

Southport and Ormskirk Hospital NHS Trust

Southport & Formby District General Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Regional spinal injuries unit

Good



Medical care (including older people's care)

Requires improvement



Surgery

Inadequate



Critical care

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

We rated the hospital as requires improvement overall which is no change from the last inspection in November 2015. The same four of the five domains were judged to be requiring improvement with the caring domain rated as good. Urgent care services had a worse rating in safety being rated as inadequate from requires improvement last inspection and surgery had changed to an inadequate from requires improvement in safety and being well led.

However the regional spinal injuries service had improved from inadequate ratings in safety and being well-led to good across all domains. Medicine remained in the same ratings for all domains. Critical care services had improved in safe effective and well led to a good rating but continued to require improvement in responsiveness. Outpatient services remained at a rating of requires improvement in safety but had improved to good in all other domains. End of life services continued with good ratings in all domains.

Our key findings since our last inspection were as follows:

Urgent care

- We found evidence of significant flow issues and significant delays for patients during our inspection. Higher (worse) than average numbers of patients were waiting between four and 12 hours to be admitted into the hospital following a decision being made. The department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours. We saw patients waiting in corridors in public areas which we were concerned impacted negatively on their privacy and dignity. We saw some elements of sepsis care which were worse than the regional average. Re-attendance rates for patients were consistently higher (worse than) than the national average. We also saw an example of poor management of a patient suffering with sepsis. National audits were undertaken which highlighted poor performance in a number of areas but action to improve care in these areas was not sufficient.
- Staff did not have a focused approach to reviewing mortality. Although most areas were visibly clean, the floor of a storeroom was not, with debris and dust on the floor and around equipment. Some major incident equipment was stored in a disorganised way with items piled high and unlabelled.
- Patient records were not audited the records we reviewed showed that tools to manage risks to patients such as observations, risk assessments and early warning scores were not always recorded. Although national and local guidelines and care pathways were in place, they also were not always evidenced in records.
- Compliance with mandatory training did not meet the trust target of 90%. We shared staff concerns that medical staffing levels were low and at times appeared unsafe. Although nurse staffing levels were adequate, sickness levels were higher than the NHS national average.
- Staff were open to risk because of a lack of security arrangements on site. Staff felt leaders from the executive team were not supportive and that the culture was reactive with action taken 'too little, too late', rather than having a proactive approach.

North West Spinal Injuries Unit

- Following a rating of inadequate during the inspection in November 2014, the service is now rated as good overall because the trust had invested significantly in nurse staffing and we saw that the staffing ratios had increased to adequate levels. The centre had a dedicated spinal medical team with on-site medical cover between the hours of 9am and 9pm Monday to Friday. Out of hours the centre was supported via spinal on-call including a consultant and the trust out of hours hospital at night team.

Summary of findings

- They had renamed the former intensive care and high dependency units as it was revealed that intensive care was not delivered at the centre. The centre demonstrated a clear admission policy with strong individual assessment for admission in accordance with the national clinical reference group classification for clinical priority. There was also a focus on discharge planning and there was good multidisciplinary working to support this. A case manager facilitated the discharge process. The consultants reviewed their patients six monthly or annually to ensure patients were reaching their goals.
- In March 2016 the safety thermometer showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had only been one fall with harm. Since the last inspection staff had been supported to manage patients with challenging behaviour. The partnership working document was discussed with all patients on admission and an explanation given regarding expected behaviour in line with the trust's violence and aggression policy.

Medicine

- We found that not all wards appeared clean and well maintained. Equipment was left on wards and outside in corridors, and not all staff followed staff hygiene practices as they did not always wear suitable protective equipment between providing care and treatment to patients. There had been no formal process since July 2015 to April 2016, to ensure that the quality of care on the medical wards was maintained by senior managers and that all trust policies and procedures were being adhered to. Nurse staffing establishment levels across all wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. Consultant vacancy rates across medical services in March 2016 were high at 30%, and had been deemed as a high risk on the risk register. There was limited consultant cover on medical wards at weekends, and no ward rounds took place.
- Mandatory training statistics showed that only one medical ward had achieved the trust target of 90% in mandatory training in the period of October 2015 to February 2016. Staff training in some core areas was below the trust targets and staff reported that they had to cancel training due to low staffing levels. Not all staff had received an annual personal development review.
- Initial patient risk assessments were not consistently completed for example VTE assessments. Access and flow throughout medical services was poor and so patients were being cared for and treated on wards that were not appropriate to their needs. Due to a high demand for beds throughout the Hospital, some areas of the hospital were being used inappropriately to care and treat patients. For example the GPAU and the discharge lounge were being used as bedded areas. Escalation wards did not provide all the necessary amenities to ensure a high quality service was experienced by all patients, and call bells were not always in reach of patients.
- There was inadequate storage for staff belongings on the ward which posed a security issue for staff. There was no security team on site to ensure the safety of staff and visitors in the event of violence and aggression from patients or visitors. There had been 76 police call outs to the trust, with the main reason being due to physical abuse/ violence from patients to staff.

Surgery

- Safety did not have a sufficient priority across surgical services. Systems and processes were not always reliable to keep people safe. Incidents were not always properly identified and we saw evidence of previous incidents being repeated. Risk assessments were not always completed and mitigation of identified risk did not always take place. Medically deteriorating patients were not always identified promptly, nor did they always receive the prompt medical attention the required, once they were identified. The mortality and morbidity of surgical specialties are not reviewed by the trust board.

Summary of findings

- Staffing levels on wards were frequently insufficient and these were not addressed quickly. Staff were distressed at the low staffing levels and the heavy workload. We observed the impact that the low staffing levels had on patient safety and patients' needs being met.
- In addition to the above issues, matters identified during the previous inspection remained evident. There were problems with the replacement of theatre equipment and there was still no pager system in place which had connectivity across the entire hospital.
- There was no clear vision about the future of surgical services across the trust. However, decisions about the future of surgical services could only be made as part of a decision in the wider healthcare economy. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken. There was also a combative approach to dealing with disciplinary matters across the division for both nursing and medical staff.
- There were poor patient outcomes as indicated by high elective readmission rates and poor performance in national audit programmes. We found that nutrition and hydration needs were not always addressed. In addition staff were not implementing trust policy for fasting guidelines prior to surgery, meaning that people were being left longer than recommended without fluids.
- They experienced significant difficulties with patient flow. Services were not organised efficiently. This further exacerbated patient flow issues. Surgical services did not always meet the individual needs of patients who had complex requirements. Complaints were not used as a means of improving services.

Critical Care

- The critical care services were previously rated as 'requires improvement' for responsive following our last inspection because we had concerns around delayed discharges and the provision of single sex accommodation. During this inspection, we found that significant improvements had been made to reduce the number of delayed discharges. However, further improvements were still needed to ensure patients received appropriate care.
- The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit. Patient's relatives spoke positively about the care and treatment they received.
- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. The consultants covering the unit during out of hours were also responsible for other areas, such as providing anaesthetic cover for the surgical and maternity services however, there was a second on-call consultant to provide additional cover and support. There was one speech and language therapist across the hospital during weekdays. This meant staff on the unit occasionally experienced a delayed response after referring patients for this service.
- There was effective teamwork and clearly visible leadership within the services. Most staff were positive about the culture within the critical care services and the level of support they received from their managers. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional quality and governance meetings.

End of Life

Summary of findings

- Conversations between district nurses and GPs around the commencement of the IPOC to support patients at the end of life were not always documented. The service should ensure that all GP involvement is documented in the IPOC when the decision is made for this to be commenced.
- Completion of mental capacity assessments was not consistent, even when indicated on the DNACPR. The trust was not using the unified DNACPR process and hospital DNACPR forms did not travel with the patient when they left hospital. There was no audit of DNACPR forms or decisions despite the system for reviewing these forms being identified as an area for improvement in the last CQC inspection in 2014.
- The complaints process and governance processes around monitoring incidents required improvement. The trust should ensure the new incident monitoring system includes dissemination of feedback and lessons learned to all relevant areas, including the mortuary.
- Syringe drivers were not being checked four hourly in line with hospital standards. The service should continue to educate and audit this process.
- Prior to our inspection there had been no-one actively taking the part of executive lead for EOLC and there was no non-executive director with responsibility for EOLC.
- Anticipatory EOL care medication was prescribed appropriately in hospital and in the community. Hospital staff were knowledgeable about responding to deteriorating patients and hospital care records reflected this with appropriate evidence or establishment of ceilings of care documented. There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) of those thought likely to be dying which was well embedded in community services. EOL services were adequately staffed and as well as the SPC team which was clinically led by a consultant in palliative medicine, there was a Transform team which promoted advance care planning, the amber care bundle and provided EOLC training.
- The delivery of EOLC was planned in accordance with the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People including the introduction of the IPOC. Actions were being taken to meet the national framework, Ambitions for Palliative and End of Life Care, including cross boundary working to coordinate care and the generation of data via national and local audits to review and improve services. Patients had comprehensive assessments of their needs which included pain assessments and in hospital, nutrition and hydration assessments. There was good evidence of multidisciplinary team working and seven day services were in place. There was a rapid transfer process in place which the team were working to improve.

OPD

- The previous 'requires improvement' rating was due to safety incidents not being communicated with the trust board. This has since been addressed, however other issues of concern were found.
- We raised a control of infection issue in the eye clinic that was raised during the inspection. The trust responded quickly and an action plan to improve was put in place; however, some issues were not addressed.
- The hospital performed well against national targets. Waiting times for appointments were better than average with 50% of patients receiving an appointment within five weeks of referral. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment.
- There were a large number of appointment cancellations that had a variety of causes including IT issues and patients receiving multiple appointments in error. However, managers were gathering evidence and had set improvement targets
- Some areas of mandatory training showed poor results and managers acknowledged that work was needed.
- The outpatient improvement project was still progressing from 2014; changes had been made to the environment, clinical coding and staffing ratios. Phase four had been suspended due to staffing issues, which was to address the high cancellation numbers.

Summary of findings

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

In Urgent and Emergency Services

- The service must ensure mortality is discussed monthly and minutes taken to evidence discussion.
- The service must ensure mandatory training compliance reaches and consistently achieves the trust target.
- The service must ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- The service must ensure the actions identified following our concerns about the death of a patient during our inspection, are implemented in accordance with planned timescales
- The service must ensure all patients receive timely (particularly initial) observations whilst in the department
- The service must ensure staff use and evidence use of the sepsis care pathway for patients suffering sepsis.
- The service must increase middle grade staffing to ensure rotas can be planned without the routine use of consultants or junior doctors to back fill vacant middle grade shifts. Where it is not possible to recruit staff, ensure suitable alternative and sustainable solutions are identified and implemented.
- The service must ensure action plans following CEM audits target areas of poor performance and improve practice.
- The service must ensure staff make use of the trust capacity assessment documents when required and properly evidence that where a patient lacks capacity best interests have been adequately considered.
- The service must improve performance, particularly in relation to the department of health four hour target, wait times following a decision to admit, ambulance handovers.
- The service must ensure robust processes are in place to mitigate risks to staff in relation to violence in the work place.
- The service must improve the organisation of major incident equipment in the store room.
- The service must develop and embed a clear escalation process with identified actions for managers and executives.

In surgery

- The service must take action to ensure that there are adequate staffing levels present on all wards to provide safe level of care and treatment for the acuity and dependency of the patients on the wards.
- The service must take action to ensure that Oxygen is prescribed to patients, in line with recommended guidelines, prior to administration.
- The service must take action to ensure that all patients, particularly those who are very confused and able to wander off a ward, are cared for in a secure environment.
- The service must take action to ensure that a system of feedback is in place for staff who have reported incidents.
- The service must take action to ensure that medically deteriorating patients are always identified as they deteriorate and are medically reviewed in line with trust policy.
- The service must take action to ensure that mortality and morbidity events in surgical services are reported to the trust board.
- Surgical services must take action to ensure that the plan for the replacement of old theatre equipment is implemented.

Summary of findings

- Surgical services must take action to ensure that all risk assessments are appropriately completed for patients.
- Surgical services must take action to ensure that a system is in place to identify trends and reasons for the high readmissions rates in elective surgery.
- Surgical services must take action to develop an action plan to reduce the high readmission rate in elective surgery.
- Surgical services must take action to improve performance in relation to the indicators in the following national audits,

-The national emergency laparotomy audit

-The national bowel audit

-The national lung cancer audit

-The national hip fracture audit

- Surgical services must take action to ensure that patients are being fasted for surgery in accordance with national guidelines and trust policy.
- Surgical services must take action to ensure that the surgical admissions process is designed to facilitate a timely flow through the surgical process.
- Surgical services must take action to ensure that patients are cared for in treatment areas with full access to toilet facilities and meals.
- Surgical services must take action to ensure that care is provided to patients with complex needs in a manner that is responsive to the needs that they have.
- Surgical services must take action to ensure that patients with dementia and other cognitive impairments are cared for on wards that take account of these needs in terms of physical environment.
- Surgical services should use service user complaints about to drive service improvements.

In End of Life Care

- The service must improve the consistent use and completion of formal pain assessment; assessment of nutritional and hydration status in the community; mental capacity assessments when indicated on the DNACPR.

In Medicine

- The service must take action to ensure that all staff have the up to date training they require to be able to safely care and treat patients and performance development reviews are in line with trust policy.
- The service must take action to ensure that all wards and corridors are clean and well maintained, and equipment is stored appropriately.
- The service must ensure that all records relating to patients are kept securely and computers are locked when left unattended to prevent breaches in data protection.
- The service must take action to ensure that all Initial patient risk assessments are consistently completed for all patients.
- The service must ensure that there are sufficient numbers of qualified, competent staff across all medical wards.
- The service must take action to improve the access and flow throughout the medical wards, to reduce bed occupancy and prevent patients being cared for on wards that are outside their specialty.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Staff did not have a focused approach to reviewing mortality. Although most areas were visibly clean, the floor of a storeroom was not, with debris and dust on the floor and around equipment. Some major incident equipment was stored in a disorganised way with items piled high and unlabelled.

Patient records were not audited by department staff and only a small number were reviewed by the trust each month which was not representative. When reviewing records we found that tools to manage risks to patients such as observations, risk assessments and early warning scores were not always recorded. Although national and local guidelines and care pathways were in place, they also were not always evidenced in records.

We saw some elements of sepsis care which were worse than the regional average. We also saw an example of poor management of a patient suffering with sepsis.

National audits were undertaken which highlighted poor performance in a number of areas but action to improve care in these areas was not sufficient. Compliance with mandatory training did not meet the trust target of 90%. We shared staff concerns that medical staffing levels were low and at times appeared unsafe. Although nurse staffing levels were adequate, sickness levels were higher than the NHS national average.

We found evidence of significant flow issues and significant delays for patients during our inspection. Higher (worse) than average numbers of patients were waiting between four and 12 hours to be admitted into the hospital following a decision being made. The department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours. We saw patients waiting in corridors in public areas which we were concerned impacted negatively on their privacy and dignity.

Re-attendance rates for patients were consistently higher (worse than) than the national average.

Summary of findings

Staff were open to risk because of a lack of security arrangements on site. Staff felt leaders from the executive team were not supportive and that the culture was reactive with action taken 'too little, too late', rather than having a proactive approach.

Regional spinal injuries unit

Good



Following a rating of inadequate during the inspection in November 2011, we have now rated the North West Regional Spinal Injuries Centre (NWR SIC) services as good overall because; Since the last inspection in November 2014 the trust had invested significantly in nurse staffing

- and staffing levels had improved. The trusts review in July 2014 highlighted that 18 whole time equivalent members of nursing staff were required to ensure that the centre complied with all national recommendations for safe staffing. We saw that the staffing ratios had increased to adequate levels.
- The centre had a dedicated spinal medical team with on-site medical cover between the hours of 9am and 9pm Monday to Friday. Out of hours the centre was supported via spinal on-call including a consultant and the trust out of hours hospital at night team. The lead consultant told us that since the recruitment of the third consultant to the team the access to medical cover had improved considerably. There was a 24 hour, seven day a week spinal consultant on call service available.
- In March 2016 the safety thermometer showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had only been one fall with harm.
- Ward areas were visibly clean and cleaning schedules were displayed on the ward and in the acute respiratory centres (ARC's). Staff were seen to comply with the infection control policy. Mandatory hand hygiene monthly audit results for the centre in December 2015, January and February 2016 were 100% compliant. The environment and cleanliness audit showed 99% compliance in March 2016 which was an acceptable limit.
- The environment for patients had improved since the last inspection with refurbishment of the day room. Patients and relatives confirmed this

Summary of findings

provided a pleasant area in which to relax and socialise away from the ward. The rehabilitation centre had access to a variety of equipment to meet patients' individual needs and to support and maintain patients' independence. There was adequate equipment in the centre to ensure safe care. Therapy staff carried out risk and competency assessments to ensure patients were safe to use assistive technology and electric wheelchairs.

- We observed the safe manual handling of patients which included the use of hoists by two members of staff. A draft policy was under development that outlined patient responsibilities for safe use of wheelchairs.
- The ward had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines.
- Care and treatment was evidence based and staff provided care for patients with spinal injuries based on the National Institute for Health and Care Excellence (NICE) guidelines including guidance published in February 2016.
- Since the last inspection the trust had renamed the former intensive care and high dependency units of the NWRSIC as it was revealed that intensive care was not delivered at the centre. This had had an implication for registered nursing staff to have a post registration award in critical care nursing which no longer applied.
- Data from the National Spinal Injuries database for 2013/14 and 2014/15 showed a reduction in admission waits and a reduction in delays in discharge. The additional capacity of the outreach service had enabled patients referred from major trauma centres to be admitted faster. Data showed the percentage of acute outreach visits within five days at the time of the inspection was 100%.
- Since January 2015 the centre had recruited a nursing practice-based educator and there was ongoing review of the in-house education programme. Team development and specialist training had begun. A self-assessment competency process was in place for all clinical staff with skill acquisition relevant to role.

Summary of findings

- The centre demonstrated a clear admission policy with strong individual assessment for admission in accordance with the national clinical reference group classification for clinical priority. There was also a focus on discharge planning and there was good multidisciplinary working to support this. A case manager facilitated the discharge process. The consultants reviewed their out-patients six monthly or annually to ensure patients were reaching their goals.
- Since the last inspection staff had been supported to manage patients with challenging behaviour. The partnership working document was discussed with all patients on admission and an explanation given regarding expected behaviour in line with the trust's violence and aggression policy.
- There was a clear strategy for the unit which was supported by the trust business planning strategy and the executive team. The five year strategy for the NWRSIC had not yet been made available following the sustainability review.
- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. Ward managers reported that they had good relationships with their immediate matron who was visible on the unit.
- **However;**
- Compliance rates for mandatory staff training had been below the trust target since December 2015. The training schedule showed there were low numbers of nurses trained in specialist areas for example; venepuncture, intra venous cannulation, blood transfusions and skin bundle training. The matron reported that some additional new core mandatory training 'prevent' training had affected the overall training statistic figures as not all staff had received this. Staff raised it was sometimes difficult to leave the ward due to staffing levels to attend training.

**Medical
care**

Requires improvement



At the last inspection in November 2014, we rated medical services at Southport district general

Summary of findings

**(including
older
people's
care)**

hospital as requires improvement overall. The service required improvement in safe, effective, responsive and well-led domains and was rated good in the caring domain.

At this inspection we rated medical services at Southport and Formby district hospital as requires improvement overall and again rated medical services to require improvement in the safe, effective, responsive and well-led domains. We rated the caring domain as good.

- We found that not all wards appeared clean and well maintained. We found that equipment was left on wards and outside in corridors, and not all staff followed staff hygiene practices as they did not always wear suitable protective equipment between providing care and treatment to patients. There had been no formal process since July 2015 to April 2016, to ensure that the quality of care on the medical wards was maintained by senior managers and that all trust policies and procedures were being adhered to. We found from reviewing ward dashboards that matron checklists were not being completed formally since July 2015. The checklist included checking the ward environment, equipment, infection control and ward documentation. The matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures.
- Nurse staffing establishment levels across all wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. All staff we spoke with reported concerns about staffing levels across medical services.
- Consultant vacancy rates in across medical services in March 2016 were high at 30%, and had been deemed as a high risk on the risk register. There was limited consultant cover on medical wards at weekends, and no ward rounds took place.

Summary of findings

- Mandatory training statistics provided by the trust via ward dashboards showed that only one medical ward had achieved the trust target of 90% in mandatory training in the period of October 2015 to February 2016.
- Staff training in some core areas was below the trust targets and staff reported that they had to cancel training due to low staffing levels.
- Not all staff had received an annual personal development review. Compliance rates varied across medical wards.
- Initial patient risk assessments were not consistently completed for example VTE assessments. We reviewed 30 records and found 13 records did not have all risk assessments fully completed or reviewed.
- There was inadequate storage for staff belongings on the ward which posed a security issue for staff.
- There was no security team on site to ensure the safety of staff and visitors in the event of violence and aggression from patients or visitors. There had been 76 police call outs to the trust, with the main reason being due to physical abuse/violence from patients to staff.
- Due to a high demand for beds throughout the Hospital, some areas of the hospital were being used inappropriately to care and treat patients. For example the GPAU and the discharge lounge were being used as bedded areas.
- Although most records trolleys were new and were kept locked, we found that not all records were kept securely and there were governance issues with staff leaving computer terminals with confidential information accessible to others.
- Access and flow throughout medical services was poor and so patients were being cared for and treated on wards that were not appropriate to their needs. Escalation wards did not provide all the necessary amenities to ensure a high quality service was experienced by all patients, and call bells were not always in reach of patients.

Summary of findings

- Due to a change in the executive team, not all staff were clear of the vision and strategy and direction of the trust.

However,

- Medical care services were delivered by hardworking, caring and compassionate staff that treated patients with dignity and respect. Staff often worked extra hours due to staffing shortages to ensure continuity for their patients.
- Medical services used evidence based practice to care and treat patients and took part in developing good practice through participation through national and local audits.
- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, and review of records, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- Nursing staff spoke highly of their immediate managers and matrons and felt supported by them to carry out their role.
- There was a focus on discharge planning within the trust. There was a discharge team, bed management team and matrons who worked hard to ensure that patient's journey home was well co-ordinated and timely.

Surgery

Inadequate



We found that the surgical service was inadequate for safe and well-led, required improvement for effective, responsive and good for caring. These findings differed from the findings of the previous inspection in respect of the safe and well-led domain, which were previously rated as required improvement in November 2014.

- Safety did not have a sufficient priority across surgical services. Systems and processes were not always reliable to keep people safe. Incidents were not always properly identified and we saw evidence of previous incidents being repeated. Risk assessments were not always completed and mitigation of identified risk did not always take place. Medically

Summary of findings

deteriorating patients were not always identified promptly, nor did they always receive the prompt medical attention the required, once they were identified. The mortality and morbidity of surgical specialties are not reviewed by the trust board.

- We also found that staffing levels on wards were frequently insufficient and these were not addressed quickly. We looked at rotas and saw that wards were frequently below their planned rates. Staff were distressed at the low staffing levels and the heavy workload. We observed the impact that the low staffing levels had on patient safety and patients' needs being met.
- In addition to the above issues, matters identified during the previous inspection remained evident. There were problems with the replacement of theatre equipment and there was still no pager system in place which had connectivity across the entire hospital.
- Surgical services were inadequate for well-led because there was no clear vision about the future of surgical services across the trust. However, decisions about the future of surgical services could only be made as part of a decision in the wider healthcare economy, once there was greater management certainty within the trust. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken. There was also a combative approach to dealing with disciplinary matters across the division for both nursing and medical staff, with long suspensions in place while investigations were conducted into matters of professional competence.
- Surgical services required improvement for effective because there were poor patient outcomes as indicated by high elective readmission rates and poor performance in national audit programmes. We found that nutrition and hydration needs were not always addressed. In addition staff were not

Summary of findings

implementing trust policy for fasting guidelines prior to surgery, meaning that people were being left longer than recommended without fluids.

- Surgical services required improvement for responsiveness because they experienced significant difficulties with patient flow. Services were not organised efficiently in that there was no surgical admissions unit where patients could attend on the morning of their surgery. This further exacerbated patient flow issues. Surgical services did not always meet the individual needs of patients who had complex requirements. Complaints were not used as a means of improving services.
- In addition to there being no clear vision for surgical services, morale was poor amongst significant sections of clinical staff. Staff reported concern about the length of time that disciplinary investigations took and that clinical staff were suspended for lengthy periods of time. Staff reported that this approach created a culture of fear.

Critical care

Good



We gave the critical care services at Southport and Formby District General Hospital an overall rating of 'good'. However, we rated the services as 'Requires Improvement' for responsive.

This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients were supported with the right equipment. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating.
- The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. The consultants covering the critical care unit during out of hours were also responsible for other areas, such as

Summary of findings

providing anaesthetic cover for the surgical and maternity services. However, there was a second on-call consultant to provide additional cover and support.

- Patients received care and treatment by multidisciplinary staff that worked well as a team. A consultant-led ward round took place twice a day on the critical care unit. Staff carried out a daily assessment of delirium (acute confusion) in patients using the 'Confusion Assessment Method for intensive care' (CAM-ICU) guidelines.
- The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Patient's relatives spoke positively about the care and treatment they received. They were supported with their emotional and spiritual needs. Feedback from surveys showed patient's relatives were positive about the services. There were systems in place to support vulnerable patients.
- There was effective teamwork and clearly visible leadership within the services. Most staff were positive about the culture within the critical care services and the level of support they received from their managers. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional quality and governance meetings.

However, we also found that: -

- The critical care services were previously rated as 'requires improvement' for responsive following our last inspection because we had concerns around delayed discharges and the provision of single sex accommodation.
- During this inspection, we found that significant improvements had been made to reduce the number of delayed discharges. However, further improvements were still needed to ensure patients received appropriate care.

Summary of findings

- The number of patients with delayed discharges had improved from 487 during 2014 to 294 during 2015. However, recent capacity issues across the hospital meant there was a worsening trend and there had been 111 delayed discharges between January 2016 and March 2016. There were 86 'mixed sex' breaches on the unit between April 2015 and March 2016.
- This meant a significant number of patients were still affected by delayed discharges and patient's privacy and dignity was affected as a result of 'mixed sex' breaches.
- The majority of staff had completed their mandatory training and appraisals. However, this was below the hospital's target of 90% training completion.
- There was one speech and language therapist across the hospital during weekdays. This meant staff on the unit occasionally experienced a delayed response after referring patients for this service.

End of life care

Good



At the last inspection in November 2014 we found EOL services to be good in all five domains of Safe, Effective, Caring, Responsive and Well Led. At this inspection we found good EOL services across all the domains with the exception of Effective which we found requires improvement. They were rated as good overall because;

- Incident reporting systems were in place and actions were followed up following investigation.
- Anticipatory EOL care medication was prescribed appropriately in hospital and in the community. Hospital staff were knowledgeable about responding to deteriorating patients and hospital care records reflected this with appropriate evidence or establishment of ceilings of care documented. There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) of those thought likely to be dying which was well embedded in community services. EOL services were adequately staffed and as well as the SPC team which was clinically led by a

Summary of findings

consultant in palliative medicine, there was a Transform team which promoted advance care planning, the amber care bundle and provided EOLC training.

- The delivery of EOLC was planned in accordance with the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People including the introduction of the IPOC. Actions were being taken to meet the national framework, Ambitions for Palliative and End of Life Care, including cross boundary working to coordinate care and the generation of data via national and local audits to review and improve services. Patients had comprehensive assessments of their needs which included pain assessments and in hospital, nutrition and hydration assessments. There was good evidence of multidisciplinary team working and seven day services were in place. There was a rapid transfer process in place which the team were working to improve.
- EOL care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The service was delivered by staff who were committed to providing a good service and there was good clinical leadership from a consultant in palliative medicine. Community services in particular, were highly regarded by patients and families. In the hospital staff were mindful of prioritising EOL patients for side rooms when the situation allowed and the Oasis unit provided space for relatives to stay. Accommodating people's preferred place of care (PPC) was important to staff and their success rate at achieving this was over 80% in the year to December 2015. There was a clear strategy in place and all the EOL and palliative care staff we spoke with understood what the service was setting out to achieve and how their role fitted in. Staff were positive about EOL care and felt well supported.

