and abilities to run the service. However, they did not always understand or manage the priorities and issues the service faced. Not all Leaders were visible and approachable in the service for patients and staff.

The medicine core service was covered by two divisional management teams. One for the integrated medicine and patient flow division (IMPF) and the other for the tertiary services division.

The leadership team for tertiary services were newly recruited, as the tertiary services division had only formed in April 2021. The tertiary service included cardiology, cardiothoracic, cystic fibrosis, oncology, heart failure services and a national artificial eye service. They provided services for the wider population of Lancashire and South Cumbria.

Although the triumvirate told us they undertook walk arounds on the wards, staff within the IMPF division said they had only seen the assistant director of nursing and chief nurse. We saw no evidence of ward walk arounds taking place.

Matrons were responsible for the wards we visited. The matrons were visible and visited the wards regularly and escalated any concerns. Matrons told us they had an open-door policy to support staff if needed and staff said they regularly saw the matron on the wards.

Ward managers and matrons told us they recognised the need to upskill nurses which would also reduce vacancies at higher bands. Most wards had programmes of learning and acting up opportunities for band 5 and 6 nurses to help them work towards promoted positions. We saw effective ward managers who had a good oversight of their wards and all wards we visited appeared well organised, tidy and had a calm atmosphere.

Staff spoke positively about their ward managers and matrons and said they were well supported.

Divisional workforce plans had identified gaps in staffing and managers were working on ways to increase uptake of posts and retention of workforce. Exit interviews had identified some senior medical staff did not wish to stay at the trust due to its location and the trust was working to try and encourage doctors to remain at the trust.

Vision and Strategy

The service had a vision for what it wanted to achieve and a one-year strategy to turn it into action, however this was not something that the staff were aware of nor had they been engaged in developing.

The tertiary services division told us they had developed a formal one-year strategy which aligned with the trust one year strategy, with an emphasis on recovery following COVID-19 pressures. The senior leadership team told us they had been engaging with the new team looking at where they had been and where they wanted to go next. They had also worked together to look at how they could align with the trust's five year vision.

The IMPF leadership team told us their divisional strategy and vision had been developed and linked in with wider divisions. They had started to work on their vision, with the development of the medical SDEC, which would link in with the emergency village model. They told us the SDEC model was currently being trialled with the hope of rolling this out for other specialties. They also told us they wished to increase the number of substantive medical staff within the division, something that was a long-standing concern. After the inspection the trust provided evidence that the SDEC model had been developed with the involvement of staff and patients. They explained that since the last CQC inspection a lot of work had been undertaken to increase the establishment.

There was a draft five-year strategic framework in development for the trust, which had not yet been shared with staff, so we could not corroborate that staff in the service had awareness of it. The trust advised that plans and timelines had been submitted which included stakeholder engagement in order to develop the wider trust strategy.

Staff spoken with were not aware of the divisional or trust wide strategy or visions.

Culture

Staff did not all feel respected, supported and valued. Staff were mostly focused on the needs of patients receiving care. The service was working towards an open culture where patients, their families and most staff could raise concerns without fear, however, this was not yet embedded.

We held focus groups with staff and some staff with protected characteristics gave negative feedback about their experiences, and lack of support and career development.

During the inspection we saw teams working together well, with a good rapport evident amongst staff from different disciplines, they were motivated and positive about their work. We spoke with members of staff at all levels, who told us things were improving and that new divisional management teams had made significant improvements. Staff told us the wards were well run and focused on patient care with good learning and support. Staff felt there was more visibility of the director of nursing and associate director of nursing.

Most staff told us there was an open culture and they felt able to raise concerns with their line manager and most felt they were supported and encouraged to develop.

Senior leaders told us they were focussed on improving the workforce and skills across the divisions and working closely with all staff to make improvements.

The senior leadership team within the IMPF division told us they were working to improve behaviours within the division. They were developing work plans with the aim of improving professional standards.

There was a staff equality, diversity and inclusion ambassadors' network, but there were no other staff networks within the trust to offer staff with protected characterises support and advice. Staff we spoke with, who had protected characteristics.

Governance

We were not assured that leaders operated effective governance processes throughout the service. Staff were mostly clear about their roles and accountabilities and had some opportunities to meet, discuss and learn from the performance of the service.