However there were areas for improvement:

- Conversations between district nurses and GPs around the commencement of the IPOC to

Summary of findings

support patients at the end of life were not always documented. The service should ensure that all GP involvement is documented in the IPOC when the decision is made for this to be commenced.

- Completion of mental capacity assessments was not consistent, even when indicated on the DNACPR. The trust was not using the unified DNACPR process and hospital DNACPR forms did not travel with the patient when they left hospital. There was no audit of DNACPR forms or decisions despite the system for reviewing these forms being identified as an area for improvement in the last CQC inspection in 2014.
- The complaints process and governance processes around monitoring incidents required improvement. The trust should ensure the new incident monitoring system includes dissemination of feedback and lessons learned to all relevant areas, including the mortuary.
- Syringe drivers were not being checked four hourly in line with hospital standards. The service should continue to educate and audit this process.
- Prior to our inspection there had been no-one actively taking the part of executive lead for EOLC and there was no non-executive director with responsibility for EOLC.

Outpatients and diagnostic imaging

Good



The hospital was previously inspected by the Care Quality Commission in November 2014 and outpatients and diagnostic imaging received a rating of 'requires improvement' for safe and good for the other domains of caring, responsive and well-led. At this inspection, we gave the outpatient and diagnostic services a rating of 'good' overall, however we rated the services as 'requires improvement' for safe. This was because: The previous 'requires improvement' rating was due to safety incidents not being communicated with the trust board. This has since been addressed, however other issues of concern were found.

Summary of findings

We had a control of infection issue in the eye clinic that was raised during the inspection. The trust responded quickly and an action plan to improve was put in place; however, some issues were not addressed.

At this inspection, we found the hospital performed well against national targets. Waiting times for appointments were better than average with 50% of patients receiving an appointment within five weeks of referral. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment.

There were a large number of appointment cancellations that had a variety of causes including IT issues and patients receiving multiple appointments in error. However, managers were gathering evidence and had set improvement targets

A large number of audits were performed to ensure patients received treatment in line with best practice guidance and there was evidence of collaborative working with neighbourhood trusts.

Some areas of mandatory training showed poor results and managers acknowledged that work was needed. When something went wrong, the outpatients and diagnostic departments responded well to patients and investigated the causes to make sure errors did not reoccur.

The outpatient improvement project was still progressing from 2014; changes had been made to the environment, clinical coding and staffing ratios. Phase four had been suspended due to staffing issues, which was to address the high cancellation numbers.

Southport & Formby District General Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Regional spinal injuries unit; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging services

Detailed findings

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Background to Southport & Formby District General Hospital

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

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

Urgent care for adults is provided at Southport and Formby DGH whilst children's urgent care services are provided from Ormskirk DGH. Acute care is provided at both hospitals and there were 23,084 admissions between September 2014 and August 2015 across the trust. There are 497 beds, 455 General and acute beds across the trust. Critical care services are provided through 15 critical care beds at Southport and Formby DGH. Maternity services are provided from 27 beds at Ormskirk District General Hospital.

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh;

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two Inspection Managers, 12 CQC inspectors, a CQC Pharmacy Inspector and a variety of specialists including Executive Director of Nursing & Quality; Senior Quality and Risk Manager; Head of Safeguarding; Race and equality expert; A&E Consultant;

Detailed findings

A&E Staff Nurse; Medical Consultant; Ward Manager in Medicine; Surgical Consultant; Theatre Manager; Critical Care Consultant; Advanced Nurse Practitioner; Paediatric Consultant; Paediatric Nurse; Outpatients Nurse; Retired Consultant in Palliative Care; EOLC Nurse - Director of Nursing; Consultant in Trauma & Orthopaedics; Consultant Nurse Orthopaedics; Occupational Therapist; Health Visitor.

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

How we carried out this inspection

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

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

The inspection team inspected the following six core services at the Southport and Formby District General Hospital.

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care

- End of life care
- Outpatients.

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

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

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

Facts and data about Southport & Formby District General Hospital

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

is mixed compared to the England average. Deprivation is about the same as the average and about 16% (3,250) children live in poverty. Life expectancy for both men and women is lower than the England average.







Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Regional Spinal Injuries Unit	Good	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Critical care	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided at Southport Hospital by the emergency department (ED) under the trust's Urgent Care Clinical Business Unit.

The ED operates 24 hours a day, seven days a week. The department saw 40,160 patients between April 2015 and January 2016, of which 1.5% (594) were children up to the age of 16 years. 36% of patients arrived by ambulance. On average, 132 people attend the ED each day.

Whilst the emergency department can provide care for patients suffering trauma, it is not a major trauma centre. More severely injured patients are therefore taken by ambulance or helicopter to the nearest trauma centre at local hospitals if their condition allows them to travel. If not, they are stabilised at Southport Hospital and then treated or transferred in line with their needs. Patients with spinal injuries can be treated on site at the hospital's regional spinal injury centre.

There is a designated entrance for patients brought in by ambulance. Patients arriving by ambulance wait to be triaged in a main corridor before being assigned to a suitable area. Ambulatory patients wait in a seated area and are called through to a triage room when appropriate.

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

Patients with minor illnesses or injuries are treated in one of three cubicles or one of three specialist rooms for deep

vein thrombosis, eye problems or limb injuries (a plaster room) between the hours of 7:30am and 10pm each day. After this time patients with minor injuries are cared for by nurses and medical staff in the majors area.

Patients with more serious illness or injury are seen and treated in the 'majors' area or in resuscitation bays. The majors area has 11 bays and the resuscitation area has four bays. Although the ED predominantly provides care for adults (the trust's paediatric ED at Ormskirk is available for children), one of the resuscitation bays is suitable for children.

The department also has a five bedded observation ward, predominantly run by advanced nurse practitioners.

During the inspection we spoke with five patients and carers and 26 staff from different disciplines including executive directors, doctors, matrons, nurses, emergency and advanced nurse practitioners, reception and domestic staff. We also reviewed 24 patient records and observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Urgent and emergency services

Summary of findings

In May 2015, urgent and emergency services at Southport Hospital were rated as requiring improvement. This was because we had concerns about equipment servicing, checking of controlled drugs, staffing levels, failure to meet Department of Health targets for providing care in a timely way and allegations of bullying from junior medical staff.

Following this inspection, we have again rated urgent and emergency services overall as requiring improvement. This is because:

- Although there was a culture of reporting and learning from incidents, staff did not have a focused approach to reviewing patient deaths (mortality).
- A storage room holding major incident equipment was visibly dirty with dust and debris on the floor. Whilst some major incident equipment was stored in an organised way, in one room we saw boxes of equipment piled on top of each other with no obvious labelling, and an unpackaged decontamination suit was found strewn across these boxes.
- Managers told us they did not audit patient records. This meant they were not able to assure themselves of good practice. We did find monthly audits relating to the use of clinical observations and early warning scores which were completed by trust wide audit staff. However only a small number (between four and ten) were reviewed each month which was not representative. When we reviewed records we found that tools to manage patient risks such as observations, risk assessments and early warning scores were not consistently recorded in patient records. We also saw an example of poor care where a patient experienced delays being monitored and receiving treatment for sepsis. This left us concerned that staff were not consistently using tools to help identify patients at risk of deterioration or identifying these risks themselves.
- Although national and local guidelines and care pathways were in place to support staff providing care, we found the use of the pathway for managing sepsis was limited and some elements of sepsis care were worse than the regional average.
- National audits were undertaken which highlighted poor performance in a number of areas, including the treatment of patients with sepsis and paracetamol overdose, mental health risk assessments and communication with carers of patients with cognitive impairment. Although some of the results were not dissimilar to the national average, senior medical staff acknowledged they were concerning. Despite this they agreed that sufficient action to improve care in these areas had not taken place.
- Mandatory and statutory training compliance was not meeting the trust target of 90%. Only 63% of medical staff and 77% of nursing staff were up to date with mandatory training and only 45% of medical and nursing staff were up to date with statutory training. This gave an overall figure for training in nursing and medical staff of only 58%. Figures provided for safeguarding training showed that low numbers of staff had completed level two and three training.
- Senior medical staff highlighted concerns regarding medical staffing levels and recruitment difficulties, particularly for middle grade doctors. This had been identified during our last inspection and remained a concern. Whilst consultants and locums worked to fill vacant shifts, some shifts were left understaffed. Doctors described feeling that staffing levels were unsafe at times. Although nurse staffing levels were usually in line with establishment, sickness levels were higher than the NHS national average.
- We found evidence of significant flow issues and significant delays for patients during our inspection. We saw patients waiting on corridors for up to five hours, with no privacy. This impacted on their dignity. Although nurses were present, assessment by medical staff was delayed until patients were moved to bays.
- During our previous inspection we identified that the department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours. This remained the case during this inspection. However additionally, we now saw that the department was above the England average for the time taken to complete initial assessments as well as the number of patients

Urgent and emergency services

waiting between four and 12 hours for admission following a decision to admit being made.

Re-attendance rates for patients were also worse than the national average.

- Staff liaised with a local mental healthcare team when caring for patients. However we were less assured that staff consistently undertook or evidenced assessments of mental capacity, particularly when administering medicine to patients under restraint.
- Staff were open to risk because of a lack of security arrangements on site.
- All the staff we spoke to felt leaders from the executive team were not supportive. Some described the culture as reactive, with actions taken 'too little, too late', rather than proactively addressing issues and improving performance.

However, we also saw elements of good practice. For example:

- Nurse staffing had improved and fill rates were adequate based on establishment requirements.
- Medicines and controlled drugs were managed and stored correctly. Pain was assessed and managed effectively and food and refreshment was offered to patients in the department.
- A new practice development facilitator had been recruited in April 2016 to improve the focus on training. Competency was being managed with the majority (all but two) of new staff undergoing formal trust induction. Appraisal rates met the trust target of 90%.
- Staff from different disciplines worked together to provide holistic care for patients. Processes enabled staff to report safeguarding concerns and seek advice when required.
- Some local audits were undertaken which helped staff identify good practice as well as areas for improvement.
- Services were available seven days a week. Staff could access all the information they needed in order to provide care for patients.
- Patients we spoke with were happy about the overall care provided by staff despite long delays. They felt involved in their own care and understood what was happening. They felt they were given enough privacy

during examination and treatment and that staff listened and discussed fears and anxieties with them. We saw evidence that staff provided continuing support to those who had lost a loved one under distressing circumstances by inviting them to the department to answer questions following their loss.

- Fundraising by staff enabled them to buy furniture for a newly refurbished relatives' room.
- Staff were familiar with the local population and changing needs over time. Services were available to meet individual needs such as translation, sign language, specialist nurses and a local mental health team. Written advice was also available about specific illness or injury. Complaints were monitored, and learning was shared amongst staff to help make improvements.
- Senior staff in the department had clear aspirations about the future with a strategy in place. Innovative work took place which supported the department by providing care to patients suffering trauma or alcohol misuse.
- The department worked to improve results following a CQC Accident and Emergency patient survey 2014 which reported key areas of concern. An action plan was in place and progress was monitored.
- Following our escalation of concerns during the inspection, staff formulated a comprehensive plan to provide assurance that care would improve. We saw that the plan was being implemented following our inspection with more patients being seen, treated or discharged within four hours, fewer ambulance handover delays and better staffing levels.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate



Urgent and Emergency services were rated as requiring improvement at the previous comprehensive CQC inspection in May 2015. However, following this inspection we have rated services as inadequate in relation to keeping people safe and protected from abuse and avoidable harm.

This is because:

- Although there was a culture of reporting and learning from incidents, staff did not have a focused approach to reviewing patient deaths (mortality). This led us to be concerned that there was limited measurement or monitoring of safety performance.
- A storage room holding major incident equipment was visibly dirty with dust and debris on the floor. Whilst some major incident equipment was stored in an organised way, in one room we saw boxes of equipment piled on top of each other with no labelling, and an unpackaged decontamination suit was found strewn across these boxes.
- Closed circuit television was in use but there was no obvious signage to inform people of this.
- Minimal numbers (no more than ten) patient records were reviewed each month in relation to the use of early warning scores. However, managers told us that no other audits of records were completed. This reinforced our concerns that there was limited measurement or monitoring of safety performance. When we reviewed records we found that tools to manage risks to patients such as observations, risk assessments and early warning scores were not always recorded in patient records. This led us to believe that patient risks were not managed as well as they should be and that safety was not a sufficient priority.
- We saw an example of poor care of a patient suffering with sepsis. Here we saw numerous delays providing care and treatment over a period of 16 hours.
- Mandatory and statutory training was in place. However following concerns identified during our previous inspection, the department was still not meeting the trust target of 90% compliance. Figures provided by the trust showed that on average only 63% of medical staff

and 77% of nursing staff were compliant with mandatory training and only 45% of medical and nursing staff were compliant with statutory training. This included advanced life support training, for which figures showed that no nursing or medical staff were compliant.

- Safeguarding training compliance was also low with only 30% of nurses and medical staff trained to level three standards. Figures for level two training were unclear. The trust did not sufficiently clarify this for us despite being asked.
- Senior staff raised concerns in relation to medical staffing levels and recruitment difficulties, particularly for middle grade doctors. We found evidence to support these concerns. Whilst consultants and locums worked to fill vacant shifts, doctors said 17 shifts between March and April 2016 had been understaffed and described feeling that this was unsafe because risks to people using services increased when staffing levels were less than they should be. Although nurse staffing levels met establishment, sickness levels were consistently higher than the NHS national average.

However:

- Following concerns identified during our previous inspection, we saw that medicines and controlled drugs were now being managed appropriately and stored correctly.
- A new practice development facilitator had been recruited in April 2016 which staff hoped would improve training compliance.
- There was a process in place which enabled staff to seek advice or report safeguarding concerns which staff were familiar with.
- The department had a comprehensive plan in place to reassure the inspection team following concerns about delayed care for one patient suffering with sepsis. The plan was implemented immediately and results showed improvements with more patients being seen, treated or discharged within four hours, fewer ambulance handover delays and better staffing levels.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Incidents were reported electronically. Staff received automatic email receipts following submission.

Urgent and emergency services

- Between October 2015 and January 2016, the department reported 120 incidents. Ninety-four of these were classed as resulting in low or no harm, seven as moderate harm, three as severe harm and two resulting in death. Fourteen incidents were classed as near misses. Eighty-five incidents were classed as affecting patients, with the remainder affecting staff. Incidents were reported regardless of cause, some of which were not necessarily attributable to the actions of staff in the department.
- Between February 2015 and January 2016 the trust recorded three serious incidents. These related to adverse media coverage, a delay in diagnosis and a medication incident.
- The medication incident was categorised as a never event. Never Events are serious incidents that are wholly preventable because guidance or safety recommendations to provide protective barriers are available and should have been implemented. The never event occurred because a drug which was meant to be given by mouth was instead injected into the patient's vein. We saw that a root cause analysis investigation took place following this incident, which included actions to limit future recurrence which was monitored through to completion.
- Learning following incidents was disseminated via meetings and bulletins.
- Debriefs took place following distressing incidents. Minutes from one debrief showed staff had an opportunity to discuss their feelings about the incident.
- Senior medical and nursing staff were aware of the Duty of Candour. This is a legal duty to inform and apologise to patients if there have been mistakes in care that led to significant harm. We saw examples of Duty of Candour being implemented when required.
- Mortality meetings were not held routinely. Senior medical staff explained these had stopped but instead patient deaths were discussed on an ad hoc basis during other meetings. Despite reviewing minutes of a number of departmental meetings, we found no evidence that mortality was discussed formally by department staff. Reviewing mortality helps promote learning and provides assurance that patients are not dying as a result of unsafe care. Without this, we were concerned there was a lack of assurance of safe care and that staff may not identify areas for improvement if required.

Cleanliness, infection control and hygiene

- The areas we inspected were visibly clean and tidy except for a storeroom containing general stock, including gloves and aprons, and major incident equipment. The floor was visibly dusty with debris around boxes of equipment.
- An infection control link nurse was assigned to the department. Link nurses act as a point of contact, sharing information between specialist teams and nurses in the clinical area.
- Monthly infection prevention and control audit reports were completed by the trust. We reviewed a number of these, which covered topics such as the incidence of hospital acquired infections; Clostridium Difficile (C-Diff) and methicillin-resistant Staphylococcus aureus (MRSA), hand hygiene compliance and commode cleanliness. Reminders about how to reduce infection were also included. The reports showed there were no cases of C-Diff or MRSA in the ED between September 2015 and February 2016. Hand hygiene audits were completed, with the exception of September 2015 and scores were 100% and commode cleanliness showed a 0% failure rate except in October 2015 when results indicated further cleaning was required. We saw evidence that the issue was referred to a senior nurse for immediate action.
- In the CQC Accident and Emergency patient survey 2014 patients rated the department 8.4 out of ten for cleanliness which was about the same as other trusts surveyed in England.
- Hand sanitizers and hand washing guidance was available throughout the department.

Environment and equipment

- Patients brought in by ambulance entered through a separate entrance from ambulatory patients which improved privacy and ensured staff were aware they were ambulance patients.
- The department was built to accommodate up to 21 patients on trolleys including 11 majors trolleys and four resuscitation trolleys. However, we saw examples when patient numbers rose to more than double this figure (at 4:30pm on one day, 46 patients were in the department with 32 patients requiring care in the majors area. At 10pm there were 48 patients in the department, with 33 patients in the majors area). When the department

Urgent and emergency services

reached full capacity, some patients had to wait in corridors until a suitable area could be found. At 2:30pm on one day there were six patients waiting on corridors. By 10pm this had increased to seven.

- Closed circuit television (CCTV) was used in areas such as reception, the outside ambulance bay, the rear entrance and the minors and majors areas. We saw no signage to warn people that they were under surveillance despite there being a legal requirement to do so. When we asked nursing staff about this they could not identify any signage either.
- There was a room specifically for mental health patients to wait for further assessment, care or treatment whilst in the ED. The room had a secure key code entry system, toilet facilities and no ligature risk points.
- During our previous inspection we identified there was no dedicated room for loved ones to wait in a quiet place, and following this inspection this remained an issue. Instead, loved ones were directed to the room designated for mental health patients. Should a mental health patient require use of the room, relatives had to wait elsewhere. However, following fund raising efforts, a new room for relatives was being organised. Furniture had been ordered and the room was expected to be ready by the end of May 2016.
- We examined adult and paediatric equipment in the ED which was checked weekly or after use. Some equipment was stored in 'grab boxes' to ensure equipment for specific procedures could be sourced quickly. Resuscitation trolleys housed specific equipment and records showed these were checked and re-sealed weekly. All the equipment we checked was within expiry date.
- Major incident equipment was stored in different areas of the ED including two locked cupboards, a secure store room and the main entrance. Whilst the equipment in the cupboards was stored in an organised way, the equipment in the secure storeroom was not. Here we found unlabelled boxes piled on top of each other which we were concerned would be difficult to reach quickly. We also found an unpackaged decontamination suit lying on top of other storage trolleys.

Medicines

- All the medicines and controlled drugs we checked were stored appropriately and within expiry date. Controlled drug usage was appropriately recorded. Medicines were restocked by trust pharmacy staff.
- Records showed that fridges used to store medicines at low temperature were checked daily and within the correct temperature range.
- Two medicine management link nurses worked in the department. This helped to maintain a focus on medicines and ensured staff had a point of contact for medicine related queries.
- Six nursing staff were trained to prescribe certain medicines in the ED. Other nursing staff used patient group directives (PGDs) to provide medicine for patients such as sodium chloride or medicine to treat hypoglycaemia (low blood sugar). PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. If nurses trained to prescribe were not on duty or unavailable, medical staff could prescribe medicines instead.

Records

- Patient records were in paper format and stored securely behind the reception area.
- We reviewed 24 patient records during the inspection. These were legible with information provided about the presenting problem, triage priority, date and time of attendance. Risk assessments were included in some records but not all. For example, mental capacity assessments were missing in two records, and a safeguarding risk assessment and a social circumstances assessment missing in a further two records.
- The matron explained that patient records were not routinely audited. However information provided by the trust showed that a small number of records (between four and ten) were audited each month which focused on recording clinical observations and early warning scores. These showed that between April 2015 and February 2016 records reviewed had a full set of observations, correctly calculated early warning scores and that staff completed flow charts when required. However we were concerned that small sample sizes may not fully represent overall compliance.
- The trust provided an additional trust-wide audit (dated April 2016) of patient records in the hospital. However

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only a few of these records related to the ED. The results concluded there was very limited assurance about record keeping standards across departments with only 13% of records demonstrating good practice. We saw that the trust had an action plan which included sharing findings with other senior nurses, reviewing areas of low compliance, and identifying areas for improvement by July 2016.

Safeguarding

- Staff used safeguarding flow charts to help ensure that vulnerable children and adults were cared for appropriately and referred to other agencies if required. These were visible on staff noticeboards providing clear instructions for staff to follow.
- Safeguarding children and adults training was mandatory with a compliance target of 90%. Staff completed one of three levels of training based on the level of contact with patients. NHS England guidance states that all non-clinical staff should complete level one safeguarding training and that nursing and medical staff should complete level two training as a minimum. Figures provided for clinical staff in the main ED showed that 91% of nurses were trained in level one adult safeguarding and 87% in child safeguarding. All nurses on the observation ward had completed level one adult safeguarding and 70% had completed level one child safeguarding. All nursing staff from the hospital alcohol liaison team had completed level one safeguarding for both adults and children. The figures provided for level two training were unclear. For example, only one nurse was included in the figures for 'nursing staff' (but showed compliance with level two training). No details were provided about how many medical staff had completed level two training. From the information provided about other staff groups, only 30% of reception staff, and 60% of observation ward staff had completed level two training. All allied health professionals and additional clinical service staff (healthcare professionals) were compliant (four staff in total). We asked the trust to provide clarity about level two figures but we did not receive this. However a report citing trust wide figures in January 2016, confirmed our concerns that not enough staff were compliant with the minimum requirement. This showed that only 58% of

trust staff were compliant with level 2A and 53% compliant with level 2B training, and only 65% of staff were compliant in level three. However, further level three training dates were scheduled for June 2016.

- Two safeguarding link nurses worked in the department to act as points of contact for staff and maintain specialist knowledge.
- During office hours staff could obtain advice from line managers and link nurses before making a referral to social services. Out of hours advice was available via the hospital bed manager or on call manager before making referrals to a social services emergency duty team.

Mandatory training

- Training was described as mandatory or statutory depending upon the topic. Mandatory training topics included hand hygiene, infection control and information governance. Statutory training topics included resuscitation, consent, Mental Capacity Act and Duty of Candour. Personal training compliance could be viewed by each staff member via the intranet.
- Practice development facilitators, link nurses, the matron and the ED manager worked to ensure staff training was up to date and reminders to complete training were seen in senior staff meeting minutes. However, we found pockets of low compliance in some areas, against a trust target of 90% (95% for information governance training).
- Figures provided by the trust showed that only 63% of medical staff and 77% of nursing staff were up to date with mandatory training and only 45% of medical and nursing staff were up to date with statutory training. Compliance was lowest for; advanced life support (0% of staff) and food hygiene (0% of nursing staff).

Assessing and responding to patient risk

- Processes were in place to manage potential risks for patients. These processes helped staff assess the condition of patients and prioritise the order in which they were cared for. For example, baseline clinical observations were taken and the Manchester Triage System (MTS) and Early Warning Score (EWS) systems were used. Abnormal clinical observations can indicate early deterioration in patients. The MTS is a clinical risk management tool used worldwide to prioritise patients based on how unwell they are and how quickly they need to be seen. EWS systems analyse clinical

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

- The time taken to initially assess patients was found to be in line with the England average and better than the Department of Health target of 15 minutes with an average time of five minutes between February 2015 and April 2016. However, despite this, a review of records during the inspections showed that processes to assess patients were not routinely used in a timely way. Here, we found that out of 16 patients, nine waited more than 15 minutes for initial observations to be taken and five patients waited longer than one hour. EWS scores were not recorded in four records and in ten other records, EWS score calculations were delayed by longer than 15 minutes. One patient waited over two hours for a EWS score to be calculated and another waited three hours 40 minutes. One patient waited the longest with a delay of four hours 48 minutes to take initial observations or calculate a EWS score.
- We reviewed the clinical record of the patient who waited longer than four hours for initial clinical observations. We found that as well as delays taking initial observations and calculating an early warning score, there were delays in administering antibiotics and, organising a medical review. Sadly the patient passed away. We escalated our concerns about the care this patient received to the trust executive team. They took immediate action to review the care provided and formulated an action plan to improve care for other patients. The actions included assigning a lead 'sepsis' doctor to each shift, introducing patient safety nurses to improve compliance with clinical pathways and timely observations, organising further training, and increasing the number of staff available to triage patients upon arrival.
- In addition to delays assessing patients, the department did not operate using a rapid assessment and treatment (RAT) model or use senior medical intervention during initial patient assessments. RAT models and early senior medical intervention can help ensure treatment starts early rather than completing triage, medical assessment and treatment as separate processes.
- Risks to patients can increase if ambulance handovers are delayed. Handover times should not exceed 30 minutes and delays of over 30 minutes and 60 minutes were monitored. Between February 2015 and March

2016 the trust reported an average of 224 delays between 30 and 60 minutes each month and 106 delays of over 60 minutes each month. The majority of delays were reported as occurring because there were no available beds in the hospital leading to patients unnecessarily remaining in the ED. Senior medical staff described this as 'exit block', explaining that egress out of the department was inadequate and had been for the last two winters, and that staff turnover at board level had made long term planning more difficult.

Nursing staffing

- The ED assigned different grades of nursing staff to areas of the ED in an organised way. Emergency Nurse Practitioners (ENPs) were assigned to the minors area, one nurse was assigned to every four patients in the majors area and one nurse cared for every two patients in the resuscitation area.
- Nursing establishment was calculated using a draft staffing tool formulated by the National Institute of Health and Care Excellence (NICE) as well as experience based judgement to assess staffing requirements. This determined a requirement for eight nurses on early shifts, nine on late shifts and seven during the night whilst one ENP staffed the minors area. Three health care assistants (HCAs) worked on early shifts, three worked on late shifts and two worked during the night.
- Fill rates helped managers review whether staffing met the establishment level. Between October 2015 and February 2016 the average fill rate for nurse staffing during the day was 99% and at night was 103%. For healthcare assistants the rates were lower; 82% during the day and 74% at night. However, six new healthcare assistants had been recruited since February.
- There were four nurse vacancies at the time of our inspection. Interviews were in progress with one nurse recruited so far. Staff told us nursing applicants were not always suitable which slowed the recruitment process.
- Gaps in nurse staffing were filled with agency or bank staff. Between April 2014 and March 2015, an average of 8.5% nurses in the ED were agency and bank nurses.
- Sickness absence rates were monitored. Between April 2015 and March 2016 the average sickness rate for nurses was 7%. This was above the average sickness rate for NHS staff nationally of 4.2% (between May 2015 and March 2016). Staffing and sickness issues were discussed at senior team meetings every two to four months.

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- Nursing handovers took place three times daily. We observed one handover where details were passed from early shift to late shift staff about patients in the department, available beds in the department and wider hospital, recent incidents and deaths in the department. A handover document was signed by nurses providing and receiving handover information. However, we were concerned that the handover took one and a half hours to complete, in a very busy area of the department which led to frequent interruptions. This made the process appear inefficient and time-consuming. Furthermore, when we asked staff about specific patients following handover, they were unable to provide details which led to further concerns about whether staff were retaining the information handed over to them in this way.

Medical staffing

- Consultants worked between 8am and 10pm Monday to Friday and between 9am and 6pm at weekends. Four consultants were employed but six were required, leaving two vacancies. Middle grade doctors worked in the department 24 hours a day, seven days a week. Five middle grade doctors were employed against an establishment of 6.5.
- Five staff grade doctors were employed which was in line with current establishment. However one of these was supernumerary until the end of April 2016 and we saw written evidence that a senior consultant recommended at least eight and ideally ten doctors of this grade be employed, (based on guidance by the Royal College of Emergency Medicine)
- There was one trainee doctor but no senior trainee doctors (trainee doctors in year four, five or six of training). Senior trainee doctors can ease the pressure on consultants because they have more experience than newer trainees.
- Vacancies were filled by locums or consultants. The average locum rate between April 2014 and March 2015 was 22%. Senior medical staff told us that efforts to recruit trainee doctors were made, often with little success. This was because the trust had only been accepting trainees since 2010, which meant many had been assigned elsewhere. More trainees were expected to move into the deanery system in 2018 which medical staff hoped would improve the situation.
- Since September 2015 three middle grade doctors had left employment or were absent through sickness, causing gaps in the rota. Gaps were being filled by locums or consultants who worked flexibly. We saw that consultants covered middle grade shifts three times in April, and twice in March 2016. However despite efforts, five shifts in March and 12 shifts in April 2016 remained uncovered by middle grade or consultant staff. Five of them were filled by junior doctors with the others remaining uncovered. One doctor told us that all avenues to cover the shifts were exhausted and acknowledged that on some days staffing felt unsafe for patients.
- When medical staffing was low, administrative duties such as reviewing x-ray reports and writing discharge summaries ceased, causing back logs of work. We were shown approximately 60 patient records awaiting written discharge summaries.
- Senior medical staff described medical staffing as a 'significant concern', particularly in relation to middle grade staffing. In March 2016 a senior consultant wrote to executive directors to formally document the issues. Despite us asking the trust to provide evidence of associated actions, none was provided which raised concerns that no action had taken place to address the concerns raised.
- Staff were hopeful that the situation would ease in May 2016 when a new locum would begin work and another doctor who was supernumerary would begin filling a substantive role.
- The sickness rate for medical staff between April 2015 and March 2016 was 2.4%, which was below the NHS average sickness rate of 4.2% (between May 2015 and March 2016).
- Staffing and sickness were discussed at senior team meetings held every two to four months.
- Handovers took place on a twice daily basis. We attended a morning handover meeting which was attended by consultants and middle grade staff but not by junior doctors.

Major incident awareness and training

- The trust had an up to date policy and plan for major incidents, including pandemics.
- Major incident action cards were used which provided clear instructions about staff roles should a major incident be declared.

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- Two major incident link nurses worked in the department. Link nurses have extra knowledge about topics which enables them to share learning with staff and act as a point of information.
- Scenario based training took place for on-call managers and mandatory training was provided for all other staff. However, only 20% of medical staff and 43% of nursing staff had completed the training against a target of 90%. The trust told us one of the link nurses assigned to review and initiate training in the department was instead assigned back to their nursing role in the department because it was so busy. This meant staff were not yet trained to use the latest procurement of chemical incident suits or a decontamination tent.
- A 'train the trainer' day was scheduled for May 2016 which would help ensure staff could train their colleagues internally.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



In May 2015 we rated urgent and emergency services as good for providing effective care. However following this inspection we have changed the rating to requiring improvement. This is because;

- Although national and local guidelines and care pathways were in place to support staff providing care, we found use of the pathway for managing sepsis was limited and some elements of sepsis care were worse than the regional average.
- National audits were undertaken which highlighted poor performance in a number of areas. Although some of the results were not dissimilar to the England average, senior medical staff acknowledged the results were concerning. Despite this they also agreed that sufficient action to improve care had not taken place. Some local audits were undertaken but we were not assured that results were consistently shared with staff providing care because there were no established regular meetings where learning could take place.
- The department monitored re-attendance rates for patients which were consistently higher (worse than) than the national average.
- Staff liaised with a local mental healthcare team to ensure patients with mental healthcare needs received appropriate care. However we were less assured that staff consistently measured or evidenced assessments of mental capacity, particularly when administering medicine to patients under restraint.

However;

- Competency was managed with the majority (all but two staff between April and October 2015) of new staff undergoing formal trust induction. Appraisal rates met the trust target of 90%.
- Pain was assessed and managed effectively. Food and refreshment was offered to patients in the department.
- Staff from different disciplines worked together to provide holistic care for patients. Services were available seven days a week and staff had access to systems which enabled them to provide care and treatment to patients.

Evidence-based care and treatment

- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) to help manage a range of issues such as acute myocardial infarction (DG15). Guidelines were accessed on the intranet with some copies in folders at the main nurses' station or on a staff noticeboard.
- Staff also had access to local care pathways such as the sepsis pathway. These were based on national guidance. Updates to pathways were disseminated in meetings and promoted through staff notices from the risk and governance team. However we found examples where the use of pathways was not always evident. For example, we saw three patient records where despite treatment being provided for sepsis, there was no record of the pathway being officially implemented. We found evidence in a staff notice issued by the risk and governance team in December 2015, of a fourth patient for whom staff did not implement the sepsis pathway.
- Following this we looked for evidence of any local audits to measure the use of the pathways. We saw that the trust had audited the care of sepsis patients and compared this with national performance. Results showed that between February 2015 and January 2016 Southport ED performed better than the regional average in three areas (taking blood cultures within three hours, administering second litre fluids and providing oxygen therapy within four hours of

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admission). However they performed worse than other centres regionally in ten other areas; assessment by critical care staff within four hours occurred in only 19% of patients compared to a regional average of 41%, antibiotics were administered within three hours in only 63% of patients compared to 71% regionally and the overall figure for appropriate care was 33% for patients compared to a regional figure of 46%.

- We found evidence of other local audits such as monitoring the time taken to take computerised tomography scans for patients following trauma or head injury. Results showed these were done on average within 62 minutes (for trauma patients) or within 49 minutes (for head injury patients). The target for both of these was 60 minutes. A major trauma coordinator nurse worked with staff internally to promote learning and support staff caring for trauma patients.
- The hospital alcohol liaison team (HALT) audited the use of a care pathway for patients. Results showed that between August 2015 and April 2016, the risk of alcohol withdrawal was assessed within four hours in 77% of eligible patients, early warning scores were recorded within one hour in 95% of patients and all patients seen by the team were seen by or referred to other teams prior to discharge from hospital.

Pain relief

- Pain was assessed using a score based system where zero indicated the patient had no pain and ten indicated the patient was experiencing significant pain. This allowed staff to quantitatively measure the level of pain experienced by patients and provide appropriate pain relief, if required.
- We reviewed five records in relation to pain. Four of these records showed that pain was assessed with analgesia provided when required. However, one patient was provided with pain relief (paracetamol) but no pain score was documented in the notes.
- In the CQC Accident and Emergency (A&E) patient survey 2014 the ED scored 6.3 out of ten for how long it took to receive pain relief medication after making a request, and seven out of ten for feeling that staff worked to help control pain. This was about the same as other trusts surveyed in England.

Nutrition and hydration

- In the CQC A&E patient survey 2014, the department scored seven out of ten for patients feeling able to get suitable food or drinks in the department which was about the same as other trusts surveyed in England.
- During a busy afternoon where a number of patients were waiting in a corridor, we saw that food and refreshments were offered regularly.

Patient outcomes

- The trust participated in three yearly national audit programmes by the Royal College of Emergency Medicine (CEM) for consultant sign off (2013), severe sepsis and septic shock (2013/14), paracetamol overdose (2013/14), mental health in the ED (2014/15) and assessing for cognitive impairment in older people (2014/15).
- The audit for consultant sign off reviewed how often patients were seen or discussed by a senior doctor or consultant. The audit reviewed 50 patients who, according to CEM standards, should all have been seen or discussed by senior doctors or consultants. The results showed that senior doctors saw only 26% of these patients (lower than the national average of 48%). Consultants saw only 16% of these patients (comparable with the national average). A higher proportion of senior doctors and consultants reviewed patients by way of discussion with colleagues; 53% of senior doctors (in line with the national average) and 37% of consultants (better than the national average of 10%) discussed these patients.
- The audit of severe sepsis and septic shock showed that vital signs were measured and recorded in only 66% of patients against a national target of 100% (lower than the national average of 94%), high flow oxygen was initiated in only 58% of cases against a target of 100% (better than the national average of 45%) and only 34% of patients received antibiotics within one hour of arrival against a target of 50% (comparable to the national average).
- The audit for paracetamol overdose showed that out of 47 patients reviewed, none received plasma level tests or a drug called N-acetylcysteine (a medication used to treat paracetamol overdose) within one hour of arrival against a target of 100%. Despite this being a poor result, it was in line with the national average which was also zero.
- The audit for mental health in the ED showed that, whilst all patients had a history of previous mental

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health issues recorded in their record, only 58% of patients had a risk assessment completed and recorded in their record against a target of 100% (in line with the national average) and only 26% had details of referral or follow up arrangements recorded (lower than the national average of 71%).

- The audit of assessing cognitive impairment in older people showed that assessment of cognitive impairment was only completed in 36% of 100 patients reviewed. Whilst communication with services took place in 100% of all admitted patients, communication with carers was only documented in 6% of cases. Despite these low numbers, the results were generally above the national averages which showed that 11% of patients underwent assessments for cognitive impairment, and zero cases of communication with carers were documented.
- Senior ED medical staff acknowledged the findings were concerning. They told us that actions to improve services following these audits had either failed to occur due to limited capacity or if implemented, did not get to the heart of the issues identified. For example the only action following the audit for paracetamol overdose was to re-audit. We were concerned that re-auditing would only repeat findings rather than identify areas of improvement.
- A practice educator had been recruited in April 2016 and senior staff felt assured there would be a new focus to address issues identified in audits such as educating staff about the importance of timely treatment. In the meantime senior staff said they were assured of good practice by reviewing other measures such as trends in complaints and incidents.
- The department did conduct some local audits to measure outcomes. For example an audit measuring the effectiveness of three hour troponin tests (to measure levels of protein in the blood which are released when the heart muscle is damaged) compared to six hour tests undertaken in July 2015. This showed that three hour tests were appropriate and meant patients could be discharged earlier rather than waiting for six hour tests.
- An audit of outcomes for patients requiring non-invasive ventilation was in progress at the time of our inspection as well as an audit to measure outcomes for adults undergoing procedural sedation in the ED, and another audit to measure renal colic care.

- The trust also monitored how many patients unexpectedly re-attended the ED within seven days of discharge. It is good practice for less than 5% of patients to re-attend the ED. Between January 2013 and October 2015, between nine and 13% of patients re-attended. This was consistently higher (worse than) the England average which varied between seven and eight percent.

Competent staff

- Processes were in place to ensure staff were competent and able to fulfil their roles in the ED. For example, new nursing staff underwent a trust induction. Records showed that all new staff starting in April, July, September and November 2015 completed the induction. However 50% of staff starting in May 2015 (one out of two staff) and the single staff member starting employment in October 2015 did not undergo induction. No new staff commenced employment in June or August 2015.
- Consultants acted as clinical supervisors for medical staff on placement in the ED. This involved meeting with trainee doctors regularly and monitoring educational progress throughout their ED placement.
- Staff received appraisals via their line manager each year. Records showed that 93% of staff were up to date with appraisals in January 2016.
- There were opportunities to develop professionally and this was discussed at senior team meetings held every two to four months. For example, some staff opted to act as link nurses which allowed them to develop specialist knowledge in areas such as wound care, manual handling, infection control and major incidents. However, three nurses told us there were insufficient resources to allow development in their roles. Staff were not supported to develop to emergency or advanced nurse practitioner roles. We saw an example where pressures in the department had led to a major incident link nurse being unable to fulfil the role.
- Learning was shared to ensure competencies were consistent in the therapy team. Here, staff met monthly and discussed individual patient stories, care and treatment ensuring everybody benefited from individual staff experiences.
- Staff in the hospital alcohol liaison team (HALT) compared competencies and levels of confidence in

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staff both before and after completing specialist training in ambulatory detoxification for eligible patients. The results showed that both competency and confidence improved markedly.

- Nurse revalidation was discussed at team meetings. Here, staff were reminded about the importance of building portfolios and maintaining a focus on reflective practice as part of revalidation.

Multidisciplinary working

- A range of nurses and medical staff with specialist knowledge worked in the ED to provide holistic care for patients. These included specialist nurses for alcohol misuse and trauma care. These specialist staff formed the hospital alcohol liaison team (HALT) and the role of trauma nurse coordinator.
- The HALT supported patients and staff in the ED by providing specialist care for eligible patients and working with other local agencies to support patients in the community. The trauma nurse liaised with staff both within the trust and regionally within established trauma networks to support trauma patients, facilitate repatriation and provide training.
- The department was also supported by the trust's 'therapy' team consisting of occupational therapists, a physiotherapist and a therapy assistant. Here staff acted as a link between the hospital and patients being discharged following trauma or injury. The team also formed the department's Thoracic Wall Injury Support Team (TWIST), who undertook home visits to review patients who had suffered thoracic wall injuries which helped avoid unnecessary admission or to enable patients to be discharged more efficiently.
- Staff also worked in partnership with staff from the local psychiatric team ensuring specialist care provision for mental health patients. We saw staff working with the team to provide care for a patient in the ED. They reviewed the patient with a plan to return later for review prior to discharge. When the patient became unwell, the team were requested to re-attend and arrived shortly afterwards.
- We also saw evidence of links between the department and the paediatric ED based in Ormskirk. For example, paediatric staff were transferred to assist the department and provide ongoing support following the arrival of a seriously ill child.

- Collaborative work was also in progress with a local specialist hospital to improve the care of patients suffering head injury. Staff involved with this work hoped to begin a clinic for patients with minor head injury in the future.

Seven-day services

- The ED was open 24 hours a day seven days a week, 365 days per year.
- Some services within the ED were available seven days per week. The hospital alcohol liaison team operated between 8am and 8pm between Monday and Friday and 9am until 5pm at weekends. The Therapy team also operated seven days a week.

Access to information

- Staff accessed IT systems to source information about patients and capacity within the department. The systems held details about the number of patients in the department, numbers waiting to be seen, those in the department for longer than four hours and showed plans to admit or discharge patients.
- A Picture Archiving and Communication system (PACS) allowed designated staff to view scans of patients taken anywhere in the region.
- Staff sourced specialist information for topics including major incidents or safeguarding from link nurses based in the department.
- Noticeboards displayed information to help staff care for patients. Information included contact telephone numbers for care coordinators, and interpreters, reminders about screening patients for certain types of infection, skin care protocol and the body mass index chart.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff worked in line with the principle of implied consent when caring for patients who were able to make decisions. For those unable to make decisions about their care (for example, unconscious patients) decisions were made in line with best interests.
- For patients receiving care under the Mental Health Act, staff liaised with the local mental health team who undertook assessments and initiated care plans for patients if necessary.
- The trust had a process for assessing mental capacity. Forms were available for staff to complete so that

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information relating to an assessment could be recorded. If a patient lacked capacity, staff could complete a separate form to record care given in a patient's best interests.

- We reviewed five records of patients requiring mental capacity assessments. In two of these records we found that capacity assessments had not been completed. Instead, notes had been recorded. We were particularly concerned that a capacity document had not been completed for a patient who was restrained and given medicine whilst in the department. We saw no evidence that the patient had consented or lacked the capacity to consent to this treatment. We discussed this with the matron who confirmed that documentation which should have been completed was not. She confirmed she would be taking immediate action to speak with the staff involved to ensure learning took place.
- We saw that capacity tests and Deprivation of Liberty Safeguards (DoLS) were discussed during team meetings. Minutes provided evidence that staff were reminded about the process for completing capacity assessments and action should tests be challenged by medical staff.
- Between September 2015 and March 2016 the department made four DoLS applications. However, the trust were unable to report whether these were authorised or declined, citing issues with other agencies which they reported were beyond their control. However, they also provided evidence to show that plans being put in place to address this.

Are urgent and emergency services caring?

Good



Following our inspection, Urgent and emergency services have retained the previous rating of good for caring. This is because;

- Patients we spoke with were happy about the overall care provided by staff despite long delays.
- Patients felt involved in care and understood what staff told them about their treatment. They felt they were given enough privacy during examination or treatment and that staff listened and discussed their fears and worries with them.

- We saw evidence that staff provided continuing support to those who had lost a loved one under distressing circumstances by inviting them to the department to answer any remaining queries following their loss.

However;

- We saw a number of patients waiting on corridors in public areas which we were concerned impacted on their privacy and dignity.
- Results from the NHS Accident and Emergency (A&E) friends and family test fluctuated but at times only 70% of patients stated they would recommend the department to friends and family. However, the response rate was low, making results less reliable.

Compassionate care

- Due to delays in the department, we saw occasions when patients waited in corridors and areas accessible to patients and visitors. We were concerned about the lack of dignity and privacy for these patients, especially those wearing nightwear.
- However in the CQC A&E patient survey 2014 the trust scored 7.9 for the overall care provided in the ED and 9 out of ten for patients feeling they were given enough privacy when being examined or treated in the ED. This was about the same as other trusts surveyed in England.
- We spoke to five patients and one carer in the department who spoke highly of their care but described being unhappy about the delays they were experiencing. They acknowledged that the staff were very busy but described the delays as 'rubbish' and they 'always have to wait'.
- In the CQC Accident and Emergency (A&E) patient survey patients scored the department three out of ten for keeping people informed about how long they would have to wait to be examined. This was worse than other trusts surveyed in England. However, patients also scored the department eight out of ten for length of time spent waiting with an ambulance crew before being handed over to ED staff which was in line with the England average.
- The department participated in the NHS Accident and Emergency (A&E) friends and family test survey. Between February 2015 and January 2016 an average of 79% of people stated they would recommend the ED to friends or family. This was below the England average.

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Understanding and involvement of patients and those close to them

- In the CQC A&E patient survey 2014, the department scored 7.8 out of ten for feeling as involved as they wanted to be in decisions about care or treatment, and 8.2 out of ten for feeling staff explained their condition, test requirements and treatment in a way they could understand. Both these scores were about the same as other trusts surveyed in England.
- We spoke with one carer with a patient, who told us that she was aware of and understood her relative's care plan.

Emotional support

- In the CQC A&E patient survey 2014, the department scored 8.8 out of ten for patients feeling doctors and nurses listened to what they had to say and 7.2 out of ten for patients feeling that staff discussed anxieties and fears about their condition or treatment.
- The department scored 6.6 out of ten for patients feeling reassured by staff when they were feeling distressed in the ED.
- All of these scores were about the same as the other trusts surveyed in England.
- We saw evidence that staff invited those who had lost loved ones under distressing circumstances to come back to talk about the care provided. This ensured they received support when dealing with their loss.

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

Requires improvement



Following a rating of requires improvement in the May 2015 inspection report; we have again rated urgent and emergency services as requiring improvement under the responsive domain. This was because:

- The department was still experiencing significant flow issues with significant delays for patients occurring regularly.
- Following our previous inspection where we found the department was below (better than) the England

average for number of patients waiting between four and 12 hours for admission following a decision to admit being made, we found that the department was now above (worse than) the England average.

- Following findings that the department was not meeting the Department of Health target to admit, treat or discharge 95% of patients within four hours during the last inspection, we found that the target was still not being met during this inspection.
- Where the total average time spent in the department was found to be below (better than) the England average previously, we found that it was now consistently higher (worse) than the England average following this inspection. The average time taken to provide treatment was also consistently above (worse than) the Department of Health target of 60 minutes.

However:

- Staff were familiar with the needs of their local population as well as changing needs over time.
- Services were available to meet individual needs such as translation, sign language, specialist nurses, a local mental health team and leaflets for specific illness or injury.
- Complaints were monitored, and learning was shared amongst staff to help make improvements.

Service planning and delivery to meet the needs of local people

- Staff were aware of the needs of the local population and that these needs were changing. They described the majority of patients attending with minor problems in the past but said this had changed, with a greater proportion of patients now requiring care in the majors and resuscitation areas.
- Senior consultants told us elderly patient care (frailty care) accounted for approximately 25% of their work. In response to this, a specialist 'therapy' team had been set up to better manage frailty care. The team consisted of occupational therapists, a physiotherapist and two therapy assistants.
- In the department itself, we saw adequate seating in the waiting area where toilets and hand washing facilities were also available. Vending machines were fully stocked with drinks and snacks. Minimum wait times were displayed electronically and a noticeboard also displayed more specific wait times.

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Meeting people's individual needs

- A telephone translation service was available for patients or visitors whose first language was not English. Sign language was also available.
- Mental health liaison staff were available upon request 24 hours every day to provide specialist care for patients. However, a registered mental health nurse was not based in the department. The trust described this as a risk because it did not meet National Institute for Health and Care Excellence (NICE) guidance (CG25). We saw this listed on the departmental risk register with actions to try to control the risk such as having on call support available at all times.
- Specialist alcohol liaison nurses were based in the department to provide targeted care for patients affected by alcohol misuse. However they were not available during the night. Details of patients requiring assistance were handed over to the nurses when they commenced duty each morning.
- A range of leaflets were available for staff to give to patients as a reference after they left the ED, for example, information about head or arm injuries.
- Staff were familiar with patients with learning disabilities or complex needs. They told us these patients were usually accompanied by carers who were familiar with a patient's individual needs.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The department failed to meet this target between February 2015 and April 2016. The average percentage of patients admitted, transferred or discharged within four hours was 76.7% with the lowest percentage in of 53.2% in March 2016. The figures fluctuated between being below (worse than) and above (better than) the England average over this time.
- The number of patients waiting between four and 12 hours from the point of decision to admit and actual admission was generally above (worse than) the England average between February 2015 and April 2016. During this time an average of 195 patients each month waited between four and 12 hours.

- The total average time patients spent in the department between February 2015 and April 2016 was three hours and 46 minutes which was higher (worse) than the England average of between two hours ten minutes and two hours 20 minutes.
- The Department of Health target for time taken to provide treatment is 60 minutes. Between February 2015 and April 2016, the time taken by this department ranged between 52 minutes and five hours four minutes with an average time of one hour 42 minutes which was above (worse than) the England average of 50 minutes.
- The minor, major and resuscitation areas could accommodate 21 stretcher patients but we saw occasions when more than double this number were being accommodated. For example, at 2pm on one day during our inspection we saw 52 patients in these areas. At 10pm we observed 33 patients receiving care in majors and resuscitation bays that were built to accommodate 15 patients.
- When patient numbers rose beyond capacity some waited on corridors. This caused delays in medical assessment until patients were assigned to an appropriate area. At 2:30pm we saw seven patients waiting in wheelchairs or on stretchers in a corridor until suitable space became available. One of these patients had been waiting since 9:45am. Some of the patients for whom space had been found, also waited a considerable time. For example, we saw one patient who had been in the department for 17 hours; two others had been there for 14 hours and another for 13 hours. A senior nurse described the situation as 'busy but normal'. This impacted on patients because staff became overwhelmed by the number of tasks associated with having so many patients to care for. When we arrived in the department at 2:30pm on one day, we were concerned about the pressures the department was under and alerted executive staff about our concerns. They immediately attended to provide support. Actions included sourcing extra physicians to support staff, locating available beds in the hospital and assigning a consultant solely to assist with the triage process. By 4:30pm there were three patients waiting on the corridor and 46 patients in the ED. A senior member of clinical staff expressed disappointment that action had only occurred following our request, and that they had asked for assistance on a number of occasions that morning but received no response from the senior management team.

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- Staff reported that there was no formal escalation policy in place specifically for the ED at the time of inspection. However, following our inspection we saw a new ED escalation policy had been written (April 2016). This gave clear instructions about when escalation to senior managers was required. For example, red status was defined as; more than four ambulances queuing to handover patients or having 31 to 40 patients in the department at any time. Black status was defined as; more than six ambulances waiting and more than 41 patients in the department. During our inspection we saw the department experiencing what the policy defined as 'black' status.
- The department had access to an observation ward. The ward had space for 12 patients with six beds, two side rooms and four chairs. Patients requiring short term observation for medical and surgical problems such as head injury or low-risk chest pains were cared for here. However we noted that these beds were not always available to ED patients. At 8am one morning a bed coordinator confirmed that there were five 'outlier' patients on the ward (patients that were accommodated in the observation ward because more suitable areas of the hospital were full). Staff responsible for coordinating beds confirmed that it was not unusual for 'outlier' patients to be accommodated in this ward.
- Trust bed meetings were held each day and bed coordinators visited the department each weekday morning to source updates about patients waiting for discharge or beds and ensuring actions were implemented.
- We saw other supportive initiatives in place. For example, the department's therapy team supported patients, undertaking clinical assessments at home rather than patients having to remain in hospital. The hospital alcohol liaison team (HALT) worked to reduce the number of frequent attendances that could be better managed in other ways. They also assisted ED staff by attending to help individual patients by request.
- Complaints were discussed at daily 'staff huddle' meetings where learning was shared. Staff were reminded of good practice such as record keeping, in order to reduce complaints and improve the process for investigating them effectively.

Are urgent and emergency services well-led?

Requires improvement



In May 2015 we rated urgent and emergency services as being good in the well led domain. However, following this inspection, we have changed this rating to requiring improvement. This is because:

- Risks, issues and poor performance were not always dealt with effectively. For example, staff were put at risk because of a lack of security arrangements on site. A number of incidents recorded by staff showed that they were experiencing problems such as physical aggression. Emergency nurse practitioners felt particularly vulnerable during periods of lone working at night.
- Performance management did not always operate effectively. For example, quality measurement was limited and where national audits identified poor practice, action was not robust enough to ensure improvement.
- Staff satisfaction was mixed. Staff described a lack of opportunity to develop and a lack of executive presence to support and manage flow issues day to day. They felt support from executive leaders was not evident despite requests and described a reactive culture where if actions were taken, they came 'too little, too late'.
- Although there was a strategy in place, nurses we spoke to were not aware of it, or any other plans to manage flow or achieve goals.

However:

- Following allegations of bullying following our previous inspection, junior medics reported that this was no longer an issue.
- Innovative work meant the department was supported in providing care to patients suffering trauma or alcohol misuse.

Learning from complaints and concerns

- Between February 2015 and January 2016 the ED received 74 complaints and 50 compliments. In relation to complaints, 19 related to staff attitude and 38 related to clinical care.

Urgent and emergency services

- Following the CQC Accident and Emergency patient survey 2014, the department had worked to improve the key areas of concern highlighted. An action plan was in place and progress was monitored.

Vision and strategy for this service

- Senior members of the ED team wanted the service to be better for patients, where no patients waited on corridors, could be transferred to the right ward in a timely way and have a good experience whilst receiving care in the ED.
- Some of these aspirations fed into the department strategy called 'urgent care – reducing the pressure'. Written in March 2016, the strategy listed objectives and outcomes for improvement. These included re-organising the current model in the ED to incorporate GP out of hours services, ambulatory, and surgical assessment care and working with the local ambulance service to ensure no patient handover would take more than 30 minutes. The target to reach these goals was March 2017. However nurses told us they were unaware of any long term planning to manage flow or visions for the future.

Governance, risk management and quality measurement

- The directorate had a risk register in place to identify risks within the department. Information such as the date the risk was first entered; responsible staff member, description, risk rating and mitigating actions were all included.
- Directorate governance reports were completed monthly, with findings presented in a dashboard. Figures showed the frequency of identified infections each month such as clostridium difficile (C-Diff and MRSA), patient falls, staff training figures, performance in relation to department of health targets, complaints and compliments.
- Governance meetings took place monthly where senior ED staff, and staff managing risk, and audit departments discussed topics such as staffing levels, complaints, incidents, policy reviews and audit progress. However we saw limited measures in place to measure quality in terms of reviewing practice (through mortality meetings, or auditing records) or taking action when poor quality was identified through the national audit process.
- At the time of our inspection security staff were not employed by the trust but were due to be

commissioned in April 2016. Prior to this staff were dependent upon police assistance via 999. An external review of security in December 2015 concluded that "relying on police support does not provide a viable long term solution". We saw that between October 2015 and January 2016, 16 incidents describing violence or aggression towards staff were recorded, eight of which required police assistance. The incidents described verbal aggression, physical assault such as punching, restraining and throwing objects and sexual assault.

- Whilst the trust had an up to date lone worker policy in place, emergency nurse practitioners employed in the minors area expressed concern that they often worked alone between 7pm and 10pm and felt more at risk during these times. We saw that the issue had been entered onto the risk register along with actions to reduce the risk such as assigning healthcare assistants to the minors area when possible. However staff told us this was only possible on an occasional basis because healthcare assistants were not routinely available.
- Reception staff had access to panic buttons should they require urgent assistance. However, until security arrangements improved they were reliant upon colleagues for support or police attendance should an incident occur.
- Despite this, staff in the therapy team worked to ensure staff were safe when visiting patients at home. We saw minutes of meetings where staff formulated a code phrase to use should they require assistance visiting patients.

Leadership of service

- Staff described feeling supported by colleagues in the department but none of the staff we spoke to felt supported by executive staff. Senior staff said executives only visited the department if something had gone wrong despite making requests for support during busy periods.
- Senior consultants told us they had written to the executive team about medical staffing concerns but had not received any support in return. We asked the trust to provide evidence of any actions following this, but they did not provide any. Other nurses described responses from executive managers in general, as poor when issues were escalated.