We saw the structures, processes and systems of accountability were not robust.

The corporate risk register included a high risk around a lack of governance within the divisional structures to provide the correct level of assurance.

The tertiary services division told us there had been work undertaken with an external governance institute to review some of the inherited governance processes. Following our inspection, the trust provided us with a trust commissioned

external review and report of the effectiveness of the trust's divisional governance systems and processes. As a part of the external review each divisional SLT had completed a reflective self-assessment using a governance maturity matrix to assess performance across a range of indicators of good governance. Maturity matrix self-assessment indicators were each scored from one to four, with four being the highest rated maturity index score of good governance. The divisional SLTs had self-identified improvements were required across a number of governance indicators.

The SLT for the division of IMPF had assigned a self-assessed score four for care quality commission implementation. IMPF had assigned a self-assessed score between three to four for implementing best practice, and clinical audit. The division IMPF assigned a self-assessment score of three for risk management, patient safety and managing incidents, improvement implementation and lessons learnt. They assigned a self-assessment score of two for patient and carer feedback and mortality. The SLT for the division of tertiary services had assigned a self-assessed score of four for implementing best practice, risk management, patient safety and managing incidents, and a self-assessed score of three for care quality commission implementation, improvement implementation and lessons learnt, a self-assessed score between three and two for patient and carer feedback and a self-assessed score of two for clinical audit and mortality. Each divisional SLT had developed an improvement action plan, however we found that deadlines and timeframes were not set for the completion of all identified improvement actions, and limited evidence of the continuous monitoring and recording of progress against actions.

Whilst the CQC had raised immediate safety concerns following the initial inspection of this service, relating to the monitoring of patients who had been given rapid tranquilisation, we found that this incident had been repeated shortly after, showing a lack of learning from significant patient safety concerns.

We were told that the divisions had continued to submit data for national and local audits such as hip fracture, SSNAP, encephalitis and infectious disease. We did not always see recent evidence from the divisions around audits, see patient outcomes section within effective chapter of the report. The process was that audit results were reviewed at the divisional clinical effectiveness committee, whereas lower level audits were logged and monitored by the quality improvement team. The IMPF division leads told us that they had no audit outliers and that their governance lead monitored the audit outcomes and could track and chase up any incidents or concerns. The division could not demonstrate how they were assured that audit outcomes had been appropriately reviewed and that actions required to improve services and patients' outcomes had been identified and implemented.

Senior leaders told us that governance processes replicated corporate executive committees and board. There was a divisional board, a clinical effectiveness committee and a mortality committee.

Staff we spoke with understand what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Some staff told us that they were provided with information relating to learning, performance etc via newsletters and some information was provided at staff meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues but actions to reduce their impact were not always effective. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Risks in the division were identified as having limited assurance. There was a lack of oversight of the risk register, which made it difficult for the division to have a robust grip on its systems and processes; this in turn impacted on the quality and sustainability of services.

We were told that the risk registers were reviewed with the governance lead and presented six weekly at the divisional quality committee. However, we saw that the IMPF and tertiary services divisional risk registers listed a high number of risks, with many risks that had been open a long time, for example for six years.

It was not clear to us how risks and issues were escalated from ward to board, nor how they were fed back. Some risks had been on the register for a long time without evidence of improvement. For example, the care of patients living with dementia, the score was nine when it was added to the risk register in May 2017 and was currently at the same score.

The large number of risks on the register made it difficult to effectively scrutinise and manage; risks were not escalated appropriately through clear structures and processes. Senior leaders were able to identify the top three risks on their risk registers and provided information as to how they planned to reduce or mitigate these risks. However, they were not managing the risk register effectively.

Managers spoke of the daily command meetings, which were attended by the executive medical director, the executive director of nursing, quality and allied health professionals, the chief operating officer, the triumvirate leads and the ED head of department. At these meetings risks would be discussed and escalated as required.

When the tertiary services division was created, leaders told us they had reviewed the existing risk register and were working to refine this as the numbers of risks recorded was very high and many no longer needed to be included on the register.

The tertiary services leadership team told us they were hoping to migrate to the mortality dashboard by November/ December 2021 as this would give them an overview of mortality within the division.