Culture within the service

Urgent and emergency services

- Following allegations of bullying following our previous inspection, junior medics no longer felt bullied by senior management.
- Staff described a culture where the management of patient flow was not supported by leaders in the wider trust.
- Nurses described a reactive rather than proactive culture and a lack of opportunity for professional development. One nurse we spoke to was personally funding further clinical training.
- Nurses also described a culture of uncertainty following the change in executive staff and felt there was not enough information for staff about progress. They felt 'burnt out' after continually 'stepping up' to maintain safety and ensure patients were cared for.

Public engagement

- The trust used web based information to remind the public of the purpose of an ED and alternative care pathways such as the GP, 111 service or pharmacists. This formed part of the "A&E won't kiss it better" campaign.
- The trust asked patients to rate their experience of the ED in the NHS Friends and Family test. Between December 2014 and December 2015 between 70% and 90% of patients said they would recommend the department to friends and family against an England average of 87%. The latest figures in January 2016 showed that 81% of people would recommend the department. In February 2016 the figure dropped to only 53%. However these results were based on a very low

response rate of less than 2% which, although comparable with emergency departments across England, was not representative enough to provide robust conclusions.

- Following the CQC Accident and Emergency patient survey 2014, the department worked to identify areas for improvement. They devised an action plan to improve results which was in progress at the time of our inspection. This included displaying waiting times and improving medicine management training which was due to commence in June 2016.







Staff engagement

- Staff felt there had not been enough engagement from the executive team and described the presence of executives in the department during the inspection as 'unusual'.
- Department managers such as Matrons and Consultants liaised with staff in team meetings and we saw that information to support staff was displayed on a noticeboard in the main area of the department.

Innovation, improvement and sustainability

- The therapy team worked innovatively to support patients suffering trauma. Here, occupational therapists and physiotherapists worked to ensure patients could be discharged and supported in their homes rather than remaining in hospital. Requests had been received for staff to speak about their work nationally.
- Staff caring for stroke patients used telemedicine (web based video cameras) to obtain consultant advice between the hours of 5pm and 8pm each weekday.

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

Information about the service

The North West Regional Spinal Injuries Centre (NWR SIC) at Southport and Formby District General Hospital is one of 8 such centres in England. The unit takes ventilator dependent patients from areas including; Liverpool, Manchester, West Midlands, North Wales and South Cumbria.

It treats patients with spinal cord injuries or related neurological disorders both as inpatients and through an outreach programme. The centre has 33 in-patient rehabilitation beds and an additional ten beds for ventilator dependent patients. In addition, the centre's staff provide outreach care to patients using a further eight beds in three community healthcare settings, Sandpiper, Weld Road and Revitalise. These patients no longer require an acute hospital bed but still have rehabilitation goals.

The centre admits people with all levels and severity of spinal cord injury. It treats approximately 150 inpatients and 2,000 outpatients a year. The centre has the largest ventilator-dependent and weaning spinal cord injury programmes in Europe.

It has highly specialised and experienced staff in all disciplines, including specialist doctors and consultants, physiotherapists, occupational therapists and psychologists. Each patient's care is overseen by a case manager. Facilities at the centre include a hydrotherapy pool and a gym.

The centre aims to maximise patients' independence regardless of the level of their spinal cord injury, and to maintain their hope for the future.

We inspected this service as part of our comprehensive inspection of Southport and Ormskirk NHS Trust on 12 to 15 April 2016. The team included a CQC inspector, a specialist nurse consultant and a consultant surgeon.

Before visiting, we reviewed information about the service and asked other organisations to share what they knew. During the visit we held focus groups and talked individually with staff, including nurses, doctors and therapists. We talked with people who used the service. We observed how people were being cared for, talked with carers and/or family members and reviewed the care or treatment records of seven sets of adult patients. We carried out an unannounced visit on 29 April 2016.

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Summary of findings

Following a rating of inadequate during the inspection in November 2014, we have now rated the North West Regional Spinal Injuries Centre (NWR SIC) services as good overall because;

- Since the last inspection in November 2014 the trust had invested significantly in nurse staffing and staffing levels had improved. The trusts review in July 2014 highlighted that 18 whole time equivalent members of nursing staff were required to ensure that the centre complied with all national recommendations for safe staffing. We saw that the staffing ratios had increased to adequate levels.
- The centre had a dedicated spinal medical team with on-site medical cover between the hours of 9am and 9pm Monday to Friday. Out of hours the centre was supported via spinal on-call including a consultant and the trust out of hours hospital at night team. The lead consultant told us that since the recruitment of the third consultant to the team the access to medical cover had improved considerably. There was a 24 hour, seven day a week spinal consultant on call service available.
- In March 2016 the safety thermometer showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had only been one fall with harm.
- Ward areas were visibly clean and cleaning schedules were displayed on the ward and in the acute respiratory centres (ARC's). Staff were seen to comply with the infection control policy. Mandatory hand hygiene monthly audit results for the centre in December 2015, January and February 2016 were 100% compliant. The environment and cleanliness audit showed 99% compliance in March 2016 which was an acceptable limit.
- The environment for patients had improved since the last inspection with refurbishment of the day room. Patients and relatives confirmed this provided a pleasant area in which to relax and socialise away from the ward. The rehabilitation centre had access to a variety of equipment to meet patients' individual needs and to support and maintain patients' independence. There was adequate equipment in the centre to ensure safe care. Therapy staff carried out risk and competency assessments to ensure patients were safe to use assistive technology and electric wheelchairs.
- We observed the safe manual handling of patients which included the use of hoists by two members of staff. A draft policy was under development that outlined patient responsibilities for safe use of wheelchairs.
- The ward had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines.
- Care and treatment was evidence based and staff provided care for patients with spinal injuries based on the National Institute for Health and Care Excellence (NICE) guidelines including guidance published in February 2016.
- Since the last inspection the trust had renamed the former intensive care and high dependency units of the NWR SIC as it was revealed that intensive care was not delivered at the centre. This had had an implication for registered nursing staff to have a post registration award in critical care nursing which no longer applied.
- Data from the National Spinal Injuries database for 2013/14 and 2014/15 showed a reduction in admission waits and a reduction in delays in discharge. The additional capacity of the outreach service had enabled patients referred from major trauma centres to be admitted faster. Data showed the percentage of acute outreach visits within five days at the time of the inspection was 100%.
- Since January 2015 the centre had recruited a nursing practice-based educator and there was ongoing review of the in-house education programme. Team development and specialist training had begun. A self-assessment competency process was in place for all clinical staff with skill acquisition relevant to role.
- The centre demonstrated a clear admission policy with strong individual assessment for admission in accordance with the national clinical reference group classification for clinical priority. There was also a focus on discharge planning and there was good multidisciplinary working to support this. A case

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manager facilitated the discharge process. The consultants reviewed their out-patients six monthly or annually to ensure patients were reaching their goals.

- Since the last inspection staff had been supported to manage patients with challenging behaviour. The partnership working document was discussed with all patients on admission and an explanation given regarding expected behaviour in line with the trust's violence and aggression policy.
- There was a clear strategy for the unit which was supported by the trust business planning strategy and the executive team. The five year strategy for the NWSIC had not yet been made available following the sustainability review.
- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. Ward managers reported that they had good relationships with their immediate matron who was visible on the unit.

However;

- Compliance rates for mandatory staff training had been below the trust target since December 2015. The training schedule showed there were low numbers of nurses trained in specialist areas for example; venepuncture, intra venous cannulation, blood transfusions and skin bundle training. The matron reported that some additional new core mandatory training 'prevent' training had affected the overall training statistic figures as not all staff had received this. Staff raised it was sometimes difficult to leave the ward due to staffing levels to attend training.

Are regional spinal injuries unit services safe?

Good



Following a rating of inadequate during the inspection in November 2014, we have now rated the North West Regional Spinal Injuries Centre (NWSIC) services as good in relation to keeping people safe and protecting people from abuse and avoidable harm because;

- At the previous inspection in November 2014, we found that there were insufficient members of nursing staff to provide a safe service. The trust had identified poor staff to patient ratios and staff shortages had been noted as a long standing risk on the trust risk register.
- We found the nurse staffing levels had improved since the last inspection through additional funding and a positive response to a recruitment drive. The centre used some regular bank and agency staff to ensure adequate numbers. At last inspection nursing staff told us they rarely reported low staffing levels via the incident reporting system, this had improved and staff shortages were reported.
- Medical staffing had improved with a newly appointed consultant to lead the provision of improved patient care.
- There were good incident reporting systems, lessons were learnt and fed back to staff. Staff had received training and input from the psychology team to enable staff to deal more effectively with incidents of challenging behaviour.
- Nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Medicines were stored and administered safely including recording of fridge temperatures and the quality of medicine record keeping was good.
- Patients received initial assessments in a timely way and this had improved since the last inspection. Patient records included risk assessments and care plans that were completed on admission and reviewed and updated throughout their stay.

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- Mandatory training records showed 82.5 % of staff had received training in infection control, including hand hygiene all of which were improvements from the last inspection.
- NHS Safety Thermometer information was displayed and in March 2016 it showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had been one fall with harm.
- Ward areas were visibly clean and cleaning schedules were clearly displayed. Mandatory hand hygiene monthly audit results in December 2015, January and February 2016 were 100% compliant. We observed staff using the aseptic no-touch technique.
- Equipment including emergency equipment was appropriately checked and cleaned regularly.
- Systems and processes were in place to protect patients from abuse with staff trained to appropriate levels.
- The unit had made provision for the storage for essential equipment since the last inspection and the business case for additional storage was being progressed.
- In addition the centre had started to establish a system for recording the essential equipment in place and the centre had received equipment through the trusts equipment replacement programme.
- A difference was seen throughout our inspection as we observed there was a strong, visible person-centred culture. Patients received compassionate care and their privacy and dignity were maintained, patient's emotional, social and religious needs were embedded in their care and treatment. Staff provided emotional support to patients in a calm and respectful way. Patients and those close to them were positive about the way staff treated them. The staff were observed to be relaxed and cheerful whilst undertaking their work, and took time to consider individual patient's needs.

However;

- There could be wider attendance at mortality and morbidity meetings as only medical staff took part in these currently. Note taking and action plans were poor following these, which meant that opportunities to learn how to improve patient care were possibly being missed.
- The centre had limited facilities to manage infectious patients which remained a challenge.

Incidents

- Incidents and accidents were reported using a trust wide electronic system. Staff were familiar with this and understood their responsibilities to raise concerns and record safety incidents.
- From January 2015 the planned care clinical business unit, the division the NWRSIC sits, reported 238 incidents. Eleven were serious incidents. Other services within this business unit were surgical wards, theatres, out patients, ear, nose and throat and maxillofacial surgery. The reported incidents were mainly in relation to pressure ulcers, the environment, and a clinical care incident whilst in hospital. All serious incidents had been investigated and action had been taken to prevent re-occurrence. The other reported incidents were rated as low or moderate harm. This indicated that the service had a positive culture of reporting incidents.
- At the inspection in November 2014 nursing staff told us they rarely reported low staffing levels via the incident reporting system. Staff were now reporting incidents consistently and thoroughly as they had seen the benefit of newly recruited staff.
- Monthly multidisciplinary 'Harm' meetings have been introduced, attended by senior staff to review and discuss incidents, complaints and risks. During the Harm meeting we attended staff discussed incidents thoroughly and agreed what learning needed to be shared. For example senior staff felt that a medication issue needed further investigation to establish the cause and find a way to ensure this did not happen again. Key learning from these meetings were shared through ward or departmental meetings and safety huddles.
- A root cause analysis was undertaken following serious incidents being reported and feedback was given with any actions for learning. Nursing staff told us they had a learning culture and there had been improvements to feedback from incidents since the last inspection.
- In addition staff accessed e-reader files and signed to confirm this within a given time frame. A review of e reader files showed communication in respect of incidents and learning that was undertaken.
- Staff said the culture about raising concerns had become more 'open' and the sharing of feedback had improved. Staff told us how they had learnt from being fearful in the past and not reporting patients' behavioural issues.

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- Incidents reported were discussed at ward meetings, safety huddles and following handovers. Staff confirmed learning from clinical incidents was shared as appropriate.
- Mortality and Morbidity meetings were attended by medical staff only currently and were held following each death on the spinal unit. These were not held monthly as deaths were infrequent. Note taking and action plans were poor, which meant that opportunities to learn how to improve patient care were being missed. For example in relation to one death better psychological support would have assisted the family of the deceased but no clear action was identified to ensure this happened next time.
- Staff on the spinal unit were aware of the duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Medical staff reported they held informal discussions regarding duty of candour where this may be required.

Safety thermometer

- The trust submitted data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections (UTIs) and new blood clots (venous thromboembolism, VTE).
- Safety thermometer results were prominently displayed on the ward. All staff we spoke with were aware of the NHS safety thermometer and actions were taken to reduce the likelihood of harm to patients. The minutes of the ward meeting for December 2015 highlighted areas for improvement; for example for nursing staff to remind the medical staff of the timely review of VTE assessments and the importance of staff wearing protective equipment. In March 2016 the safety thermometer showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had been one fall with harm.
- From October 2014 to September 2015 there were 13 pressure ulcers reported across planned care services.

None of these were from the spinal injuries centre. There were no falls that resulted in harm and three catheter acquired urinary tract infections (UTI) had occurred during this period.

- The trust was performing within expected ranges for these measures except for UTI's, however patients with spinal injury were more likely to acquire a UTI. Staff we spoke with told us they provided specific assistance to patients to prevent UTIs and were able to explain actions that were being taken to prevent pressure ulcer development.
- As a result of the safety thermometer, a trust wide work stream was in place for improvement for pressure ulcers and care of the deteriorating patient where there had been a reduction in performance against previous months. The manager had action plans in place.

Cleanliness, infection control and hygiene

- Ward areas were visibly clean and cleaning schedules were displayed on the ward and in the ARCs. There was a daily and weekly cleaning regime to ensure that all equipment for example, wheelchairs, cushions, shower chairs and commodes were cleaned following patient use. These records were not always completed however the trust infection prevention and control team carried out their weekly swab test, checking the commodes for cleanliness and these were adequately clean and staff were observed cleaning equipment after patient use. The matron told us they would address the recording of these checks.
- The unit had limited facilities to manage infected patients in isolation, one side room only. This was an increasing problem due to an increase in incidents of infections from referring trusts for example multiple drug resistant organisms. The two bed side room was used as an isolation room for patients identified as an increased infection control risk (for example patients with MRSA (Methicillin-resistant staphylococcus aureus) and C.Diff (Clostridium difficile). However when the two-bed side room was used for isolation, the second bed could not be used. If that room was already in use, the admission of further patients with infections was delayed. These delays were particularly significant as the unit took patients from all over the UK. The use of isolation beds in the acute respiratory centre (ARC) where the most dependent patients were treated was

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problematic as there were four beds in one part of the ARC and six in the other. A business case for two pods for isolation within ARC 1 was planned to be reviewed by the trust in mid-April.

- Mandatory Hand Hygiene Monthly Audit results for the Centre in December 2015, January and February 2016 were 100% compliant. Guidance for hand washing and hand sanitizers were available throughout the centre. The environment and cleanliness audit showed 99% compliance in March 2016 which was an acceptable limit.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to and staff regularly washed their hands and used hand gel between patients. We saw wall mounted hand gel dispensers were in place. We observed staff hygiene practice and found that staff followed the personal protective equipment (PPE) guidance such as wearing gloves and aprons. Staff in each bay used a different coloured apron to help prevent cross-contamination between patient areas.
- There was clear signage outside isolation rooms so staff were aware of the increased precautions they must take when entering and leaving the room.

Environment and equipment

- The environment for patients had improved since the last inspection with refurbishment of the day room. Patients and relatives confirmed this provided a pleasant area in which to relax and socialise away from the ward. The rehabilitation centre had access to a variety of equipment, such as specially adapted wheelchairs, baths, beds and walking and standing frames to meet patients' individual needs and to support and maintain patients' independence. There was adequate equipment in the centre to ensure safe care. Therapy staff carried out risk and competency assessments to ensure patients were safe to use assistive technology and electric wheelchairs.
- We observed the safe manual handling of patients which included the use of hoists by two members of staff. A draft policy under development that outlined patient responsibilities for safe use of wheelchairs.
- Emergency resuscitation equipment was available in the centre. However, for some equipment, the sepsis trolley for example, the daily or weekly checklists were

not always signed by staff despite tamper proof seals being in place. This highlighted that the procedure for the checking of equipment was not clear to staff. The matron told us they would address this.

- The portable appliance testing (PAT) system for monitoring and recording the testing and servicing of electrical equipment such as cardiac monitors and resuscitation equipment (defibrillators) was effective and the results were recorded.
- The inspection in November 2014 found there was insufficient storage for essential equipment. This meant that corridors in the NWR SIC were cluttered, which made it difficult for staff to manoeuvre patients. The unit now has created additional storage within a treatment area and corridors were seen to be free from clutter.
- At the previous inspection there was no planned replacement programme for essential equipment including electrical wheelchairs. Since then the unit had replaced some equipment and was in the process of creating an inventory of all equipment and then to devise a 'planned' equipment replacement programme. In addition a business plan for assistive technology was accepted in March 2016.
- A random check of equipment showed these had been serviced regularly in line with the trust's policy. Electrical equipment, including hoists had portable appliance tests (PAT) completed to ensure they were fit for use.
- A ward based accreditation scheme audit, the Southport & Ormskirk Nursing Accreditation Scheme (SONAS) had commenced in December 2015. This replaced the Hygienic Environment Action Team (HEAT) audit and was a tool to understand how care was delivered, identify areas of good practice along with areas where further improvements were needed. Action had been taken to address areas where shortfalls were identified.
- Patients and staff we spoke with did comment they had to wait for showers as there are four showers for 43 patients.

Medicines

- The ward had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. The ward based staff reported a good service from the pharmacy team which included prescribing checks and to ensure adequate supplies of medicines were available.

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- There were suitable arrangements in place for the storage and management of medicines, including controlled drugs, in line with legal requirements.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward.
- We checked the controlled drugs on the ward and found the stock balances were correct and the registers had been signed by two members of staff when drugs were dispensed. The volume of any wasted drugs was recorded accurately where necessary.
- We saw appropriate arrangements were in place for recording the administration of medicines. We looked at the prescription and medicine administration records for five patients. These records were clear and fully completed and any known sensitivities were clearly recorded in the patient's records.
- Staff confirmed read and sign sheets were circulated to disseminate any trust related medication changes or incident management issues.
- Pharmacists visited the centre regularly to review medications and to ensure patients' medicines were available for planned leave. Since the inspection in Nov 2014, arrangements to enable patients to manage their own medication had been improved for spinal outreach patients. Storage facilities included specific patient lockable storage drawers at patient's bedsides. The SONAS inspection in January 2016 highlighted good management of controlled drugs in the ward setting and good practice in the self-administration for spinal outreach patients.
- The unit staff conducted audits of antibiotic prescribing and we saw that prescribed antibiotics had clear stop dates. In addition we observed that patients had wrist bands to identify drug allergies.

Records

- A paper system for patients' records was in place which was found to be securely stored. The named nurse system was used for patients within the centre, identifying two registered nurses as having responsibility for each bay to ensure patients records were updated in a timely manner. Nursing staff used a core care plan system to record all care interactions. Nursing and medical records were seen to be well completed.
- We reviewed seven sets of adult patients' records and saw clinical assessments, diagnosis and treatment plans

clearly documented. The patient records and observation charts we checked showed that most assessments had been completed, including nutrition assessments, skin integrity assessments; modified early warning scores (MEWS), falls assessments, bed rails and observations. Turning charts were completed and up to date. Medical assessments were carried out in a timely manner and notes were clearly documented providing information on patients' progress and treatment.

- As patients are registered for life separate case management records were held for ongoing support and sign posting. We looked at three sets of notes which were clearly documented including patients care needs, rehabilitation goals and discharge planning.
- We saw comprehensive and well documented wound management plans. These showed wounds were dressed regularly and progress of healing was well documented.
- Records were checked by senior staff to ensure nursing documentation was completed appropriately. Patient information boards did not display confidential information.
- In addition to nursing and medical records, multidisciplinary team (MDT) records were held separately and were clearly recorded. We saw patient centred physiotherapy and occupational records which included actions taken and recorded communication between the teams.
- The team were reviewing the possibility of introducing joint notes and plans were in place to make nursing records more person-centred/individualised rather than the trusts standardised current documentation. The Outreach team used joint notes with all disciplines.
- All of the records we reviewed showed that an initial and reassessment of VTE assessment had been completed.
- Yearly audits were carried out to review medical, nursing and therapy records with to identify good practice and areas for improvement. The SONAS action plan following the inspection in January 2016 highlighted areas for improvement for completing and reviewing records in a timely manner and for care plans to be individualised. The matron told us this was ongoing work with staff.
- We saw examples of completed patient passports and sharing of patient treatment plans, goals and medication management between the acute and primary care setting teams.

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Safeguarding

- The centre had appropriate processes for safeguarding patients from abuse.
- There was a process for identifying potential safeguarding issues and concerns with a flow chart being displayed in the ward setting to advise staff of the escalation process.
- Staff knew where to find policies for safeguarding vulnerable adults and children from abuse including the whistleblowing policy.
- The policy covered issues including domestic and sexual abuse, female genital mutilation, radicalisation, forced marriage, sexual exploitation and honour-based violence.
- Following the safety huddle, the centre coordinator was heard reading the safeguarding flow chart to staff as a learning exercise. Seven of the staff of different grades we spoke with, were aware of how to escalate a safeguarding concern. In addition, staff were able to describe how to observe patients for signs of abuse or neglect, such as marks on their body or dehydration.
- Safeguarding training was included in induction training for temporary staff before commencing work on the wards.
- Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse, how to raise an alert and that the trust had a whistleblowing policy in place.
- Training statistics provided by the trust's electronic staff training database showed that in planned services division, the division that spinal injuries centre comes under 95% of nursing staff and 75% of medical staff had completed safeguarding training level 1 up to March 2016. The trust target was 90%. All nursing staff were required to attend safeguarding training level 1. In addition registered nurses had to complete level 2 and level 3 safeguarding via e reader and HCA's level 2-via e reader.
- The training statistics from the trust showed that compliance in safeguarding level 2 training was low. We were informed by the centre manager that this was because there had been a shift from attending training to staff working towards the new safeguarding level 2 e-readers training. Staff were working towards completing this training.

- There was a trust monitoring tool in place to look at the number of safeguarding referrals made each month. Safeguarding adults steering group meetings took place each month and were attended as necessary.

Mandatory training

- We looked at staff mandatory training records. The mandatory training was in areas such as health and safety, fire, manual handling, and infection prevention and control on a rolling programme.
- The trust had a target of each directorate achieving 90% compliance. Compliance rates for mandatory staff training in the NWRSIC up to February 2016 were less than 80% for registered nurses and non- registered staff. The manager reported there was a greater move towards E-learning and staff were being encouraged to remain up to date. The matron told us that training sessions were being booked for those staff who still required training.
- Staff told us that mandatory training generally met their needs.
- We saw the electronic records for appraisals which showed compliance for March 2016 was 87.5%, this had increased from 78.3% in February 2016. This did not meet with the trust's target of 90%.

Assessing and responding to patient risk

- Staff in the NWRSIC used the national early warning score (NEWS) to record routine physiological observations such as blood pressure, temperature and heart rate, and monitors a patient's clinical condition in accordance with the trust's deteriorating patient policy. This assisted staff to seek a response from increasing the frequency of the patient's observations or to seek an urgent review by a senior nurse or a doctor. We looked at 8 sets of NEWS scores for patients and found they had been completed in accordance with trust policy. Risk assessments were carried out formally and informally with any ongoing risks highlighted via the trust risk register. Assessment tools included NEWS, VTE, Falls, SKIN Bundle, MUST and High Impact Interventions. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Regular Service Specification peer review took place with the Cheshire and Merseyside Critical Care Network.

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A recent peer review for the NWRsIC took place on the 9 March 2016. The report was not available at the time of this inspection. The overall feedback was that there were no immediate serious risks or concerns.

Incidents

- Incidents and accidents were reported using a trust wide electronic system. Staff were familiar with this and understood their responsibilities to raise concerns and record safety incidents.
- From January 2015 the planned care clinical business unit, the division the NWRsIC sits, reported 238 incidents. 11 were serious incidents. Other services within this business unit were surgical wards, theatres, out patients, ear, nose and throat and maxillofacial surgery. The reported incidents were mainly in relation to pressure ulcers, the environment, and a clinical care incident whilst in hospital. All serious incidents had been investigated and action had been taken to prevent re-occurrence. The other reported incidents were rated as low or moderate harm. This indicated that the service had a positive culture of reporting incidents.
- At the inspection in November 2014 nursing staff told us they rarely reported low staffing levels via the incident reporting system. Staff were now reporting incidents consistently and thoroughly as they had seen the benefit of newly recruited staff.
- Monthly multidisciplinary 'Harm' meetings have been introduced, attended by senior staff to review and discuss incidents, complaints and risks. During the Harm meeting we attended staff discussed incidents thoroughly and agreed what learning needed to be shared. For example senior staff felt that a medication issue needed further investigation to establish the cause and find a way to ensure this did not happen again. Key learning from these meetings were shared through ward or departmental meetings and safety huddles.
- A root cause analysis was undertaken following serious incidents being reported and feedback was given with any actions for learning. Nursing staff told us they had a learning culture and there had been improvements to feedback from incidents since the last inspection.
- In addition staff accessed e-reader files and signed to confirm this within a given time frame. A review of e reader files showed communication in respect of incidents and learning that was undertaken.
- Staff said the culture about raising concerns had become more 'open' and the sharing of feedback had improved. Staff told us how they had learnt from being fearful in the past and not reporting patients' behavioural issues.
- Incidents reported were discussed at ward meetings, safety huddles and following handovers. Staff confirmed learning from clinical incidents was shared as appropriate.
- Mortality and Morbidity meetings were attended by medical staff only currently and were held following each death on the spinal unit. These were not held monthly as deaths were infrequent. Note taking and action plans were poor, which meant that opportunities to learn how to improve patient care were being missed. For example in relation to one death better psychological support would have assisted the family of the deceased but no clear action was identified to ensure this happened next time.
- Staff on the spinal unit were aware of the duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Medical staff reported they held informal discussions regarding duty of candour where this may be required.

Safety thermometer

- The trust submitted data as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections (UTIs) and new blood clots (venous thromboembolism, VTE).
- Safety thermometer results were prominently displayed on the ward. All staff we spoke with were aware of the NHS safety thermometer and actions were taken to reduce the likelihood of harm to patients. The minutes of the ward meeting for December 2015 highlighted areas for improvement; for example for nursing staff to remind the medical staff of the timely review of VTE assessments and the importance of staff wearing protective equipment. In March 2016 the safety

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thermometer showed harm free care had been provided for pressure ulcers, catheter acquired urinary tract infections and VTE assessments. There had been one fall with harm.

- From October 2014 to September 2015 there were 13 pressure ulcers reported across planned care services. There were no falls that resulted in harm and three catheter acquired urinary tract infections (UTI) had occurred during this period.
- The trust was performing within expected ranges for these measures except for UTI's, however patients with spinal injury were more likely to acquire a UTI. Staff we spoke with told us they provided specific assistance to patients to prevent UTIs and were able to explain actions that were being taken to prevent pressure ulcer development.
- As a result of the safety thermometer, a trust wide work stream was in place for improvement for pressure ulcers and care of the deteriorating patient where there had been a reduction in performance against previous months. The manager had action plans in place.

Cleanliness, infection control and hygiene

- Ward areas were visibly clean and cleaning schedules were displayed on the ward and in the ARCs. There was a daily and weekly cleaning regime to ensure that all equipment for example, wheelchairs, cushions, shower chairs and commodes were cleaned following patient use. These records were not always completed however the trust infection prevention and control team carried out their weekly swab test, checking the commodes for cleanliness and these were adequately clean and staff were observed cleaning equipment after patient use. The matron told us they would address the recording of these checks.
- The unit had limited facilities to manage infected patients in isolation, one side room only. This was an increasing problem due to an increase in incidents of infections from referring trusts for example multiple drug resistant organisms. The two bed side room was used as an isolation room for patients identified as an increased infection control risk (for example patients with MRSA (Methicillin-resistant staphylococcus aureus) and C.Diff (Clostridium difficile). However when the two-bed side room was used for isolation, the second bed could not be used. If that room was already in use, the admission of further patients with infections was delayed. These delays were particularly significant as

the unit took patients from all over the UK. The use of isolation beds in the acute respiratory centre (ARC) where the most dependent patients were treated was problematic as there were four beds in one part of the ARC and six in the other. A business case for two pods for isolation within ARC 1 was planned to be reviewed by the trust in mid-April.

- Mandatory Hand Hygiene Monthly Audit results for the Centre in December 2015, January and February 2016 were 100% compliant. Guidance for hand washing and hand sanitizers were available throughout the centre. The environment and cleanliness audit showed 99% compliance in March 2016 which was an acceptable limit.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to and staff regularly washed their hands and used hand gel between patients. We saw wall mounted hand gel dispensers were in place. We observed staff hygiene practice and found that staff followed the personal protective equipment (PPE) guidance such as wearing gloves and aprons. Staff in each bay used a different coloured apron to help prevent cross-contamination between patient areas.
- There was clear signage outside isolation rooms so staff were aware of the increased precautions they must take when entering and leaving the room.

Environment and equipment

- The environment for patients had improved since the last inspection with refurbishment of the day room. Patients and relatives confirmed this provided a pleasant area in which to relax and socialise away from the ward. The rehabilitation centre had access to a variety of equipment, such as specially adapted wheelchairs, baths, beds and walking and standing frames to meet patients' individual needs and to support and maintain patients' independence. There was adequate equipment in the centre to ensure safe care. Therapy staff carried out risk and competency assessments to ensure patients were safe to use assistive technology and electric wheelchairs.
- We observed the safe manual handling of patients which included the use of hoists by two members of staff. A draft policy under development that outlined patient responsibilities for safe use of wheelchairs.
- Emergency resuscitation equipment was available in the centre. However, for some equipment, the sepsis

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trolley for example, the daily or weekly checklists were not always signed by staff despite tamper proof seals being in place. This highlighted that the procedure for the checking of equipment was not clear to staff. The matron told us they would address this.

- The portable appliance testing (PAT) system for monitoring and recording the testing and servicing of electrical equipment such as cardiac monitors and resuscitation equipment (defibrillators) was effective and the results were recorded.
- The inspection in November 2014 found there was insufficient storage for essential equipment. This meant that corridors in the NWRSIC were cluttered, which made it difficult for staff to manoeuvre patients. The unit now has created additional storage within a treatment area and corridors were seen to be free from clutter.
- At the previous inspection there was no planned replacement programme for essential equipment including electrical wheelchairs. Since the unit had replaced some equipment and was in the process of creating an inventory of all equipment this would then form part of the medical equipment bids process the trust operates. In addition a business plan for assistive technology was accepted in March 2016.
- A random check of equipment showed these had been serviced regularly in line with the trust's policy. Electrical equipment, including hoists had portable appliance tests (PAT) completed to ensure they were fit for use.
- A ward based accreditation scheme audit, the Southport & Ormskirk Nursing Accreditation Scheme (SONAS) had commenced in December 2015. This replaced the Hygienic Environment Action Team (HEAT) audit and was a tool to understand how care was delivered, identify areas of good practice along with areas where further improvements were needed. Action had been taken to address areas where shortfalls were identified.
- Patients and staff we spoke with did comment they had to wait for showers as there are four showers for 43 patients.

Medicines

- The ward had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. The ward based staff reported a good service from the pharmacy team which included prescribing checks and to ensure adequate supplies of medicines were available.

- There were suitable arrangements in place for the storage and management of medicines, including controlled drugs, in line with legal requirements.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward.
- We checked the controlled drugs on the ward and found the stock balances were correct and the registers had been signed by two members of staff when drugs were dispensed. The volume of any wasted drugs was recorded accurately where necessary.
- We saw appropriate arrangements were in place for recording the administration of medicines. We looked at the prescription and medicine administration records for five patients. These records were clear and fully completed and any known sensitivities were clearly recorded in the patient's records.
- Staff confirmed read and sign sheets were circulated to disseminate any trust related medication changes or incident management issues.
- Pharmacists visited the centre regularly to review medications and to ensure patients' medicines were available for planned leave. Since the inspection in Nov 2014, arrangements to enable patients to manage their own medication had been improved for spinal outreach patients. Storage facilities included specific patient lockable storage drawers at patient's bedsides. The SONAS inspection in January 2016 highlighted good management of controlled drugs in the ward setting and good practice in the self-administration for spinal outreach patients.
- The unit staff conducted audits of antibiotic prescribing and we saw that prescribed antibiotics had clear stop dates. In addition we observed that patients had wrist bands to identify drug allergies.

Records

- A paper system for patients' records was in place which was found to be securely stored. The named nurse system was used for patients within the centre, identifying two registered nurses as having responsibility for each bay to ensure patients records were updated in a timely manner. Nursing staff used a core care plan system to record all care interactions. Nursing and medical records were seen to be well completed.
- We reviewed seven sets of adult patients' records and saw clinical assessments, diagnosis and treatment plans

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clearly documented. The patient records and observation charts we checked showed that most assessments had been completed, including nutrition assessments, skin integrity assessments; modified early warning scores (MEWS), falls assessments, bed rails and observations. Turning charts were completed and up to date. Medical assessments were carried out in a timely manner and notes were clearly documented providing information on patients' progress and treatment.

- As patients are registered for life separate case management records were held for ongoing support and sign posting. We looked at three sets of notes which were clearly documented including patients care needs, rehabilitation goals and discharge planning.
- We saw comprehensive and well documented wound management plans. These showed wounds were dressed regularly and progress of healing was well documented.
- Records were checked by senior staff to ensure nursing documentation was completed appropriately. Patient information boards did not display confidential information.
- In addition to nursing and medical records, multidisciplinary team (MDT) records were held separately and were clearly recorded. We saw patient centred physiotherapy and occupational records which included actions taken and recorded communication between the teams.
- The team were reviewing the possibility of introducing joint notes and plans were in place to make nursing records more person-centred/individualised rather than the trusts standardised current documentation. The Outreach team used joint notes with all disciplines.
- All of the records we reviewed showed that an initial and reassessment of VTE assessment had been completed.
- Yearly audits were carried out to review medical, nursing and therapy records with to identify good practice and areas for improvement. The SONAS action plan following the inspection in January 2016 highlighted areas for improvement for completing and reviewing records in a timely manner and for care plans to be individualised. The matron told us this was ongoing work with staff.
- We saw examples of completed patient passports and sharing of patient treatment plans, goals and medication management between the acute and primary care setting teams.

Safeguarding

- The centre had appropriate processes for safeguarding patients from abuse.
- There was a process for identifying potential safeguarding issues and concerns with a flow chart being displayed in the ward setting to advise staff of the escalation process.
- Staff knew where to find policies for safeguarding vulnerable adults and children from abuse including the whistleblowing policy.
- The policy covered issues including domestic and sexual abuse, female genital mutilation, radicalisation, forced marriage, sexual exploitation and honour-based violence.
- Following the safety huddle, the centre coordinator was heard reading the safeguarding flow chart to staff as a learning exercise. Seven of the staff of different grades we spoke with, were aware of how to escalate a safeguarding concern. In addition, staff were able to describe how to observe patients for signs of abuse or neglect, such as marks on their body or dehydration.
- Safeguarding training was included in induction training for temporary staff before commencing work on the wards.
- Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse, how to raise an alert and that the trust had a whistleblowing policy in place.
- Training statistics provided by the trust's electronic staff training database showed that in planned services division, the division that spinal injuries centre comes under 95% of nursing staff and 75% of medical staff had completed safeguarding training level 1 up to March 2016. The trust target was 90%. All nursing staff were required to attend safeguarding training level 1. In addition registered nurses had to complete level 2 and level 3 safeguarding via e reader and HCA's level 2-via e reader.
- The training statistics from the trust showed that compliance in safeguarding level 2 training was low. We were informed by the centre manager that this was because there had been a shift from attending training to staff working towards the new safeguarding level 2 e-readers training. Staff were working towards completing this training.

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- There was a trust monitoring tool in place to look at the number of safeguarding referrals made each month. Safeguarding adults steering group meetings took place each month and were attended as necessary.

Mandatory training

- We looked at staff mandatory training records. The mandatory training was in areas such as health and safety, fire, manual handling, and infection prevention and control on a rolling programme.
- The trust had a target of each directorate achieving 90% compliance. Compliance rates for mandatory staff training in the NWRSIC up to February 2016 were less than 80% for registered nurses and non-registered staff. The manager reported there was a greater move towards E-learning and staff were being encouraged to remain up to date. The matron told us that training sessions were being booked for those staff who still required training.
- Staff told us that mandatory training generally met their needs.
- We saw the electronic records for appraisals which showed compliance for March 2016 was 87.5%, this had increased from 78.3% in February 2016. This did not meet with the trust's target of 90%.

Assessing and responding to patient risk

- Staff in the NWRSIC used the national early warning score (NEWS) to record routine physiological observations such as blood pressure, temperature and heart rate, and monitors a patient's clinical condition in accordance with the trust's deteriorating patient policy. This assisted staff to seek a response from increasing the frequency of the patient's observations or to seek an urgent review by a senior nurse or a doctor. We looked at 8 sets of NEWS scores for patients and found they had been completed in accordance with trust policy. Risk assessments were carried out formally and informally with any ongoing risks highlighted via the trust risk register. Assessment tools included NEWS, VTE, Falls, SKIN Bundle, MUST and High Impact Interventions. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Regular Service Specification peer review took place with the Cheshire and Merseyside Critical Care Network.

A recent peer review for the NWRSIC took place on the 9 March 2016. The report was not available at the time of this inspection. The overall feedback was that there were no immediate serious risks or concerns.

Nursing staffing

- Since the last inspection in November 2014 the trust had invested significantly in nurse staffing and staffing levels had improved with a number of vacancies now filled. The trust's review of staffing on NWRSIC undertaken in July 2014 highlighted that 18 whole time equivalent members of nursing staff across all bandings were required to ensure that the centre complied with all national recommendations for safe staffing. The nursing establishment was calculated using a draft staffing tool formulated by the National Institute of Health and Care Excellence (NICE) as well as experience based judgement to assess staffing requirements. We saw that the staffing ratios had increased; for the acute ward and rehabilitation this was currently 1:6.9 (Mon-Fri) and 1:8.25 on a late shift and weekends and 1:11 at night. For the acute respiratory centres (ARC), ARC 1 had 2 RN's 24 hours per day and ARC 3, three RN's and one HCA for six patients with one HCA who worked between the two areas.
- The staffing ratios were 1:2 for any patients assessed as requiring level two care (high dependency). This was a significant improvement from the previous inspection where staffing levels in the rehabilitation area of NWRSIC were assessed regularly as 1:16 on the early shift, 1:22 on the late shift and 1:33 on the night shift. Patients cared for on the centre are highly dependent and require greater than average levels of nursing care and expertise.
- Staffing levels were appropriate during the inspection and it was evident senior staff were constantly reviewing the needs of the acute and rehabilitation areas if changes in patients' needs or staff occurred. A respiratory team worked with the nursing and medical team. Currently allied health professionals were not on the staffing rota despite playing a significant role in patient care. The respiratory team was a multi-disciplinary team made up of medical, allied health professionals and nursing staff, who dealt with all aspects of ventilation and respiratory management, including secretion management, tracheostomy care and acute and long term invasive and non-invasive ventilation. Staffing levels were reviewed every six

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months using the 'safer nursing care tool (Shelford Group, 2013)' endorsed by the National Institute for Health and Care Excellence. This is an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff.

- Business cases to increase the therapy team staffing to provide a dedicated speech and language therapy at the centre had been approved however a business case for dietetic staffing was being put forward again.
- Recruitment campaigns had been carried out both locally and overseas to help improve the service for staff and patients. In addition the centre had been recruiting student nurses who were awaiting their registration from the nursing and midwifery council. They worked as health care assistants to gain experience on the unit before a permanent contract was provided. Staff would escalate issues to the matron if they were concerned about capacity to cope with patients. Six patients were on leave at the time of this inspection which is another factor required to take into account around staffing levels.
- The expected and actual staffing levels were displayed and updated on a daily basis on notice boards on the ward and outside ARCS 1 and 3. Senior staff carried out checks throughout the day to monitor the acuity of patients and escalated any staffing shortfalls due to unplanned sickness or leave. There was some unplanned staff absences during the inspection, however this was well managed by senior staff. Staff were aware of the escalation policy and of the correct procedure to follow when short staffed. Matron assured herself the standard was 'good enough' by observing and meeting with the Band 7's and feeling confident they are competent to raise any concerns.
- Staffing levels at the time of the inspection on the acute/rehabilitation 43 bedded ward had the following skill mix. The ward manager on the morning shift: 4 RN's plus 10 HCA's. On the afternoon shift, 4 RN's and 5 HCA's and at night: 3 RN's and 3 HCA's.
- ARC 3 which had 3 level 2 patients plus 3 other patients; the staffing was 3 RN's and 1 HCA. There were three patients receiving mechanical ventilation (machines to help people breathe) in the intensive care area of the centre. The dependency levels of these patients had been categorised as level 2. Core standards for intensive care units recommend a minimum of one nurse to two level 2 patients at all times so the ARC was within these

guidelines. Nurses allocated to the ARC areas felt they had sufficient time to give safe and appropriate care to their patients. Room 11, the outreach ward had 4 patients staffed by 1 RN, 1 occupational therapist and 1 physiotherapist which was assessed as safe.

- Nursing and health care staff of different grades were assigned to the different patient areas. A senior staff member was in charge as the ward coordinator. In addition, a senior nurse covered ARC 1 and ARC 3 and the Spinal Outreach ward. The matrons met regularly to discuss nurse staffing levels and ensure a good allocation of staff and skills were appropriately deployed and shared across all wards. The staffing levels for ARC's 1 and 3 were monitored by the critical care network for Cheshire and Merseyside's staffing specifications for intensive care units.
- The trust reported that as of the end of March 2016, the vacancy rate was 18% and sickness was 4% in the previous financial year. The centre had three band 5 nurse vacancy posts that had been subject to recruitment. Senior management were concerned regarding the length of time it was taking to recruit staff and the training of new staff was lengthy. There remained regularly 35-40 shifts out to bank and agency per week.
- Staffing levels were maintained by staff working overtime, the use of bank staff and agency staff. Ward managers tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so patients received an appropriate level of care. There was a cohort of competent staff, for example those with suction competencies so patients could receive safe care.
- There continued to be some use of agency staff in the centre although this had decreased considerably since the last inspection. The trust reported that as of the end of February 2016, the spinal unit overall had used 12.5% agency nursing staff and 9% support workers. Agency staff underwent an induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment. The centre had a contract with an agency and had confirmation that 2 staff could work from an agency.
- All new staff were supernumerary. There was an in-house development programme for both health care assistants and registered nurses, which included a skill and competency acquisition and supported learning via

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a mentor / preceptor. A preceptorship programme was in place for all newly appointed Band 5 staff and supervision was provided in line with professional guidelines.

- A programme of clinical supervision had been introduced for all nursing staff in order to facilitate communication and improve the team ethos. Nursing staff spoke of how the input from a new consultant was having a positive impact on patients and staff. The addition of two Band 7 nurses had improved the team's skill set.
- The centre reviewed staffing levels using the 'safer nursing care tool' endorsed by the National Institute for Health and Care Excellence. This is an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff. Managers agreed there does need to be a dependency/acuity tool relating specifically to the spinal speciality. In addition the matron used the intensive care society guidelines however they were trying to develop their own tool as the intensive care tool does not address the patient's dependency. In addition staff used their clinical judgement if patients in the ARC were not ventilated to determine safe staffing.
- The centre had developed a specific induction pack for new nursing staff including a skills log to assess staff competencies. An RN and HCA confirmed they had experienced a 'positive induction' and were allocated a preceptor, completed a staff nurse development book which included a spinal specific section.
- We observed two morning nursing handovers which were named 'safety huddles' on ARC1 and the spinal ward and we attended a ward round on ARC1. We discussed with the matron that 'safety huddles' were generally short meetings to communicate the urgency of resolving safety issues and critical situations rather than a sit down handover of 13 staff which is what we observed. In addition we observed how some staff were recording 'notes' on pieces of paper. We had concerns regarding patient confidentiality with this method, although staff told us they shredded this before they left the centre. We discussed a more informative electronic handover record which would have pre-recorded significant patient information in place.
- Information shared was thorough and respectful of patients. Clear guidance was provided for all staff with

the focus on patient safety and dignity. If clinical concerns were raised regarding a patient during the discussion, an action was discussed and a plan formulated to address these.

Medical staffing

- The centre had a dedicated spinal medical team with on-site medical cover between the hours of 9am and 9pm Monday to Friday. Out of hours the centre was supported via spinal on-call including a consultant and the trust out of hours hospital at night team. The lead consultant told us that since the recruitment of the third consultant to the team the access to medical cover had improved considerably.
- There was a 24 hour, seven day a week spinal consultant on call service available. The on call consultant was available to provide face to face or telephone advice to ward patients, including outreach patients contactable through the first on-call doctor. The rota for medical cover included the details for junior and middle grade doctors.
- In addition specialist advice for Healthcare Professionals (HCP) by the on call consultant was available 24/7 via telephone to provide advice to local and regional trauma units and hospitals. During the working hours there was also an on call rota for outreach nurses, where community nurses and nurses from other hospitals could contact them for specialist advice. If the advice sought was regarding therapy then a senior therapist would be contacted.
- An agreement was in place for respiratory consultant support for the service from a Aintree hospital.
- Out of hours the ward nurse in charge was available to give advice via the telephone to community nurses or other hospital nurses.
- Advice was only provided by either a consultant or a band 6 nurse who had been trained in the management and care of a spinal cord injured person.
- The centre adhered to the national standard of providing an outreach visit to a new patient within 5 days of the referral date. The data base records confirmed this.

Major incident awareness and training

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- There was a major incident and business continuity plan available for staff. This included the key risks that could affect the provision of care and treatment. Guidance for staff in the event of a major incident was readily available. Exits were clearly signposted.

Are regional spinal injuries unit services effective?

(for example, treatment is effective)

Good



Following a rating of requires improvement during the inspection in November 2014, we have now rated The North West Regional Spinal Injuries Centre (NWR SIC) services as good in relation to being effective because;

- Care and treatment was evidence based and staff provided care for patients with spinal injuries based on the National Institute for Health and Care Excellence (NICE) guidelines including guidance published in February 2016.
 - The service continued to develop care pathways and standard operating procedures. Care pathways were followed in line with national guidance. Work was in progress to update some of the guidelines.
 - Since the last inspection the trust had renamed the former intensive care and high dependency units of the NWR SIC as it was revealed that intensive care was not delivered at the centre. This had had an implication for registered nursing staff to have a post registration award in critical care nursing which no longer applied.
 - Patients nutrition and hydration needs had been assessed using a MUST risk assessment and we saw patients had food and drinks where appropriate. Since the last inspection there had been a refurbishment of the day room which provided a pleasant area for patients to dine and socialise away from the ward.
 - Patients were assessed for pain relief and patient records demonstrated timely assessment and administration of pain relief.
 - Staff had the skills and knowledge regarding consent, MCA and DoLS.
 - There was a highly skilled and effective respiratory team working at the centre that provided safe and effective care for the ventilated patients and others who required respiratory support.
- Data from the National Spinal Injuries database for 2013/14 and 2014/15 has shown a reduction in admission waits and a reduction in delays in discharge. The additional capacity the outreach service has brought has enabled patients referred to the centre from major trauma centres to be admitted faster. The centre has been compliant with the five day initial outreach visit for acute referrals from April 2015 to March 2016.
- However;
- There was no budget for assistive technology and any equipment was purchased using charitable funds. A business case has been submitted to the trust board for assistive technology to enhance delivery of a safe service.

Evidence-based care and treatment

- Care and treatment was evidence based and staff provided care for patients with spinal injuries based on the National Institute for Health and Care Excellence (NICE) guidelines. Staff spoken with were aware of updated spinal injury NICE guidance published in February 2016. As one of 8 Spinal cord injury centres nationally, the centre provides part of the service review of spinal cord injury service provision. This review involved establishing the changes required nationally to meet patients' needs.
- Staff we spoke with told us policies and procedures reflected current guidelines and were readily available from the hospital intranet. We looked at three policies which were up to date and reflected national guidelines. For example, bowel management guidelines post spinal cord injury. However three of the procedures we looked at did not include the date reviewed, the next review date or include the staff group aimed at.
- We saw examples in care plans used within the centre where national guidelines were followed and referenced alongside trust policy, for example, autonomic dysreflexia, a potentially dangerous complication of spinal cord injury and bowel and bladder management.
- The service continued to develop care pathways and standard operating procedures. Care pathways were followed on the spinal unit, in line with national guidance, examples included acute injury patient pathway. The pathways provide safe and effective decision making support for trained users.

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- During 2014/15 staff participated in local and national clinical audits. Audit meetings were held quarterly with multi professional team members where any changes to guidelines would be raised.
- Compliance with national guidelines and other evidence based practice was monitored through audit; such as the Southport & Ormskirk Nursing Accreditation Scheme (SONAS) and peer review. The spinal ward had an action plan for improvement following their rating of inadequate in November 2014.
- The service had developed improvement in information for healthcare professionals. For example, following assessment, the outreach team had produced a document with written advice and instructions. This document had been developed by the NWRISIC by taking into account standards and protocols for SCI management practised nationally. This document has also been developed in co-operation and discussion with the outreach team at the Midlands Spinal Injuries Centre at Oswestry.
- Development of the spinal service was ongoing with evidence of increasing hospital visits and telephone advice being provided.

Pain relief

- Patients were assessed for pain relief and management of their long term condition. Pain relief was managed on an individual basis, and was regularly monitored. Nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Protocols were in place for the safe use of pain relief medication.
- Patients' medication records showed that pain relief had been prescribed appropriately and they were treated in a way that met their needs.
- Patients we spoke with told us they were asked if they required pain relief and they received this in a timely and effective way.
- Medical and nursing staff had access to a dedicated pain management team for advice as necessary for patients.

Nutrition and hydration

- All patients received a nutritional assessment, the Malnutrition Universal Screening Tool (MUST) on

admission. This identified patients at risk of poor nutrition, dehydration and swallowing difficulties. We saw completed assessments where appropriate action had been taken when indicated.

- A variety of weighing equipment was available, including bed or wheelchair scales.
- Patients spoke favourably about the meals, comments included "The food is good, I have no complaints", "Food is hot when it arrives" and "there is reasonable choice but can get monotonous when in for weeks".
- A protected meal time was in place to encourage and enable patients to have adequate nutrition and hydration. Patients now received meals on trays, rather than food served directly from the trolley; however they had not yet adopted the red tray system for identifying vulnerable patients. They had an allocated health care assistant (HCA) who advised the staff delivering the meals if the patient required assistance and to what level required. Consideration was being given to the red tray system to identify patients who required assistance.
- We observed patients receiving support and there were sufficient staff members to support patients with meals to have their nutritional needs met in a safe and timely way. In addition to staff members, volunteers who had been trained by the speech and language therapy team supported patients with eating and drinking where appropriate.
- Access to dietetics and speech and language therapy support was available via the trust services however a business case had been accepted to increase dietetics and speech and language services for the centre.
- Staff represented the centre at the trust nutritional steering group to raise issues and improve the service for patients.

Patient outcomes

- Clinical outcomes were goal focused as set out in patient passports. Goal setting was an important part of the recovery process for patients with spinal injury. Patients were involved at each stage of the goal setting process and the philosophy and strategy adopted by the centre was effective.
- Patient's passports and care plans identified and recorded their goals which were monitored in partnership with the multidisciplinary staff team.

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Minutes of a monthly meeting attended by multi professional team members highlighted plans to develop the patient passports to enable auditing in the future.

- The centre had an active case management team that provided support to the ward in all aspects of the discharge planning process for these complex patients. The team held separate documentation which was not linked to the patient's nursing notes at ward level. Consideration was being given to multi-disciplinary records.
- The eight regional spinal units nationally have been submitting data to the National Spinal Injuries database since October 2013, there is now some comparable data available. Data from the National database for 2013/14 and 2014/15 has shown a reduction in admission waits and a reduction in delays in discharge. The additional capacity the outreach service has brought has enabled patients referred to the centre from major trauma centres to be admitted faster. Other data was around delays in discharge and the percentage of patients discharged home.
- The centre has been compliant with the five day initial outreach visit for acute referrals from April 2015 to March 2016. Staff were aware of audits undertaken on the ward, including care as care should be audits, monthly hand hygiene, infection control, mortality reviews and the National Patient Led Assessment of the Care Environment (PLACE).
- The trust was supported by a CQUIN programme (Clinical Quality Incentive Scheme) and the data from that has shown 100% compliance since its introduction in April 2014 with exception of one month for outreach visits within 5 days of referral.
- The audit of activity of the respiratory team NWRSC 2012-2015 monitored year on year activity of outpatients, outreach visits and telephone consultations related to direct patient care. Results showed that if the advice given by the respiratory specialists is taken, it facilitated a smoother transition of care, and allowed the patient to be ventilated and managed from a respiratory point of view in a manner in keeping with best practice.

Competent staff

- The centre had a local induction pack for newly appointed staff providing support via a dedicated

mentor or preceptor. Staff confirmed they had a period of supernumerary status on commencement of post. Three newly appointed staff said that their inductions had been planned and well delivered.

- The centre had developed comprehensive training packs for students and preceptors.
- Staff said they had annual appraisals and were supported to undertake development to meet identified needs. For the year to date, appraisals were completed for 88% staff which was just lower than the trusts target of 90% for development reviews. Outstanding staff had dates scheduled and a process for appraisal monitoring and delivery is in place.
- Since January 2015 the centre had recruited a nursing practice-based educator and there was ongoing review of the in-house education programme. Team development and specialist training had begun and included multi-professional solution-focused training, clinical supervision, building resilience & emotional intelligence and attendance at leadership education sessions.
- There was a self-assessment competency process in place for all clinical staff with skill acquisition relevant to role. Staff told us that their training was conducted during their working hours so they did not have to attend training in their private time.
- Reports were shared on a monthly basis at the spinal management meeting for staff training which was low in some areas. The training schedule showed there were low numbers of nurses trained in venepuncture, IV cannulation, blood transfusions, skin bundle training and immediate life support. Ward staff told us that getting time away from the ward for training was sometimes difficult due to staffing levels. The matron informed us that training days were being scheduled for May and June 2016 and we saw the staff allocated to these sessions.
- There was a good skill mix of competent staff for both adult patients and paediatric out patients.
- The centre maintained its own local records for training and acknowledged some difficulties with the availability of some training.
- Clinical supervision for nursing staff was being introduced for assessing competency, reflective learning and supportive practice.
- The centre had a number of identified link nurses, these were nurses trained to provide advice and guidance to other staff in various areas of care that included,

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infection control, pressure ulcer care, tissue viability and end of life care. Link nurses undertook 'train the trainer' sessions, then cascaded learning down to ward staff. In addition there were lead nurses in these areas to provide support and guidance.

Multidisciplinary working

- We saw evidence of multidisciplinary team (MDT) working at the centre and staff confirmed there was strong MDT working. A weekly grand round was held, attended by the whole MDT. Weekly meetings including ward round, admissions, patient and goal-planning attended by medical, nursing, psychology, therapy, case management, matron and outreach staff.
- We attended the daily board rounds in the acute areas which involved respiratory specialists, therapy, nursing and medical staff. Nurse in charge of each area then communicated with other staff.
- In addition therapy meetings with nursing staff to discuss progress against goals for each patient, weekly MDT meetings and 8 weekly goal planning meetings were held.
- Therapists worked alongside patients and staff on the ward, reviewed patients and actively taught them during the initial mobilisation period. Specialist consultant advice was available within the centre. The multidisciplinary respiratory team made up of medical, allied health professionals and nursing staff, dealt with all aspects of ventilation and respiratory management, with additional medical input and support provided by a local acute hospital. This meant there was effective support for inpatients and for patients discharged into the community with respiratory conditions.
- Staff we spoke with were aware when and how to access and refer to members of the MDT team including specialist care advice in and out of hours
- We observed handovers which took place in ARC 1 and ARC 3 separately as those staff remained in that area and we attended the handover on the main ward. We saw that there was effective communication and the handovers were well structured.
- The centre staff had established links with catering team, pharmacy, infection prevention and control team, dietetics, speech and language therapists and trust-based nursing services including tissue viability, end of life services and safeguarding team.