They told us that their highest risk was in fulfilling the cancer pathway due to a shortage of haematologists.

Staff were encouraged to speak up about risks and we saw examples of where staff on wards had raised risks for inclusion on their risk registers.

There was a lack of action with regards to assessing the risks to patients who were waiting to be treated within the division and across the trust. No plan appeared to be in place to clinically prioritise those patients, regardless of where they were on the waiting list.

Information Management

The service did not collect reliable data and analysed it well. Staff could not always find the data they needed to understand performance, make decisions and/or improvements. The information systems were not all integrated within the core service.

The IT systems used in the trust for information management and governance were outdated. They did not always enable staff and leaders to perform their roles effectively. The trust did not have a reliable system for monitoring patients on the waiting list.

Staff told us they completed mandatory training in information governance and were aware of the need to maintain confidentiality and to keep patients' records secure. We saw that the compliance rate amongst doctors, for the completion of information governance mandatory training, was 87.1% for doctors within the tertiary service division and 71% for those within the IMPF division. The trust target compliance rate was 85%. We did not view the compliance data for nursing or healthcare staff.

The divisions were using both electronic and paper records, which posed a risk to patient safety.

Staff accessed information relating to policies and guidance electronically as well as information being available via electronic groups and social media platforms.

The service did not consistently report incidents externally in a timely manner. We reviewed incidents that occurred within medical services between August 2020 and September 2021 and found that there were significant delays in staff reporting incidents the on national reporting and learning system over 90 days especially those that were moderate, severe and deaths. We were concerned that the rating of harm was not always accurate at the point of initial reporting which led to delays in reporting externally.

Engagement

Leaders and staff did not always actively and openly engage with patients, staff, the public and local organisations to plan and manage services. There was a lack of engagement with equality groups. The service collaborated with partner organisations to help improve services for patients.

The friends and family test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should be given the opportunity to provide feedback on their experience. Data displayed on the ward quality boards provided a snapshot of the feedback provided with details of the number of reports received and the percentage that were positive.

Nationally published FFT data from September 2021 showed that the core service had an average of 98% positive feedback, with the ratings ranging from 89% on one ward to 100% on eight of the wards. This was an increase in positive feedback compared with an average of 94% in September 2019. Out of a total of 1,028 eligible respondents, in September 2021, only 345 responses were returned.

The leadership teams told us they wanted to improve the processes in place to gather patient feedback about service developments and planned to put in 'listening clinics' for patients. We were not told when this would commence.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They understood quality improvement methods and had some skills to use them. Leaders encouraged innovation and participation in research.

Managers on the wards spoke of initiatives that had been rolled out across the division and/or trust, which had been developed and introduced by members of their teams. We saw examples of innovative products and processes which had been designed by staff and those staff were proud to discuss their projects and were happy these were later

acknowledged and integrated into normal practice. These included a ‘shortness of breath kit’ developed by a staff member. This consisted of a box containing all the emergency kit that might be required when a patient was suddenly short of breath, for example, a sterile oxygen mask, oxygen tubing etc. This meant that in the case of an emergency any member of staff could immediately find the required equipment in one place.

Senior managers told us they were committed to encouraging innovation and quality improvement projects across the division. They told us that since the introduction of the clinical quality academy, the divisions had had several of their proposed projects shortlisted and accepted.

Work was being undertaken to ensure all junior doctors were part of a quality improvement programme to aid with their development.

The tertiary service division told us they had led on initial conversations around cardiology networks at an Integrated Care System (ICS) level as well as their work leading on and contributing to the haematology network. The cardiology team generated the highest research income in the trust and were one of four cardiothoracic research centres in the UK.

We were also told us that the trust’s cardiology team had been nominated for a national Innovation of the year award category with their work on low contrast interventions where patients were at risk due to kidney pathology.

The tertiary service management team told us they had been piloting the use of video lessons learned sessions, where they would re-enact an incident and look at what went wrong and why, as well as what went well. This was shared with the division and wider trust for learning purposes.

Additionally, similar themes from the previous inspection, around the lack of appropriate mental capacity assessments, risk assessment and waiting times, were found during this inspection.