- Safety huddles took place daily. We observed that patient safety issues were discussed and important information exchanged to ensure the safety of patients and any organisation issues were shared.

Seven-day services

- The protocol for out of hours rehabilitation services ensured that out of hours services were provided for the patients on the spinal centre where their physical condition or treatment outcomes would significantly deteriorate.
- The centre has access to a spinal consultant over the 7-day period.
- Patients were not routinely seen by a consultant at weekends if their condition was stable.
- The centre has access to on-call physiotherapy, chaplaincy, catering and other trust services including pathology, pharmacy and radiology.
- In-patient nursing care is provided on a 24/7 day basis, with the spinal outreach service being supported via an on-call service out of hours. Therapy Services was currently provided Monday to Friday during office hours, however, 7-day working was being pursued via business case submission.
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Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Trust policies were available via the trust intranet.
- Paper patient records were in place however computers were available at the centre which enabled staff access to monitor patients, patient and trust information.
- Policies and protocols were kept on the trust's intranet which meant all staff had access to them when required.

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- Wards we visited displayed information with regards to patient safety, training, and upcoming events. Newsletters with current changes in ward performance and actions were readily available for staff to read.
- Noticeboards displayed current information and staff in the centre had access to minutes of meetings and protocols.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knew the principles of consent and we saw written records where consent had been obtained from patients prior to procedures. Patients confirmed they were asked for their consent to procedures and they had been given accompanying information leaflets. Patients gave us examples of how procedures had been explained to them so that they fully understood and could ask questions before giving their consent.
- Records we reviewed showed that patients had consented to the treatment they were due to receive. In addition two records included completed WHO safety checklists situated in the theatre pathway documentation.
- When we spoke with staff, they were aware of their responsibilities in obtaining consent and obtaining a best interest assessment if someone did not have capacity.
- All staff on the NWSIC had completed e-readers training in relation to Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training and staff knew about the key principles of the MCA and how these applied to patient care. Information provided by the trust showed that 83% of staff trust wide had completed mental capacity act level 1 training and 76% had completed level 2 training. The trust target was 80%.
- Staff had some knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). A senior nurse told us of an example where restrictive practice was implemented appropriately and how this was used for teaching staff.
- The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. There were no examples of DoLS paperwork for us to see during this inspection.

Use of technology and telemedicine

- In March 2016 a business case had been approved to provide a recurrent programme of procurement and replacement for assistive technology to enhance delivery of a safe service.

Are regional spinal injuries unit services caring?

Good



Following a rating of requires improvement during the inspection in November 2015, we have now rated the North West Regional Spinal Injuries Centre (NWSIC) services as 'Good' for Caring because;

- Throughout our inspection we observed there was a visible person-centred culture. Patients received compassionate care and their privacy and dignity were maintained, patient's emotional, social and religious needs were embedded in their care and treatment. Staff provided emotional support to patients in a calm and respectful way.
- Patients and those close to them were positive about the way staff treated them. The staff were observed to be relaxed and cheerful whilst undertaking their work, and took time to consider individual patient's needs.
- Staff recognised and respected the totality of people's needs. Patients were involved in their care and treatment, and were empowered to make decisions about their care. Staff actively worked in partnership with patients and empowered them to have a voice and realise their potential. They were given full and easy-to-understand explanations and instructions from staff when they required them.
- Patients received emotional and psychological support as part of their rehabilitation programme. They told us psychological support was good including how the whole team had helped them face the future. Additional support was available from a specialist sexual health counsellor, smoking cessation and alcohol liaison teams.
- The friends and family test results were very positive with a higher than national response rate and in September and October 2015, 100 percent of people would recommend the spinal centre as a place to receive care.

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- This was a marked improvement from the previous inspection when we reported that low staffing levels meant that sometimes staff were slow to respond to the needs of patients and did not always respect their dignity. There were also no effective strategies in place to deal with the challenging behaviour of some patients.

Compassionate care

- The staff team were enthusiastic and we observed patients being treated with compassion, kindness, dignity and respect. In addition staff were heard sharing humour where appropriate between themselves and patients.
- Patients and relatives we spoke with described the staff as caring, kind, dedicated and supportive. Staff were respectful in their interactions with patients. One patient commented the care was compassionate: "Without the emotional support and staff listening to me, I don't know how I would be getting through this trauma".
- Patients said that staff always introduced themselves. Staff had been encouraged to participate in the 6C's of care project with emphasis on Care, Compassion, Communication, Competence, Courage and Commitment and 'Hello my name is'. (NHSCB, 2012)
- The friends and family test (FFT) average response rate for the hospital was 27.1% which was higher than the national average of 25.1%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. Results showed the majority of patients who responded would recommend the spinal unit to their friends or relatives as a place to receive care and treatment. For example, in May 2015 the score was 91% and in September and October 2015 the ward scored 100%.
- However this result was not wholly an accurate reflection due to the long stay nature of the patient's at the spinal centre as the feedback could be sporadic. The spinal centre had introduced a 'You said, we did' process, led by patients and the multi-disciplinary team. One improvement made by listening to patients was the introduction of a new meal trolley which patients confirmed had improved the temperature of the meals when served. In addition the spinal centre was developing a new questionnaire for patients on discharge.
- We spoke with patients and their relatives who reported they received a high level of support. One patient told us, "The staff go beyond duty at times and have provided me with emotional support throughout my stay."
- Comments and cards from family members provided us with further examples of compassionate care.
- We spoke with three volunteers who shared examples of support given to patients with spinal injuries.
- We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity. Staff knew their patients well and could discuss their needs.
- We saw an example of good person centred care at the spinal outreach unit. For example, at Sandpiper we spoke with three patients who told us they had clearly identified goals and a programme of activity. The patient's care plans confirmed this individualised care. One patient told us, "It's a cracking idea being in the community and having this stepping stone before I am home. Staff are giving me confidence to move forwards with my life."
- All patients appeared to be well cared for: for example, they looked comfortable and where possible were washed and dressed in day clothes.
- We spoke with fourteen patients during a 'focus group' and a further seven patients and four relatives during the inspection. All patients said the multi-disciplinary team provided them with "very good" care and support and a good and caring service. Staff and patients had developed good relationships with patients and their relatives.
- Staff were passionate, proud and committed about the care and treatment they provided and we observed positive and caring interactions with patients.
- We observed examples where staff showed compassion and kind behaviour towards patients. On the Acute Respiratory Unit (ARC) a patient called out in some distress. The nurse went straight to the patient, listened to them, showed compassion and sought prompt medical attention.
- Patient information was managed securely. Records were securely held in lockable trolleys. We observed staff using the 'family room' to hold conversations in confidence.

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- During the spinal injuries focus group three patients stated they regularly waited for night sedation. We raised this with the matron at the time of our inspection and action was taken to rectify the situation and discuss this with the night staff.

Understanding and involvement of patients and those close to them

- Staff actively involved patients in their care. Patients and relatives we spoke with confirmed they felt involved in their care. They had opportunities to speak with the consultant looking after them about their treatment goals. Patients and relatives we spoke with knew about their relative's diagnosis, treatment plans and any investigations. The trust had introduced 'passports' which identified if a relative/friend wanted to be involved in a patient's care. Passports were currently under review with input from the psychologist. Patients and relatives spoke positively about information they received from staff both verbally and written.
- Nursing staff told us that goal setting was an important part of the recovery process for patients with spinal injury, and that the philosophy and strategy adopted by the centre was effective. This enabled patients to be decision makers and completely involved in their care.
- The centre published a regular newsletter for patients and their families. The newsletter provided an overview of the achievement of various patients who had received treatment at the centre. It also highlighted the developments taking place at the centre, including any improvements to the environment and any research projects being undertaken.
- Patients were aware of their named nurse and consultant. This information was displayed on a board above their bed.
- Patients told us they were involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients told us they felt safe on the spinal ward on admission or when appropriate they had received an orientation to the ward area.
- We spoke with patients about the support they received from physiotherapists and occupational therapists. One patient reported that staff discussed their exercises and they had good relationships with the therapists.
- Patients were made aware of volunteer services including: Spinal Unit Action Group, a charity which supported patients and ex-patients of the centre.

Activities included social evenings and coffee bars on the ward and assistance with travel and accommodation costs for relatives. Other examples included peer support teams and spinal injuries association.

- A new programme of education days for relatives and friends were due to start in April 2016 and in addition a 'welcome meeting' for relatives of newly admitted patients.
- A patient forum for inpatients was in place for patients to raise issues with a focus on outcomes.
- We looked at the minutes from three patient group meetings. These confirmed good attendance and actions on feedback from the patients.

Emotional support

- Staff built up trusting relationships with patients and their relatives. Patients and relatives told us they received considerable support.
- Patients and relatives were given further emotional support by the 'Patient group' which involved ex-patients. These meetings gave both patients and relatives encouragement. A relatives 'welcome meeting' had recently been introduced to assist relatives to feel part of their loved ones rehabilitation.
- Relatives told us that there were regular meetings with staff to update them on their relative's progress. Patients were also involved in these meetings.
- The multi-professional team included a clinical psychologist provided treatment and ran educational sessions. Topics included coping with spinal injury, bladder and bowel management. Patients and staff confirmed this was a valuable supportive service.
- Patients told us psychological support was excellent. One patient told us how the whole team had helped them face the future. They did not feel they would have coped if it wasn't for the help of the staff team. Additional support was available from a specialist sexual health counsellor, smoking cessation and alcohol liaison teams.
- Staff could access counselling services or support from management if they had concerns about their emotional well-being.
- Information leaflets were available to provide patients and their relatives with information about chaplaincy services. Services were available for patients 24 hours a day, seven days a week if needed. There was also a multi-faith centre that provided a place for quiet time.

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- Visiting times on the centre were open to meet the needs of the relatives and patients. This allowed relatives to support patients if they wanted to.

Promotion of self-care

- Patients we spoke with were clear of their goals and their daily rehabilitation programme which involved the physiotherapist and occupational therapists. The promotion of independence and self-care was an important part of the goal setting process.
- Patients were supported from admission towards as much independence as it was possible for them to achieve. One patient told us they had just started to stand and understood why they took this at a slow pace; they reported the staff explained their routine clearly.

Are regional spinal injuries unit services responsive to people's needs? (for example, to feedback?)

Good



Following a rating of requires improvement during the November 2014 CQC inspection; we have now rated the NWR SIC services as good for services being responsive to people's needs because;

- Positive changes had been made to improve the access of the service for patients. The centre demonstrated a clear admission policy with strong individual assessment for admission. Patients were admitted with all levels and severity of spinal cord injury, regardless of age, gender, race or ability.
- The introduction of a spinal specialist nurse had enabled good working relationships with the major trauma centres (MTC). The centre had a waiting list and was now actively monitoring numbers awaiting admission. Weekly admissions meetings discussed prospective admissions, discharges and feedback from outreach visits. The length of referral to admission time had started to reduce ensuring patients started their rehabilitation sooner.
- The in-patient spinal cord injury rehabilitation program provided a service for both patients who were newly-injured, and those who experienced a late onset complication of spinal cord injury and required in-patient hospitalisation.

- There was a focus on discharge planning from admission and there was good multidisciplinary working to support this. Each patient was assigned a case manager on admission to manage their discharge process during their stay. Consultants reviewed their patients six monthly or annually to ensure patients were reaching their goals.
- The development of the spinal outreach community team had increased bed capacity and improved the patient flow from trauma centres. Data showed the percentage of acute outreach visits within five days at the time of the inspection was 100%. Access to the community places had reduced the waiting time for patients at the centre.
- Since the last inspection staff had been supported to manage patients with challenging behaviour. The partnership working document, which was developed following last CQC inspection, was discussed with all patients on admission and an explanation given regarding expected behaviour in line with the trust's violence and aggression policy. In addition staff had received solution focussed training to support them.
- The day room had been refurbished and improvements had been made to storage space for patients' equipment.
- The increase in staffing meant patients were able to attend workshops or planned sessions with allied health professionals, such as occupational therapists, because there were sufficient staff to assist them with washing and dressing prior to the sessions.
- The centre was developing its volunteer workforce to improve the social aspect of rehabilitation at the centre.
- Complaints were handled in line with the trust's policy and trends and themes were monitored. Patients we spoke with felt they would know how to complain if they needed to.
- Call bells were available for each patient and we observed patients had access to these. Minutes of the December centre meeting showed responding to patients call bells in a timely way was raised with staff.

However,

- Although patients were still unable to access the gym facilities in the evenings as there were no staff members available to supervise them. Patients spoken with did not consider this an issue as they had completed their programme for the day.

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Service planning and delivery to meet the needs of local people

- The patient population for the North West Regional Spinal Injuries Centre (NWR SIC) extends to 6.5 million in the North West, plus the Midlands, North Wales and Isle of Man populations. Access was by referral from other hospitals and healthcare professionals. Due to the huge diverse range of patients admitted to the centre, each patient was assessed on their individual need. Trust data showed that during 2014/15 approximately 211 patients were referred to the centre. In addition the centre sees in excess of 2000 outpatients per year.
- The NWR SIC in-patient spinal cord injury rehabilitation program provided a service for both patients who were newly-injured, and those who experienced a late onset complication of spinal cord injury and required in-patient hospitalisation. The complications could include urological, skin surgery, neurosurgery or other medical and surgical procedures.
- The centre developed and reviewed its service in line with requirements from specialist commissioning. All admission decisions were made on a case-by-case basis in accordance with the national clinical reference group classification for clinical priority.
- The development of the spinal outreach community team had increased bed capacity and improved the patient flow from trauma centres. The spinal specialist nurse carried out an initial assessment before patients were admitted. Rehabilitation programmes were individually designed for each patient on the needs of the spinal cord injury population requirements.
- The NWR SIC were the first centre to develop a community outreach team where professionals gave verbal advice, visited patients who were not suitable for admission to the NWR SIC to enable them to access the most appropriate services to meet their individual needs. The outreach team had seen 130 patients face to face over the last 3 years who may be admitted or may require some rehabilitation for their spinal injury.
- Link nurses in each major trauma centre have been developed and trained by the centre to develop and maintain links to ensure patients with spinal cord injury are referred appropriately and in a timely way.
- Figures looked at showed the length of referral to admission time had started to reduce ensuring patients can start their rehabilitation sooner.
- The centre could treat 42 in-patients with SCI at any given time and has the largest ventilator-dependent and weaning spinal cord Injury programmes in Europe. The average age of patients is 56, but the most common age is 63.
- The service commissioned eight additional beds across Southport and Preston for patients who were medically fit for discharge but still had rehabilitation goals to achieve prior to discharge.
- The centre continued to forge links with other trusts, providing specialist support for patients, for example respiratory and urology services.
- The centre provided continuity of care and was responsive to different processes when planning discharges. They had links with at least 34 clinical commissioning groups across the region and were required to be flexible to meet patients' needs.
- All NWR SIC patients had a lifetime link with the centre. This meant if patients required additional rehabilitation they could contact the service. In addition the consultants would review their patients six monthly or annually to ensure patients were reaching their goals.
- A business case had been accepted for an annual programme of procurement and replacement for assistive technology, wheelchairs and mobilisation equipment.
- The requirement for additional isolation facilities would ensure referral to admission times for both vented and non-vented patients would be reduced further.
- The performance management framework showed the percentage of acute outreach visits within five days at the time of the inspection was 100%. December 2015 the rate was 94%, however this was due to an error entered on the database. It was accepted that, acute outreach visits were carried out within the five days.
- Each patient was assigned a case manager on admission to manage their discharge process during their stay. The majority of patients had complex discharge requirements with different requirements from each CCG.
- A comprehensive discharge letter that included information from all relevant healthcare professionals (psychologist, consultant, physiotherapist, occupational therapist and others) was sent to the patient's GP or referring organisation.

Meeting people's individual needs

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- Goal planning meetings were held with each individual patient during their admission. We looked at five patients' passports where their goals were identified. Goals were signed off when achieved.
- The trust used a red wrist band to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- Patients told us they were treated as individuals and of their attendance at goal planning meetings, which were held regularly to encourage patients and their families to be proactive with the process.
- The centre was developing its volunteer workforce to improve the social aspect of rehabilitation at the centre. Patients at the outreach service told us of trips out, TV nights and games evenings.
- Case managers worked with occupational therapy services to support patients to be integrated back into the community, support with funding and with local agencies to facilitate a safe discharge.
- The spinal injuries service had access to the hospitals psychiatric team to assess patients if necessary and staff were aware of how to treat and support patients with a learning disability or mental health needs. Staff records confirmed this.
- Patients told us their faith and cultural needs were respected and met. Ninety three per cent of staff working on the NWR SIC had received mandatory training in equality and diversity.
- Each patient had the name of their consultant displayed by their bed and the nurses advised the patients at the start of their shifts whom they were responsible for.
- Translation services and interpreters were available to support patients whose first language was not English. Staff were aware of the translation services and leaflets were available for patients about the services and the care they were receiving.
- There was support available for patients with spinal injury who had other medical conditions such as diabetes. There were a range of specialist nurses who provided specialist advice to staff, patients and their relatives. These included tissue viability, palliative care and diabetes. We observed a nursing handover and we found that for those patients who had been at end of life, referrals had been made to the palliative care service for specialist advice.
- Since the last inspection improvements to support staff to manage patients with challenging behaviour had

been addressed. We spoke with the ward manager re the partnership working document, which was developed following last CQC inspection. This highlighted staffs concerns with challenging patient's behaviour. The document was discussed with all patients on admission and an explanation given regarding expected behaviour in relation to patients and staff in line with the trust's violence and aggression policy. In addition staff had received solution focussed training approaches to support the staff in everyday working.

- There was a planned programme of bladder management as many patients had indwelling catheters. These were dealt with in a timely manner as the HCA's had been trained to complete intermittent catheterisations which had resulted in more timely response to patient need.

Access and flow

- The National Spinal cord database has been developed to ensure all patients who have experienced a spinal cord injury are referred to their local Spinal Cord Injury Centre. Since 2013 the centre only accepts acute referrals through the database. Consultant to consultant and GP referrals are accepted for non acute referrals.
- Assessments were carried out within five days of referral in line with the national standards and the centres pathway to assess the patient and to provide support and advice to the referring hospital. The introduction of a spinal specialist nurse had enabled good working relationships with the major trauma centres (MTC). The local MTC's had a spinal nurse to support patients whilst they were awaiting admission to the centre. The nurses had been trained by the NWR SIC's spinal team.
- Patients who were referred and did not need admitting were given out patient appointments or managed through the spinal outreach team. Patients referred via their GP were seen as outpatients.
- The average length of stay varied, some patients were 2-4 weeks whilst others were 3-6 months. This was due to the specialist nature of patients' needs and the right kind of bed being available, for example ventilation. This makes it difficult to compare the average length of stay of patients.
- The additional capacity the outreach service has brought to the centre had enabled patients referred to

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the centre from trauma centres to be admitted faster. The length of referral to admission had reduced ensuring patients were able to commence their rehabilitation sooner.

- A weekly admissions meeting for the multi-disciplinary team was held where all discharges, referrals, admissions and bed availability was discussed for the week ahead. Patients were admitted in priority order and the sex of the patient had to be considered as each bay was single sex.
- There was a focus on effective discharge planning for patients which started on admission when patients were given an estimated date of discharge. We were told main causes for delay in discharges were linked to the provision of community services for patients with complex packages of care.
- Patients who were nearing the end of their rehabilitation were assessed on suitability for an outreach bed; these were located in local care homes and a disabled holiday facility and were managed by the centres outreach team until discharge.
- There was a discharge team who supported patient discharges which were complex or required rapid discharge. The complex discharge log showed discharges were often delayed due to waiting for care packages, funding issues or for equipment that was needed in the home.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Patients and relatives we spoke with knew how to raise concerns or make a complaint. Staff encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- Leaflets and information was displayed throughout the centre on which explained the complaints procedure and how to access the Patient Advice and Liaison Service (PALS)
- Patients reported they were generally satisfied with the service during the focus group and said they were able to raise any concerns. Patients would be advised to make a formal complaint if their concerns remained.
- Complaints were monitored by senior staff and all complaints, incidents and compliments were reviewed at the monthly spinal management meeting with any trends analysed. This information was not currently filtered into the directorate dashboard.

- Due to the nature of the work within the centre, the NWR SIC received few complaints, any received were dealt with promptly and learning gained.

Are regional spinal injuries unit services well-led?

Good



Following a rating of inadequate during the inspection in November 2014, we have now rated the North West Regional Spinal Injuries Centre (NWR SIC) services as Good for Well-led because;

- There was a clear strategy for the unit to provide patient-centred care, delivered to an international standard by a specialist integrated team. This was supported by the 2015-16 trust business planning strategy and the executive team.
- Since the last inspection there had been changes to the management of the spinal team. Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. Staff reported there was a change for the better and they described an improved picture of the service. Ward managers reported that they had good relationships with their immediate matron and would see them often on the ward.
- Staff were clear on the changes within the unit and their responsibility of delivering quality care.
- Risks within the planned care division were discussed regularly at both ward and divisional level and escalated where necessary. We saw that the spinal centre and divisional risk register reflected the concerns managers expressed.
- Performance on the unit was being monitored to identify areas for improvement and to quantify the impact of actions taken. The unit was involved in the national service review of spinal cord injury provision.

Vision and strategy for this service

- The centre had a strategy to provide 'Excellent, holistic, compassionate, patient-centred care, delivered to an international standard by a specialist integrated team'. Staff we spoke with were aware of the drive to develop the service forward and of the centres core values. The

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NWRSIC had a business planning strategy for 2015/16 which is the basis for the five year strategy. The five year strategy for the NWRSIC had not yet been made available following the sustainability review.

- Within the trusts priorities NWRSIC was noted as one of eight spinal cord injury centres who nationally formed part of the service review of spinal cord injury provision. The NWRSIC was going through an immense period of change due to changes within commissioning arrangements, management of SCI nationally and an internal drive to make improvements in order for it to become a leader in spinal cord rehabilitation.
- Since the last inspection business cases had been submitted to the trust board for increased isolation facilities, increased storage facilities, dedicated dietetics and speech and language therapist and a budget for wheelchairs and assistive technology to enhance the service.

Governance, risk management and quality measurement

- Risks within the planned care directorate were discussed regularly at both ward and divisional level and escalated where necessary.
- We saw that the unit and divisional risk register reflected the concerns of managers. We attended a meeting where risks were discussed. Senior staff were aware of the risk register and the current risk of abuse of staff due to violence and aggression from patients. An action plan was in place to reduce this risk including staff training around teamwork, solution focused training, patients signing a contract and trust/spinal centre security.
- An action plan in place from the last inspection which was supporting change.
- Performance on the unit was being monitored to identify areas for further improvement and to quantify the impact of actions taken.
- Staff received governance and risk management training as part of their mandatory training.

Leadership of service

- The visibility of senior management was good and there were information boards to highlight each ward's performance displayed on each ward area. There was effective communication within staff teams.
- The leadership team now consisted of a directorate manager, clinical director, matron, head of therapy services and a senior respiratory physiotherapist. Since

the last inspection the directorate manager, matron and head of therapy had been appointed. The nursing team now had clear governance and accountability; therapy leadership was more structured and with the combination of team, the service was moving forward in a positive direction. The clinical director, an internationally renowned SCI consultant told us the appointment of a new consultant had enabled him to concentrate more on developing the service nationally. Staff spoke favourably of the senior management team, confirming visible leadership was provided in the centre regularly.

- Staff told us the ward managers often took clinical shifts making them very visible on the unit.
- The new Director of Nursing had been very supportive of changes on the unit and staff training requirements.
- The current management team had been instrumental in producing business cases to develop the service and getting some of these approved. The staff felt well supported by the executive team and line managers, the head of therapy and rehabilitation services.
- The team were developing succession planning to develop the next generation of leaders for the service. This included internal leadership, external courses and specialist training. A trainee doctor had been identified and was undertaking training.
- We observed good leadership at ward level, this included role modelling by senior staff providing guidance and support to junior nurses and health care assistants. Staff told us they felt well supported to work at the centre.

Culture within the service

- The staff were committed to delivering a good service, providing compassionate care and they were highly motivated to work within the spinal centre.
- The culture was described by nursing and medical staff as one of 'encouragement to learn' with staff wanting the best for the centre.
- Since the last inspection the centre staff had progressed from a culture of being fearful to report incidents to recognising that positive action can be a result of reporting. Nursing staff told us they reported staff shortages and the impact on the centre as this had led to an increase in staffing levels with a better quality of

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care for patients. The introduction of the safety huddles for all centre staff had ensured learning from incidents was embedded into the culture of the centre. Staff reported they felt listened to.

Public engagement

- The NWRSIC encouraged previous patients with spinal injuries to visit the unit and meet with patients. These volunteers gave both patients and relatives encouragement.
- There was a patient forum which was made up of inpatients where monthly meetings were held with the centre managers to raise any concerns. Patients reported issues raised were actioned. The centre displayed a 'you said we did' board to highlight changes patients had stimulated.
- The centre had its own charitable group, made up of former staff members, current staff members and members of the public, who regularly hosted events actively working with both inpatients, outpatients and their families as well as having full engagement with the centre staff. The charities provided peer support and provided feedback to the management team as required.
- Relatives confirmed they were provided with an induction to the centre within four weeks of their relative being admitted.
- The hospital participated in the NHS 'Friends and Family test' which gave people an opportunity to provide feedback following care and treatment. The centre were developing a patient questionnaire for the spinal injury patients on discharge as they felt the friends and family test was not really appropriate due to the length of stay of the centres' patients.







Staff engagement

- Staff had been involved in the improvement changes within the unit and spoke highly of the changes since the last CQC inspection.
- The senior nursing staff had met regularly with the staff to keep them informed of the changes to the service.

Innovation, improvement and sustainability

- The centre remained a national referral centre for phrenic nerve pacer implant driven breathing to allow the high level ventilator-dependent tetraplegic to achieve independent vent-free breathing.
- The centre has been pivotal in providing training to other Spinal and Rehabilitation Centre's for the development of intrathecal baclofen pump services. Approximately 15 baclofen pumps a year were inserted by the consultant.
- Long term ventilated patients continued to benefit from the centre's alliance with Aintree University Hospitals NHS Trust. In addition the respiratory service was now supported by the weaning centre at Aintree and the centre now has the largest SCI ventilator-dependent and weaning programme in Europe.
- Urological expertise was provided by a consultant with spinal expertise in neurogenic bladder.
- The hospital was working to improve the quality standards across the wards with the introduction of the accreditation scheme audit, the Southport & Ormskirk Nursing Accreditation Scheme (SONAS). This was a tool to understand how care was delivered, identify areas of good practice along with areas where further improvements were needed. Action had been taken to address areas where shortfalls were identified following the centres review as part of the pilot.
- The centre plans to improve the environment for patients. There are plans for charitable funds to provide a hoist tracking system and the centre are looking at a bespoke television for SCI patients.

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

Information about the service

The acute medical care services at Southport and Formby District General Hospital provide care and treatment for a wide range of medical conditions; these include stroke, cardiology, general medicine, gastroenterology, respiratory and frail elderly services.

We visited the trust as part of our announced inspection on the 12-15 April 2016 and our unannounced inspection on the 29 April 2016. We visited wards 7a, 7b, 9a, 9b, 10a, 10b, 11b, Emergency Assessment Unit (EAU), GP assessment unit (GPAU) and the ambulatory emergency care unit (AEC) over the course of our inspection.

The discharge lounge was closed during our visit between 12-15 April 2016.

We observed care, looked at records for 30 people and spoke with 31 patients and four relatives and spoke with staff across all wards and disciplines including nursing staff, health care staff, therapy staff and medical staff.

Summary of findings

At the last inspection in November 2014, we rated medical services at Southport district general hospital as requires improvement overall. The service required improvement in safe, effective, responsive and well-led domains and was rated good in the caring domain.

At this inspection we rated medical services at Southport and Formby district hospital as requires improvement overall and again rated medical services to require improvement in the safe, effective, responsive and well-led domains. We rated the caring domain as good.

- We found that not all wards appeared clean and well maintained. We found that equipment was left on wards and outside in corridors, and not all staff followed staff hygiene practices as they did not always wear suitable protective equipment between providing care and treatment to patients. There had been no formal process since July 2015 to April 2016, to ensure that the quality of care on the medical wards was maintained by senior managers and that all trust policies and procedures were being adhered to. We found from reviewing ward dashboards that matron checklists were not being completed formally since July 2015. The checklist included checking the ward environment, equipment, infection control and ward documentation. The

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matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures.

- Nurse staffing establishment levels across all wards was variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. All staff we spoke with reported concerns about staffing levels across medical services.
- Consultant vacancy rates in across medical services in March 2016 were high at 30%, and had been deemed as a high risk on the risk register. There was limited consultant cover on medical wards at weekends, and no ward rounds took place.
- Mandatory training statistics provided by the trust via ward dashboards showed that only one medical ward had achieved the trust target of 90% in mandatory training in the period of October 2015 to February 2016.
- Staff training in some core areas was below the trust targets and staff reported that they had to cancel training due to low staffing levels.
- Not all staff had received an annual personal development review. Compliance rates varied across medical wards.
- Initial patient risk assessments were not consistently completed for example VTE assessments. We reviewed 30 records and found 13 records did not have all risk assessments fully completed or reviewed.
- There was inadequate storage for staff belongings on the ward which posed a security issue for staff.
- There was no security team on site to ensure the safety of staff and visitors in the event of violence and aggression from patients or visitors. There had been 76 police call outs to the trust, with the main reason being due to physical abuse/violence from patients to staff.

- Due to a high demand for beds throughout the Hospital, some areas of the hospital were being used inappropriately to care and treat patients. For example the GPAU and the discharge lounge were being used as bedded areas.
- Although most records trolleys were new and were kept locked, we found that not all records were kept securely and there were governance issues with staff leaving computer terminals with confidential information accessible to others.
- Access and flow throughout medical services was poor and so patients were being cared for and treated on wards that were not appropriate to their needs. Escalation wards did not provide all the necessary amenities to ensure a high quality service was experienced by all patients, and call bells were not always in reach of patients.
- Due to a change in the executive team, not all staff were clear of the vision and strategy and direction of the trust.

However,

- Medical care services were delivered by hardworking, caring and compassionate staff that treated patients with dignity and respect. Staff often worked extra hours due to staffing shortages to ensure continuity for their patients.
- Medical services used evidence based practice to care and treat patients and took part in developing good practice through participation through national and local audits.
- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, and review of records, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- Nursing staff spoke highly of their immediate managers and matrons and felt supported by them to carry out their role.

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- There was a focus on discharge planning within the trust. There was a discharge team, bed management team and matrons who worked hard to ensure that patient's journey home was well co-ordinated and timely.

Are medical care services safe?

Requires improvement



At the last inspection in November 2014 safe was rated as requires improvement because there were not always a sufficient number of medical and nurse staff to safeguard the health, safety and welfare of patients. This was supported by high use of locum, agency and bank staff which affected the skill mix. Also, the percentage of staff completing mandatory training in a timely way was inconsistent and in some areas well below expected levels.

We rated safe as requires improvement because:

- On the short stay unit (SSU). A high sickness rate coupled with five staff nurse vacancies meant that the SSU used a high number of temporary staffing to cover the ward (24%).
- The February 2016, staffing report demonstrated a correlation between the wards that were understaffed in that month with a greater prevalence of patient falls. For example, 7a was 89% staffed and had six falls, and the SSU was 89% staffed and had 10 falls. The wards with near 100% staffing showed a lower prevalence of falls. For example, EAU was 96% staffed and had two falls and ward 11b was 97% staffed and had two falls.
- Mortality and morbidity reviews were held in a monthly mortality surveillance group and action plans developed to reduce mortality. However, we noted that mortality and morbidity were not part of the governance meeting structure to ensure that the information was disseminated across the directorate.
- Due to a high demand for beds throughout the Hospital, some areas of the hospital were being used to care and treat patients other than those it was designed for. The discharge lounge was being used to care and treat patients; however the call bell system was not linked to the adjoining ward. The GP Assessment Unit (GPAU) was being used to care and treat patients overnight, and did not have any shower facilities. There was also no sluice room on GPAU meaning that staff would need to carry used bed pans and waste through to the adjoining ward.

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- Not all wards and corridors we inspected were clean and well maintained. Wards and corridors were cluttered with equipment, some of which was in front of fire escapes. Not all ward floors appeared clean and some ward storage areas were not well kept.
 - We observed that not all staff followed the Personal Protective Equipment (PPE) guidance such as wearing gloves and aprons on interventions with patients.
 - Nurse staffing establishment levels across all wards were variable; all had vacancies that were being filled by either staff working extra hours or agency workers. Although there was usually enough nursing staff numbers on the wards, the skill mix was not always as required. Data provided by the trust showed that between December 2015 and February 2016, 7a, 7b, 10b, 9b, 11b and 14b did not have 100% fill rate for qualified staff on the wards.
 - Consultant vacancy rates across medical services in March 2016 were high at 30%.
 - Mandatory training statistics provided by the trust showed that only one medical ward had achieved the trust target of 90% in mandatory training in the period of October 2015 to February 2016. For example, only 53% of staff on ward 10b and 67% on ward 11b were up to date with their mandatory training.
 - We reviewed compliance with safeguarding children level 2 training across eight medical wards and found that none of the wards achieved the trust target from March 2015 to February 2016. Mandatory training compliance data provided by the trust showed that ward 7A achieved only 11.5% of staff trained in safeguarding children level 2 in February 2016.
 - Training statistics provided by the trust for March 2016 showed that the medical staff had not met the trust target of 90% in any of the training elements. For example only 60% had received infection control training, 75% had received conflict resolution training and only 26% had received local fire safety training.
 - There were systems in place for the safe storage and handling of medicines and controlled drugs, however we found that medicines were not always checked and we saw no formal evidence that fridge temperatures were being audited by managers overseeing the wards.
 - There was no security team based at the hospital, instead wards were required to call the police if help was required due to violence and aggression to staff or patients. This left staff and patients potentially vulnerable due to violence and aggression from some patients and visitors.
 - Lockers and changing facilities for staff were very limited and so staff were using the tops of lockers to store their belongings.
 - Records on the ward were stored securely in lockable trolleys on the ward. However, we found on ward 11b and 7a the notes trolleys had been left unlocked and other confidential files were kept out on the wards and were not locked away.
 - Although staff were proficient in the use of the electronic system to record early warning scores (EWS), wards we visited were not reliably recording all observations at the given time. For example, on wards 9a, 7b, 14b, EWS were not completed on time for any period between April 2015 and January 2016.
 - Initial patient risk assessments were not consistently completed for example VTE assessments. We reviewed 30 records and found 13 records did not have all risk assessments fully completed or reviewed.
- However,
- There were procedures in place to accurately record incidents and staff were aware of the process of making safeguarding's to protect vulnerable patients. There were senior staff in which to provide support if required.
 - Nursing and medical handovers were completed on the changeover of every shift. The handovers were robust in that they discussed each patient and any deterioration in their condition was highlighted.
 - Performance in infection prevention and control was monitored monthly across the medical directorate. There were robust monthly infection control audits completed by the infection control team. We reviewed reports from December 2015 to February 2016 and saw that they provided ward compliance rates and leaning points. For example we in the February 2016 report the trust scored 99% in the hand hygiene audit and highlighted those wards that had failed to submit data to the audit to ensure future compliance.

Incidents

- Incidents were recorded and documented using an electronic incident reporting system to capture data on incidents or near misses. Staff could clearly demonstrate how to use the system, and identified the

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types of incidents that should be recorded and understood what constituted an incident. Examples given included patient falls, development of pressure ulcers or insufficient staffing levels on the ward. We reviewed incidents from January 2016 to March 2016 and found that medical wards had reported 471 incidents that included patient falls, staffing issues, and safeguarding.

- Between February 2015 and January 2016 medical services reported a total of 13 serious incidents, including seven pressure ulcers, one unexpected death and one homicide.
- Staff told us they were encouraged to report incidents to protect patients. Feedback from incidents was regularly fed back to the staff via team briefings and staff safety huddles. Staff were able to show us where the briefings were kept and were able to discuss incidents that had been highlighted and the actions to be taken at ward level. For example, following a medicine incident the trust had responded quickly to ensure that the event did not happen again.
- Once serious incidents were reported a root cause analysis was undertaken and feedback given with any actions for learning. We reviewed team briefing bulletins (Governance noticeboard) sent to the ward and found that incidents were highlighted, and information to staff given to prevent further occurrence. For example, pressure ulcers were highlighted as a concern and so patients need to have pressure areas checked as part of the admission process. From records reviewed we found that patients were being routinely screened for pressure ulcers and staff we spoke with were aware of the screening process.
- The bulletins welcomed feedback from staff and provided them an e-mail and telephone number in order to make comments or suggestions.
- There had been one never event, (Never events are serious, wholly preventable incidents that should not occur if the preventative measures had been implemented) in February 2016. This was related to a medication error. We reviewed that a full investigation had been completed with a chronology of events and we saw that the information had been cascaded back to the wards. The patient had been contacted and the duty of candour process followed. We reviewed that the never event had been reported promptly to the Strategic Executive Information System (STEIS).

- The Trust had a being open policy which included the duty of candour requirements. The chief executive was ultimately responsible for the duty of candour requirements, which was delegated to the director of nursing and quality and the executive medical director. Minutes of governance meetings showed that incidents were discussed and actions identified.
- Staff at all levels were aware of the duty of candour legislation, and were able to give us examples of when this had been implemented. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Mortality and morbidity reviews were held in a monthly mortality surveillance group and action plans developed to reduce mortality. However, we noted that mortality and morbidity were not part of the governance meeting structure to ensure that the information was disseminated across the directorate.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and harm free care. Performance against the four possible harms including falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was collected and performance monitored on a monthly basis. Ward dashboard performance for February 2016 showed that not all wards were compliant with assessing patients on admission for VTE. For example ward 14b was 91% compliant, the short stay unit was 92% compliant, and ward 11b was only 78% compliant in assessing patients for VTE on admission.
- Safety thermometer information was prominently displayed on all of the medical wards and the results related to that particular ward. All staff we spoke with were aware of the NHS safety thermometer and actions were taken to reduce the likelihood of harm to patients.
- Between September 2014 and September 2015, the trust data showed that there had been 12 pressure ulcers, 18 falls and 16 CAUTI's. Wards collected data monthly and reported this as part of their ward

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performance dashboard. Staff were able to explain that patients that were more susceptible to falls were cared for in beds closer to nursing stations so that they could be monitored to reduce the likelihood of falls.

Cleanliness, infection control and hygiene

- Not all wards we inspected appeared clean and well maintained. For example, we found that not all floor in areas appeared clean. On the short stay unit, we found paper and thermometer caps on the floor, we found that most wards were cluttered with dirty linen trolleys, dirty linen bags and equipment. On 11b we found clean linen stored on the top of the dirty linen trolley. Most wards were cluttered with equipment; staff reported that wards were short of storage space. On 10b and 7a the sluice area was untidy with empty discarded packets, and clean stocks were kept near the dirty utility and dirty linen had been left on the floor of the dirty utility.
- We interviewed patients with regards to the cleanliness of the wards. Viewpoints were mixed, but mostly thought the wards were clean. However one family reported on ward 9a that food debris had been on the floor for 24 hours indicating the floor had not been cleaned. Another patient on ward 9b also reported that the floor had not been cleaned properly since they had been in hospital for over 24 hours. We also found on two wards that three patients who required catheters did not have their catheter bags on stands and instead were on the floor next to the bed.
- We observed staff hygiene practice and found that not all staff followed the Personal Protective Equipment (PPE) guidance such as wearing gloves and aprons. We found that on 9b one member of staff was not wearing an apron whilst changing a catheter bag; another was walking through the ward with a used bed pan without wearing gloves or an apron. On ward 9a and 7a staff members carried dirty linen without wearing an apron and another assisted a patient from the bathroom and did not use the hand gel prior to cleaning a bed space. We found trousers and used underwear in the corridor outside of the GP assessment unit.
- There were sufficient hand wash sinks and hand gels, and soap dispensers were adequately stocked and we observed that all staff followed the 'bare below the elbows' guidance.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk. There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room.
- Hand hygiene audits were completed in line with the world health organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. All wards we visited had been compliant in hand hygiene audits apart from 11b that was 90% compliant in the February 2016 audit.
- Between December 2014 and December 2015, the trust reported two incidents of Methicillin-Resistant Staphylococcus Aureus (MRSA), 35 incidents of Clostridium Difficile (C.Diff) and 18 incidents of Methicillin-Susceptible Staphylococcus Aureus (MSSA). The trust target for MRSA was zero. Within this period One of the MRSA reported incidents were related to medical services in April 2015, and 13 cases of clostridium difficile related to medical services
- Performance in infection prevention and control was monitored monthly across the medical directorate. There were robust monthly infection control audits completed by the infection control team. We reviewed reports from December 2015 to February 2016 and saw that they provided ward compliance rates and learning points. For example we in the February 2016 report the trust scored 99% in the hand hygiene audit and highlighted those wards that had failed to submit data to the audit to ensure future compliance.
- A Hygienic Environment Action Team (HEAT) audits had stopped being completed in 2015. The HEAT audits were completed by a number of the management team including the ward matron to ensure for example that the wards were clean and tidy, equipment was clean, and infection control procedures were being completed. The audit was being replaced by a Southport & Ormskirk Nursing Accreditation Scheme (SONAS). The ward accreditation scheme which started in December 2015 was in the process of being completed across medical services. Not all medical wards had received this audit at the time of inspection.

Environment and equipment

- There was insufficient storage for essential equipment on many wards in the medical directorate. This meant that corridors and bays in the wards were cluttered with

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equipment, making it difficult for staff and patients to move freely around the wards. For example, we found two trolleys being stored in the seated waiting area of GP assessment unit (GPAU) with a further four trolleys and wheelchairs being stored in the corridor outside. We found equipment in front of a fire escape on 11b, a trolley had been left in front of a fire escape on ward 10B and a dirty laundry trolley had been left in a shower room. We also found a hospital bed, two trolleys and two wheelchairs were left in the corridor between ward 7a and 7b.

- This lack of storage added to the general appearance of wards feeling disorganised as equipment and trolleys were left out on the ward. This also risked unsteady patients falling over equipment as they moved around the ward.
- We found sharps bins were being stored on resus trolleys on the short stay unit (SSU) and 7a, without the temporary closures in place. We also found that a sharps bin was being stored on the sepsis trolley on ward 11b which was over filled, and the temporary closure was not in place.
- Lockers and changing facilities for staff were very limited. For example, we found on ward 7b, not all staff had access to a locker and were small in size, which meant some staff needed to store their belongings on top of the lockers. This did not provide staff with the necessary security for their personal possessions.
- There was no security team based at the hospital, instead wards were required to call the police if help was required due to, for example violence and aggression to staff or patients. We reviewed incident reports from January 2016 to March 2016 and found there had been 16 reports of violence and aggression across medical services. Staff we spoke with confirmed that there had been times that a security team had been required and had felt frightened by some events. Data provided by the trust reported that the police had been called into the hospital 11 times from January 2016 to March 2016. Nine of these call outs were due to either violence or verbal abuse.
- The GPAU was being used as a bedded area for six patients due to the high demand for hospital beds. The patients in those beds had access to a toilet situated at each end of the unit, however did not have direct access to shower facilities. These patients were required to go through to the attached Emergency Assessment Unit (EAU) to shower as required.
- The GPAU did not have direct access to a sluice room, therefore staff were required to carry used bed pans and waste through to the EAU.
- The discharge lounge was not in use and was being used as an extension to ward 9b. Two patients were being cared for and treated in this area. However, the call bell system was not linked to ward 9b and so relied upon staff hearing the call bell. We found the call bell was not particularly loud; however managers reported that the staff were able to hear the call bell. We observed that this was on the risk register and only independent patients were to be placed in this area. However, due to the numbers of agency staff being used this risked patients not receiving prompt care and attention as nurses who were unfamiliar to the environment may not respond or hear to the call bell sounding.
- Resuscitation equipment was available on all wards we visited and tamper proof seals were in place, and we found that checks of the equipment had been completed. However, the GPAU did not have its own resuscitation equipment and so relied upon the use of the resuscitation equipment from the EAU in the event of an emergency. We found on the Observation Ward (OBS), that a portable suction device on the resuscitation trolley had been reported as missing in February 2016 and was still waiting for a replacement.
- There was a lack of space on most of the wards in the medical directorate with which to have private conversations with patients and families. The ward manager's office was frequently used for this purpose. This was an inappropriate space and also meant that there were often times when the ward managers could not always use their offices. We observed that a junior doctor and a staff nurse were having a private discussion with relatives on the corridor outside GPAU and EAU.
- An intercom system was in operation outside each of the wards to maintain the security of patients.
- There were systems in place to maintain and service equipment. The wards we visited reported that they had no broken equipment. All equipment we inspected was in good working order and serviced. Electrical items were portable appliance tested (PAT).
- We observed that patients that required pressure relieving equipment were on suitable pressure relieving mattresses.

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- Some bathrooms on medical wards, for example 7a and 7b, had long orange pull cords situated near hand rails or hooks which meant they could be used to isolate the pull cord from the call bell and be used as a ligature point. Staff we spoke to were unaware if these had been risk assessed.

Medicines

- All wards we visited had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identified the patient before medicines were given to the patient. Regular checks of controlled drugs balances were recorded. However, we saw for instance on the Short Stay Unit (SSU) that controlled drugs had not been recorded on two occasions in March 2016, on ward 9b the controlled drugs had not been checked for five days in January 2016, and four days in April 2016. We saw no formal evidence that controlled drugs were being audited on a weekly or monthly basis by the ward managers or matrons overseeing the wards and individual ward dashboards did not provide an assurance that medicines management had been completed by matrons.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward. However, fridge temperatures were not always regularly checked on all wards. For example, we found on 7a the fridge temperature had not been recorded on three days in January 2016. On 7b fridge temperatures had not been recorded on two days in April 2016. Ward 9a had not checked fridge temperatures two days in January 2016, one day in February 2016 and one day in April 2016. We saw no formal evidence that fridge temperatures were being audited by managers overseeing the wards.
- We reviewed 20 prescription charts and found them to be accurate and up to date apart from two records where allergies had not been noted.
- Wards we visited had a pharmacist to support with patients medication. Pharmacists covered the wards

between Monday and Friday. The pharmacy was open over seven days and there was an on call pharmacist if required. Prescription charts reviewed showed evidence of a pharmacist review.

Records

- Patient records included a range of risk assessments and care plans that were to be completed on admission and reviewed throughout a patient's stay. Most patients had an individualised care plan that had been reviewed and updated.
- Records on the ward were stored securely in lockable trolleys on the ward. However, we found on ward 11b and 7a the notes trolleys had been left unlocked. Other important confidential nursing records were not kept locked away and were found to be kept out on the ward. For example on ward 7a, nursing files containing confidential patient assessments were stored opposite the nursing base station on a unit.
- We reviewed 30 patient records and found them all to be legible, included the name of the doctor reviewing the patient, and all contained a care plan.

Safeguarding

- Safeguarding policies and procedures were in place, and staff knew how to refer a safeguarding concern to protect adults and children from abuse. The trust had a safeguarding team which staff reported was a valuable resource as they also offered advice and guidance if needed. Staff reported that guidance was also available on the trust intranet. Senior nurses and a safeguarding lead nurse were also available to give advice and guidance if required.
- There was a system for raising safeguarding concerns. Staff were aware of the process and the trust safeguarding team were accessible from Monday to Friday and did not offer a 24 hour service. Advice outside of Monday to Friday was provided via the bed manager or via senior nurses on the wards.
- Training statistics provided by the trust showed that in medical services 75% of medical staff in general medicine had completed safeguarding training level 1 in March 2016 and only 50% had completed safeguarding level 2 training within this period. The trust target was

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90%. All nursing staff were required to attend safeguarding training level 1. From the wards we visited, all wards achieved above the 90% trust target apart from ward 9a which achieved 80%.

- The training statistics from the trust showed that compliance in safeguarding children level 2 training was low. We reviewed the training data for eight medical wards and found that none had reached the trust target of 90% for the whole period from March 2015 to February 2016. Ward 7A dashboard performance data reported that in February 2016, only 11.5% of staff had received safeguarding children level 2 training.
- The trust monitored the number of safeguarding referrals they made each month. For medical services there had been 26 safeguarding referrals made between January 2015 to December 2015. Safeguarding referrals were monitored, and monthly safeguarding adults steering group meetings took place.

Mandatory training

- Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as health and safety, fire, manual handling, and infection prevention and control.
- Training statistics provided by the trust for March 2016 showed that the medical staff had not met the trust target of 90% in any of the training elements. For example only 60% had received infection control training, 75% had received conflict resolution training and only 26% had received local fire safety training.
- Mandatory training statistics provided by the trust via ward dashboards showed that from the wards we visited none had achieved the trust target of 90% in all mandatory training up to February 2016. For example, only 53% of staff on ward 10b and 67% on ward 11b were up to date with their mandatory training. It was reported that the addition of 'prevent' training which was a new core mandatory training element impacted on the overall training statistic figures as not all staff had received this. However, mandatory training statistics provided by the trust showed that only the short stay unit had achieved the trust target of 90% in the period from October 2015 to February 2016.

Assessing and responding to patient risk

- The trust used an electronic system to record Early Warning Scores (EWS). The system was used to alert staff

if a patient's condition was deteriorating using a set of observations including temperature, pain score and respiratory rate. Observations were increased if there were signs of a patient deteriorating.

- The trust gathered information monthly to ascertain whether EWS observations were being completed on time. None of the wards we visited were reliably recording observations at the given time and did not meet the trust protocol. For example, on wards 9a, 7b, 14b, EWS were not completed on time for any period between April 2015 and January 2016. Actions were highlighted for improvements to be made across all wards that included the ward manager/co-ordinator to review each patient at the start, middle and end of each shift to monitor each patient. As observations were not being recorded on time this risked that if a patient was to deteriorate then it would not be escalated timely to the medical team. We saw that staff were proficient in the use of the electronic system and they informed us that it was often difficult to complete observations on time due to the low levels of staffing.
- Upon admission to medical wards staff carried out observations and risk assessments to identify patients at risk of harm. The risk assessments included falls, pressure ulcers, nutrition (malnutrition universal screening tool MUST) and use of bed rails. From the 30 records we reviewed we found 13 records did not have all risk assessments fully completed or reviewed. For example six records did not have a Malnutrition Universal Screening Tool (MUST) completed or reviewed. The MUST is a simple 5 step screening tool which helps to identify adults who are underweight and at risk of malnutrition.
- There were specialist nurses in tissue viability to support staff in grading pressure ulcers and a falls nurse to support with assessing risk of falls to patients. Patients at risk of falls wore a yellow wrist band to highlight to staff the patient was at risk. We observed that patients who were at risk of falls were wearing yellow wrist bands and there was evidence in patient records that specialist nurses reviewed patients once referred.
- Patients at risk of harming themselves or at severe risk of falls were protected by having one to one support in order to maintain their safety. Staff were able to identify these patients to us and were generally cared for nearest nursing stations to ensure patient safety.

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- Nursing handovers were completed on the changeover of every shift. We observed a morning handover on ward 7a, and saw that EWS and patient risks were discussed for all patients.
- Medical staff informed us that they received an adequate handover. There was a verbal formal handover at 9am which included the on-call teams, acute physicians, and the on-call consultant. At 9pm the day team handed over to the night team which included the surgical and orthopaedic team and night co-ordinator, however this did not include a consultant. The senior management reported that they were looking at the feasibility of an electronic handover system and included a consultant at the 9pm formal handover to improve record keeping and handovers.

Nursing staffing

- Nurse staffing establishment levels across all wards were variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. All staff we spoke with reported concerns about staffing levels across medical services. All managers reported staffing levels to be a risk and staffing was on the risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment and any shortfalls in staffing were highlighted to senior managers daily. Managers regularly moved staff around the service to fill staffing shortages. Staff reported that this often left them short on their ward once staff were moved and potentially unbalanced the skill mix on the ward.
- The National Institute for Health and Care Excellence (NICE) guidelines for safe staffing for nursing in acute hospitals was used by the trust. Each ward had a planned nurse staffing rota and any shortfalls in staff numbers were reported on a daily basis to senior managers. From reviewing the rotas we saw that staff shortages were highlighted, senior managers were aware, and plans made to ensure a safe staffing level.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- All wards we visited had staff vacancies. For example, ward 7a had eight staff nurse vacancies, 9b, had six staff nurse vacancies, ward 7b had three staff nurse vacancies and 11b had eight staff nurse vacancies. Managers reported that covering shifts could be difficult and was often left until last minute before authorisation by senior management to use agency staff was given. For example, on ward 7b, the ward manager at 9am was waiting for authorisation to fill a nursing shift that evening. This provided little time to organise shift cover to ensure safe operation of the ward.
- Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across medical services. Managers informed us that, to ensure patient safety, extra bank health care workers were used to fill the shortfalls and provide assistance to the nursing staff. However, this could risk an imbalance of skill mix and did not mitigate the need for trained nurses to be on shift to provide the care and treatment needed to unwell patients.
- The trust reported that as of the end of February 2016, they had 39.5 staff nurse vacancies across the medical wards. Ward staff and managers informed us that staffing levels were often below establishment and meant they worked extra shifts, or relied upon agency staff to cover short falls in staffing numbers.
- The average percentage of qualified nursing and unqualified nursing shifts filled from October 2015 to February 2016 was variable. The staff fill rate data supplied from the trust showed the planned verses actual levels of staff on the wards, identified that generally shifts were being covered by the correct number of nursing and non-nursing staff during the night. However, day shifts and were not always covered with the correct numbers of qualified nursing staff. To ensure the fill rate of staff was as needed, extra healthcare support workers were used to ensure there was enough staff on the ward. For example, the day fill rates for ward 9b in February 2016 were 71% for qualified staff and 123% for non-qualified staff, and ward 11b had a fill rate of 78% for qualified staff and 116% for non-qualified staff.
- Data provided by the trust showed that between December 2015 and February 2016, 7a, 7b, 10b, 9b, 11b and 14b did not have 100% fill rate for qualified staff on the wards.
- We reviewed incident reports provided by the trust that related to staffing for the period of January 2016 to March 2016, and found that staff reported incidents where there were not enough staff to cover the wards. For example, in January 2016 an incident report was

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made stating that there were only two qualified staff to 24 patients, some of which were a high risk of falls and 12 patients who were all care. On the 17 February 2016 an incident report was made due to there being no qualified staff on GPAU between 7.30am and 9.00am. This was highlighted as a risk on the risk register. We were given assurance that this was not a regular occurrence and had occurred twice. Plans were in place to ensure that the GPAU was always staffed with qualified nursing input from the EAU.

- The staff turnover rate in February 2016 was variable across all medical wards, ranging from 0% for six of the medical wards to 6.7% on ward 11b.
- Sickness rates across the medical wards varied in February 2016 between 0% on EAU, 14b and 7b and up to 15% on the short stay unit (SSU). A high sickness rate coupled with five staff nurse vacancies meant that the SSU used a high number of temporary staffing to cover the ward (24%).
- The February 2016, trust staffing report showed that the wards that were understaffed in that month generally had a greater prevalence of patient falls. For example, 7a was 89% staffed and had six falls, and the SSU was 89% staffed and had 10 falls. The wards with near 100% staffing showed a lower prevalence of falls. For example, EAU was 96% staffed and had two falls and ward 11b was 97% staffed and had two falls.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and medical inpatients across the medical wards. All medical trainees contributed to the rota.
- Consultant working hours varied between wards. Consultant cover was from 9am to 7pm Monday to Friday with cover 9am to 5pm over the weekend.
- The percentage of consultants working in medical services was 29% which was lower (worse) than the England average of 34%. The percentage of middle career doctors was 14% which was higher (better) than the England average of 6%. The percentage of registrars was 31% which was lower than the England average of 39% and the percentage of junior doctors was 26% which was higher than the England average of 22%.

- Senior managers informed us that they were recruiting more consultants to the trust and had just appointed three gastroenterologists, one imaging consultant and two acute physicians. There was still an appointment outstanding for a cardiologist.
- The trust reported that the turnover rate of medical staff was 21% and the use of locum medical agency staff was 28%.
- The trust reported that in March 2016 there was a 30.49% consultant vacancy rate across medical services equal to 5.55 whole time equivalent consultant posts.
- We observed a ward round which was attended by a consultant, junior doctors and nurses and there was good communication between the multidisciplinary team and the patients.

Major incident awareness and training

- There were documented major incident plans within medical areas with action cards to follow in the event of a major accident. We observed that action cards were placed on the wall on the wards we visited so staff would know what to do in the event of an emergency.
- Staff were aware of the actions to take in the event of an emergency and knew how to find the trust policy and access key documents and guidance.
- Staff were aware of the procedures to follow in the event of a fire.
- In the event of staff shortages a staffing escalation plan detailed the responsibilities of the managers to ensure that staff shifts were covered on a daily basis to ensure patient safety.

Are medical care services effective?

Requires improvement



At the last inspection in November 2014 effective was rated as requires improvement because the assistance given to those patients who require support to eat and drink was inconsistent and the maintenance of IV fluids in those patients unable to hydrate orally was constrained and delays were seen.

We rated effective as requires improvement because:

- We observed a meal time on the stroke unit and found that it took approximately 20 minutes to organise

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providing assistance to patients who required support to eat. This subsequently meant that food was potentially cold when being served. We also observed that some patients had care needs at that had not been attended to prior to lunch being served. For example, one patient had excessively dry lips and dried blood around their mouth, another patient was asleep when the meals were presented and so was given little time to adjust prior to eating. We also found that two patients had used urinals bottles on the table when lunch was served.

- There was no formal process of matron checklists being completed throughout medical wards from July 2015 to April 2016. The matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures. We were informed on the unannounced inspection on the 29 April 2016 that a new matron checklist was being rolled out across medical wards alongside the nursing accreditation scheme.
- Most patients had an individualised care plan that was reviewed and updated. However, we found that not all patient assessment forms were being completed fully. We found that in eight records the patient's property on admission had not been recorded, therefore wards would not be able to reconcile patient property accurately upon discharge.
- There were computers available on the wards we visited which gave staff access to patient and trust information. However, we found that computers were not always locked to prevent data from being seen by unauthorised personnel.
- Not all staff had received an annual personal development review. Compliance rates varied across medical wards. The trust supplied data that showed that not all wards had met the compliance rate of 90% in any period between March 2015 and February 2016. For example in February 2016, the short stay unit review rate was 53%, the stroke unit compliance rate was 68% and on ward 14b the compliance rate was 25%.
- Compliance in staff training was variable across the medical wards. For example, we found that from records supplied by the trust that in February 2016, there were low numbers of nurses trained in blood transfusions. Ward staff informed us that receiving training was difficult due to staffing levels and often had to cancel

training. The SSU had only 24% of staff trained in blood transfusions, EAU (33%), 11b (34%), and 9b (37%) and the stroke unit performance only reached 31% in the period between March 2015 to February 2016. This potentially meant that patients would be delayed in receiving the treatment they required.

- There was limited consultant cover on medical wards at weekends, and no ward rounds took place. We were informed that the trust was looking at expanding the medical staffing to provide a seven day reviewing process. However, there was a discharge registrar to help ensure that patients who were due to be discharged were reviewed.
- There was no routine service provided by allied health professionals out of normal working hours. However, the service was available seven days per week for those patients seen by the Ambulatory Emergency Care (AEC).

However,

- The average length of stay for non-elective geriatric medicine in September 2014 to August 2015 was 8.3 days which was lower (better) than the England average of 9.9 days. However, the average length of stay for non-elective patients on general medicine wards for the same period was marginally worse than the England average at 6.5 days compared to the England average of 6.3 days, whilst cardiology patients had an average length of stay of 7.6 days compared with an England average of 5.6 days.
- Medical services used evidence based practice to care and treat patients and took part in developing good practice through participation through national and local audits.
- The AEC saw 2119 patients between November 2013 to April 2016, which supported the trust in reducing the number of patients needing to be admitted to hospital.

Evidence-based care and treatment

- The service used national and best practice guidelines to care and treat patients. The trust monitored compliance with National Institute for Health Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified. For example an action plan for improving diabetes in adults had been developed and the recruitment of a diabetes specialist nurse to improve care and treatment for people with diabetes.

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- The Service participated in clinical audits through the advancing quality programme. The advancing quality programme aims to improve the quality of care patients receive in hospitals across the North West of England by measuring and reporting how well the hospitals are performing. The trust participated in seven of the 11 eligible audits in the period of April to September 2015 to support improvements in the quality of care for patients.
- The Service had developed action plans for improvement in performance in the clinical audits. For example, in the Chronic Obstructive Pulmonary Disease (COPD) audit, the trust reported only 25% of Antibiotics were administered to patients appropriately within 4 hours of hospital arrival. The target was 100%. The action plan although stated there was an under performance, it did not however provide a clear plan of action to take to reach 100% target. The action plan stated monitor results collected through continued participation in the advancing quality programme. This did not give clear objectives in order to meet the target.
- Stroke specialist nurses attended the accident and emergency department if a patient was admitted with a suspected stroke. Pathways were in place to ensure that patients who had suffered a stroke were treated quickly and moved to the high dependency unit or to the stroke unit for the correct care and treatment.
- Patient assessment documents were to be completed by nursing staff when patients were admitted to the ward and reviewed regularly. This formed the basis of the patient overall care plan. Most patients had an individualised care plan that was reviewed and updated. However, we found that not all patient assessment forms were being completed fully. We found that in eight records the patient's property on admission had not been recorded, therefore wards would not be able to reconcile patient property accurately upon discharge.
- The ambulatory emergency care (AEC) service was an eight chaired area that provided medical care on an outpatient basis from Monday to Friday from 7am to 7pm. The AEC was also used at weekends for those patients who required outpatient parenteral antimicrobial therapy (OPAT). AEC was based in the accident and emergency departments observation ward. The service was delivered by two advanced nurse practitioners and medically led by the accident and emergency consultants who saw patients if required.

The ambulatory care pathways included care of patients with cellulitis. The service saw 2119 patients between November 2013 to April 2016, which supported the trust in reducing the number of patients admitted to hospital and saving the trust approximately £529,750.

- We found from reviewing ward dashboards that matron checklists were not being completed formally since July 2015. The checklist included checking the ward environment, equipment, infection control and ward documentation. The matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures. The importance of the matron checklist being completed was highlighted as we found that on the Observation Ward (OBS)/Ambulatory Emergency Care (AEC) a portable suction device had been missing from the resus trolley since February 2016. This would have been highlighted on a matron ward round checklist and actions taken to ensure the ward had the necessary equipment in place. We were advised by managers that the matron checklist had recommenced in April 2016 and we saw evidence of the new documentation.

Pain relief

- Pain relief was managed on an individual basis, and was regularly monitored. Pain scores were routinely collected by nursing staff due observation rounds and recorded. We saw that pain levels were recorded. We observed this information being discussed at nurse handovers.
- There was a pain team based within the hospital to provide support and advice to staff and patients as needed and referral could be made for follow up by the community pain team.
- Patients we spoke with told us that they had access to regular pain relief.

Nutrition and hydration

- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. There was a co-ordinator to ensure that patients received help with ordering their meals using an electronic system of ordering.
- Most patients we spoke with reported that they enjoyed the food provided by the hospital. In the Patient Led

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Assessment of the Care Environment survey for 2013, 2014 and 2015 the hospital scored 87% in the quality of the food provided, which was the same as the England average.

- We observed care during a lunchtime meal on the stroke unit in a formal way using the Short Observational Framework for Inspection (SOFI). We observed that the meal trolleys arrived on the ward by 12pm. At 12:15pm a health care assistant asked who was free to support with meals. By 12:20pm all patients who required assistance were being assisted with their dietary needs by which time the meals were potentially going cold. We also observed that some patients had care needs that had not been attended to prior to lunch being served. For example one patient had excessively dry lips and dried blood around their mouth, another patient was asleep when the meals were presented and so was given little time to adjust prior to eating. We also found that two patients had used urinals bottles on the table when lunch was served.

Patient outcomes

- The trust had developed a patient safety collaborative to increase quality and safety for patients in a number of areas. The collaborative aim was to empower local patients and healthcare staff to work together to identify safety priorities and develop solutions. For example, the trust had developed a collaborative in order to reduce the number of pressure ulcers being seen in both acute and community settings. Since the start of the collaborative in July 2015 the trust reports there had been a 25.7% reduction in reported pressure ulcers since the baseline was taken. However, although the medical service dashboard performance showed there was a decrease in hospital acquired pressure ulcers from July 2015, showing only two reported pressure ulcers in August 2015 and zero in September 2015, it also showed that in January 2016 there was an increase to six pressure ulcers and in February 2016 there were five reported pressure ulcers. These reported pressure ulcer figures were higher than the numbers reported in most months prior to the collaborative starting.
- The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attacks. MINAP audit results for 2013/2014 for this trust showed the number of patients diagnosed with a non –ST segment elevation myocardial infarction

(N-STEMI- a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the England average at 96.2% (England average 94.3%). However only 26.2% of patients were admitted to a cardiac unit which was worse than the England average of 52.6%.

- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The latest audit results from July 2015 to September 2015 rated the hospital overall as a grade 'C', which is an improvement from the previous audit results from April to June 2015 when the hospital was rated as a 'D'. The trust had put into place actions to continually improve the audit results. The stroke team had dedicated protected stroke beds to avoid patients being outlied on the ward. The stroke unit had recently moved to a smaller 22 bedded unit and stroke assessors had a 24 hour, seven day per week working pattern to ensure that patients admitted through accident and emergency were seen. Stroke performance was being monitored and reviewed through a stroke task and finish group.

Although we were told that stroke beds were protected, we were informed that during the inspection there were three medical outliers on the ward and one bay was closed due to infection. This meant that if a stroke patient was to be admitted through accident and emergency it would prove more difficult or delay a patient being moved to the stroke ward.

- An external stroke review by the national stroke team took place in February 2015, which highlighted six of areas for commendation which included stating that clinical staff involved in the stroke service were loyal, motivated and passionate about stroke with strong interpersonal and inter-professional relations. The report also highlighted six recommendations to which the stroke unit was working towards service improvement.
- The national heart failure audit showed that the hospital performed better than average in two of the clinical (in hospital) indicators and in five of the clinical (discharge) indicators.

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- In the National Diabetes Inpatient Audit (NaDIA), the trust scored better than the England average in 11 of the 21 indicators. The trust had improved its performance on the 2012 audit having improved scores in 12 of the indicators.
 - The average length of stay for non-elective geriatric medicine in September 2014 to August 2015 was 8.3 days which was lower (better) than the England average of 9.9 days. However, the average length of stay for non-elective patients on general medicine wards for the same period was marginally worse than the England average at 6.5 days compared to the England average of 6.3 days, whilst cardiology patients had an average length of stay of 7.6 days compared with an England average of 5.6 days.
 - The readmission rates for all elective patients at the hospital were better than the England average, and for all non-elective patients were generally about the same as the England average. The readmission rate for non-elective geriatric medicine was slightly worse than the England average.
 - The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. The latest SHMI data for the year to June 2015 was 105.6 which was an improvement over the previous rate of 107 for the year to December 2014.
- Competent staff**
- Staff told us that they received an annual personal development review (PDR). Data provided by the trust showed a mixed response to review rates in February 2016. For example the short stay unit review rate was 53%, on the stroke unit, the compliance rate was 68% and on ward 14b the compliance rate was 25%. The compliance rate for this ward had improved since September and October where the rate was 17%. The trust target for development reviews was 90%. From the data supplied by the trust, it highlighted that four wards had not been compliant with the trust target from March 2015 to February 2016. The use of development reviews is important to ensure that staff have the opportunity to discuss their development needs or support required to help them carry out their job role.
 - In the trust wide 2015, national staff survey the trust scored 2.88 out of five for staff response to the quality of the staff appraisal. This was below the national average of 3.03.
 - Qualified nursing staff told us there were no formal systems for clinical supervision. Ward managers confirmed this. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work.
 - Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
 - New nurses appointed from abroad were provided with the support they required in order to fulfil their roles on busy wards. Their induction was tailored around them and only started their role once they and their managers felt they were ready to commence as an established member of the nursing team. Often new nurses would start at the Ormskirk hospital on the rehabilitation ward until they were deemed competent. New overseas nurses told us they were well supported by their managers and colleagues.
 - There was a temporary staff induction checklist for bank and agency staff that included medical staff.
 - Compliance in staff training was variable across the medical wards. For example, we found that from records supplied by the trust that in February 2016, there were low numbers of nurses trained in blood transfusions. The SSU had only 24% of staff trained in blood transfusions, EAU (33%), 11b (34%), and 9b (37%) and the stroke unit performance only reached 31% in the period between March 2015 to February 2016. Training in medicines management across the medical wards were also below the trust target from March 2015 to February 2016. For example ward 7a training compliance was below 31% for the whole period. EAU and the SSU compliance rate remained below 40% for the whole period. Ward staff informed us that receiving

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training was difficult due to staffing levels and often had to cancel training. Managers informed us that training days had been scheduled for May 2016 to improve ward performance.

- For staff that were not trained in cannulation, there was a process of escalation through the bed management/clinical site manager, to ensure that patients were seen by the most appropriate person, which included an anaesthetist for difficult cannulations. A business case for an IV team had been developed by the trust; however the outcome was still awaited. A clinical skills nurse was in post to enable easier access to the training to ensure more nursing staff were competent at cannulation. The wards did not report that there were any delays in cannulation of patients.
- Each ward had a number of link nurses who were trained to offer advice and guidance to other staff in various areas of care that included infection control, pressure ulcer care, tissue viability and end of life care. Link nurses undertook trust 'Train the Trainer' sessions, then cascaded learning down to ward staff. There were also lead nurses available in these areas for support and guidance. We found from visiting the wards that there were identified link nurses on the ward.
- In the trust wide 2015, national staff survey the trust scored 3.97 out of five for the staff response to the quality of non-mandatory training, learning or development. This was below the national average of 4.15.
- From September 2015, the health care support workers were required to start completing the 15 care certificate competencies. Each ward had a number of assessors to support the process. The care certificate was knowledge and competency based and set out the learning outcomes and standards of behaviours required for health care workers. Wards we visited had health care workers that had commenced the training and the programme was being rolled out to new starters. Since April 2015, there were 39 staff trust wide that had commenced the care certificate and five that had completed the care certificate.
- Staff were provided with relevant information throughout the day through daily safety huddles. Information with regards to trust learning points were shared. These included highlighted risks and things to remember.

- We saw on the EAU that they had a topic of the week where information would be provided to increase staff learning and awareness. At the time of inspection the topic of the week was female genital mutilation (FGM).
- Managers informed us that poor performance of staff was monitored and the trust capabilities policy was followed to ensure that all staff were capable and competent in carrying out their role and responsibilities. Managers were able to give examples of where poor performance in sickness and time keeping had been addressed.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, and review of records, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- Multidisciplinary team (MDT) working was well established on the medical wards. MDT meetings took place regularly and were attended by the medical staff, nursing staff and therapy staff such as a physiotherapist and occupational therapist.
- Meetings on bed availability were held several times a day to determine priorities, capacity and demand for all specialities. We attended a bed meeting and saw that they were attended by both senior management staff from medicine and surgery, and included a representative from the local ambulance trust.
- We observed handovers, which included healthcare assistants, nurses and medical staff. We saw that there was effective communication and the handovers were well structured.
- Daily ward meetings were held on the medical wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed a board round and saw that they were well attended by a range of professionals. On ward 9b the frail elderly ward, a member of the mental health liaison team attended the board round to provide support to staff.
- Safety huddles took place daily on medical wards. We observed that patient safety issues were discussed and important information exchanged to ensure the safety of patients and any organisation issues disseminated.

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- Discharge co-ordinators, matrons and bed managers visited the wards daily to support with discharge arrangements and help ensure the flow through the hospital was maximised.
- We observed a discharge co-ordinator on the ward working alongside nursing staff, providing the next step in a patient's journey to home.
- Medical patients who were being cared for and treated on surgical wards were not seen by the therapy team covering the surgical ward. This meant that there was a risk that these patients did not receive the therapy they required whilst on a surgical ward.

Seven-day services

- Patients who were not acutely ill who did not require a daily review of their condition were not routinely seen by a consultant at weekends.
- There was no routine service provided by allied health professionals out of normal working hours. However, the service was available seven days per week for those patients seen by the AEC.
- There was a dispensing pharmacy service provided on Saturday and Sunday mornings and there was an out of hours and on-call pharmacy support.
- There was a discharge registrar available at weekends to see patients requiring a medical review prior to discharge.
- There was limited consultant cover on medical wards at weekends, and no ward rounds took place. We were informed that the trust was looking at expanding the medical staffing to provide a seven day reviewing process. We reviewed the action plan for stroke services and there was a plan to recruit further consultants to provide a full seven day service.
- A majority of diagnostic services were available seven days a week, with the exception of echocardiography, bronchoscopy, histopathology, and therapeutic lower GI endoscopy.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- Trust policies were available via the trust intranet.
- There were computers available on the wards we visited which gave staff access to patient and trust information.

However, we found that computers were not always locked to prevent data from being seen by unauthorised personnel. For example, we observed computer terminals on ward 9a, AEC and 7a was displaying information without staff being present. This would allow for unauthorised access to the computer terminal and compromise data protection.

- Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.
- Wards we visited displayed information with regards to patient safety, training, and upcoming events. Newsletters with current changes in ward performance and actions were readily available for staff to read.
- On the majority of wards we observed that there were files containing minutes of meetings and protocols available to staff and in managers offices there was current information displayed on notice boards.
- The trust had taken action to ensure that passwords were not being shared across all medical wards. Amendments had been made to the night handover sheet for the bed managers to include a check that staff had their own individual username and password access to systems. For agency staff, pre-established usernames and passwords were held. Upon starting with the trust agency employees had the contact details for the IT Helpdesk (24/7) so account details could be issued. We saw no evidence that passwords were being shared, and staff confirmed this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty and ensuring adjustments such as access to specialist support, and flexible visiting. We looked at 30 patient records and found that generally documentation was completed with regards to mental capacity where required.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). DoLS are part of the mental capacity act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interests of the person, and there is no other way to look

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after them. This includes people who may lack capacity. From the records we observed we found that the DoLS documentation was completed fully and sent to the local authority.

Are medical care services caring?

Good



At the last inspection in November 2014 caring was rated as good.

We rated caring as good because:

- Most patients and their families were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
- We observed staff being open, friendly and helpful to patients and each other.
- Patients reported that they had pain relief as required to ensure they were not in any discomfort. The nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Most patients reported that the staff were 'helpful' and 'good'. One patient on ward 9b reported that the ward was 'super'.
- Patients we spoke with were complimentary about the care and attention received from the therapy staff. Patients told us that the therapy teams were excellent, and one patient reported that they had included their spouse in therapy sessions in order for therapy exercises to continue once back at home.
- Visiting times on the wards were open to meet the needs of the relatives and patients. This allowed relatives to support patients if they wanted to.

Compassionate care

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

- Most patients we spoke with reported the overall view of the quality of the service was good, and they were happy with the service received.
- We observed staff attending to patient's needs, and closing curtains or doors to protect the privacy and dignity of the patients.
- Patients reported that they had pain relief as required to ensure they were not in any discomfort.
- Every ward we visited was extremely busy. However, we observed staff taking time to speak to patients to address their needs.
- Most patients reported that the staff were 'helpful' and 'good'. One patient on ward 9b reported that the ward was 'super'.
- However, not all patients agreed that ward quality across medical services was good. We spoke with 31 patients and found that five patients reported they had not had good quality care. One patient reported that her buzzer was often ignored, another reported that care was not delivered promptly and had to wait for over two hours before being helped to attend to personal care. One patient reported that there was a lack of communication, and two patients stated that the wards were not clean.
- The friends and family test (FFT) average response rate was 27.1% which was higher than the national average of 25.1%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. Results from the FFT were generally good with 7b scoring 100% in December 2015, EAU scoring 98%, the frail elderly unit scoring 97% but ward 11b scored 59% in December 2015 and had a response rate of 29%. We observed care on ward 11b and found that staff were friendly and helpful to patients.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust scored in the top 20% of all trusts in seven of the 34 areas of the survey. These included been given enough privacy when discussing condition/treatment, being involved in decisions about care and treatment and having confidence and trust in all doctors. However the trust also performed in the bottom of all trusts for 12 of the areas covered by the survey. These included having enough nurses on duty, patient's families having an opportunity to speak to a doctor and staff informing who to contact if worried post discharge.

Medical care (including older people's care)

- The trust performed better than the England average in three of the five areas of the Patient Led Assessment of the Care Environment (PLACE), these were in cleanliness scoring 100%, food (87%), facilities (96%), and privacy and dignity (87%).

Understanding and involvement of patients and those close to them

- Patients said that staff usually introduced themselves before care and treatment took place and we observed that a named nurse and consultant was on a board behind each patient bed. However, we did find for example on ward 7a that the consultant name was not always the full name and instead was the consultant initials. A senior nurse was aware of this, and took action to rectify the name boards.
- Patients said they had been involved in their care and were aware of the discharge plans in place.
- The majority of patients we spoke with said they had received good information about their condition and treatment.
- Patients who required extra support to make their needs known had a 'patient passport' document in their records. This was completed with the patient and those close to them to ensure it expressed their preferences. We observed the booklet being used on the wards we visited to help meet the needs of patients.
- We observed staff speaking to family members keeping them informed of progress in care and treatment.
- Patients we spoke to were complimentary about the care and attention received from the therapy staff. Patients told us that the therapy teams were excellent, and one patient reported that they had included their spouse in therapy sessions in order for therapy exercises to continue once back at home.
- Each patient had an information booklet on their bedside to provide them with information as to how to make a complaint or compliment of the service.

Emotional support

- Staff reported that they felt they did not always have enough time to spend with patients due to the level of staffing on the wards.
- Visiting times on the wards were open to meet the needs of the relatives and patients. This allowed relatives to support patients if they wanted to.

- The nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff talking and interacting with patients to ensure they remained comfortable and their needs were being met.
- Chaplaincy services were available for patients 24 hours per day if needed.

Are medical care services responsive?

Requires improvement



At the last inspection in November 2014 responsive was rated as requires improvement because there were frequently more medical patients than available beds on medical wards within the hospital. The flow of medical patients throughout the hospital was disorganised and medical staff had no formal process by which to locate their patients and despite being an integrated trust there were few examples of integration between community and acute services.

We rated responsive as requires improvement because:

- Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. Bed occupancy at the hospital in January 2016 had increased from 90.8% to 94.3% in March 2016. Evidence shows that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Due to the bed occupancy rate across medical wards, a number of patients were placed on wards that did not necessarily specialise in the care they required (also known as outliers). The trust reported that there had been an increase in the number of outliers, increasing from 96 outliers in January 2016 to 111 outliers in March 2016. This risked that patients were being cared for and treated by staff on wards outside their specialty.
- There was a plan in place to ensure that medical outliers were seen by a the right speciality consultant, however staff reported that it was often left to them to bleep the medical team to ensure that patients were seen and this often caused delay if the consultant responsible was not available. Senior nurses informed us that the plan for ensuring outliers were seen was not a formalised standard operating procedure.

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- The discharge lounge was not in operation as it was being used as a bedded area due to demand for beds. This meant that medically discharged patients were required to wait on the ward until all necessary plans were in place for discharge. This did not help with access and flow and meant that patients who needed a medical bed had to wait until the bed was available or were placed on a ward not best suited to their needs.
- Call bells were available on each ward and for each bed. However, we found on a number of wards that not all patients had access to their call bell. For example, we found 12 call bells out of reach of patients during our inspection across the medical wards.

However,

- Telemedicine (the remote diagnosis and treatment of patients by means of telecommunications technology) was used for stroke patients outside of normal working hours. This meant that patients could be given the most appropriate treatment quickly and without the need for transfer to another hospital.
- Daily board rounds took place on medical wards to discuss patient discharge arrangements and to plan the next step in a patient's journey home. We found that discharge planning documents were included in patient records.
- Bed meetings occurred regularly throughout the day during the week days to review and plan bed capacity and respond to acute bed availability pressures. We attended a morning bed meeting and found that it was attended by senior staff and found the system to be effective and comprehensive.
- Complaints were monitored by senior staff and formed part of the quality dashboard for each ward. Each ward was aware of how many complaints they received on a monthly basis. This information was collated across all medical wards and filtered into the directorate dashboard.

Service planning and delivery to meet the needs of local people

- The trust operated as an Integrated Care Organisation and had commissioned community services based upon understanding the needs of the local population. The integrated care model meant Southport and Ormskirk Hospital NHS Trust was responsible for many of the adult health care services previously provided by NHS Sefton and NHS Central Lancashire. The trust had

developed its services to match the profile of the local population. For example the number of smoking related deaths for the local population was worse than the England average and so had provided stop smoking services in the community. They also had a higher prevalence of alcohol related hospital admissions for under 18's and so had developed a Hospital Alcohol Liaison Team (HALT) working within the trust. However, we found that services were not equitable across all areas. Patients who lived within the area covered by one clinical commissioning group had access to services of a specialist respiratory team. This service was not commissioned by the neighbouring clinical commissioning group. This meant that the respiratory service provided to patients was not equitable.

- The trust had developed a Frail Elderly Short Stay Unit (FESSU) to provide elderly patients with a comprehensive geriatric assessment with a multi-disciplinary approach to reduce the length of stay for the older population. We visited the ward and found that patients were assessed and a multi-disciplinary approach to care was evident.
- Telemedicine (the remote diagnosis and treatment of patients by means of telecommunications technology) was used for stroke patients outside of normal working hours. This meant that patients could be given the most appropriate treatment quickly and without the need for transfer to another hospital.

Access and flow

- Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services.
- From January to March 2016 the bed occupancy rate across medical services at the hospital were over 90%. Evidence shows that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. Bed occupancy at the hospital in January 2016 had increased from 90.8% to 94.3% in March 2016.
- Due to the bed occupancy rate across medical wards, a number of patients were placed on wards that did not necessarily specialise in the care they required (also known as outliers). For example at the time of inspection we found that there were 12 medical patients receiving care and treatment on surgical wards. We spoke to staff on the surgical wards who confirmed that this was a regular occurrence. The trust reported that

Medical care (including older people's care)

there had been an increase in the number of outliers, increasing from 96 outliers in January 2016 to 111 outliers in March 2016. This risked that patients were being cared for and treated by staff outside their specialty.

- There was a plan in place to ensure that medical outliers were seen by a the right speciality consultant, however staff reported that it was often left to them to bleep the medical team to ensure that patients were seen and this often caused delay if the consultant responsible was not available. Senior nurses informed us that the plan for ensuring outliers were seen was not a formalised standard operating procedure but the document in place had been provided to all wards. Staff we spoke with reported that the bleep system was not reliable and often did not get a response which meant they were required to phone consultants to ensure patients were seen promptly.
- We reviewed medical notes for the patients outlying on the surgical wards and found that they had been reviewed by the responsible medical team.
- From April 2013 to August 2015 the trust reported there were 2034 bed days lost due to medically fit patients being in hospital that did not need to be there. 67.5% of delays were due to patient or family choice. Managers told us that this was due to a number of care home closures and a limited choice of affordable beds. This resulted in patients remaining in hospital whilst waiting for the right care home placement.
- Medical services captured snap shot data on the last Thursday of each month of all patients whose transfer of care was delayed, with the total number of days all patients had been delayed for the month. From April 2015 to February 2016, there had been 31 delayed transfers of care which between them totalled 811 bed days lost due patients being delayed in hospital.
- At the time of the unannounced inspection we were advised that there were 14 patients who were delayed discharges across medical wards. Meaning that there were 14 medically fit patients who no longer needed to remain in a hospital bed and added to the pressures of placing patients on the right ward for safe care and treatment.
- The trust had a discharge lounge, however this was being used as a bedded area so was not in use at the time of inspection. Staff reported that this area was used often to provide extra bed spaces for patients and was part of the escalation plan during bed pressures.

Due to the closure of the discharge lounge patients who were medically discharged and ready to leave hospital were required to wait on the ward until all arrangements had been made for them to leave which prevented the use of the bed space for patients that required medical care and treatment.

- There was a focus on discharge planning within the trust. There was a discharge team that consisted of eight discharge co-ordinators that worked across wards to ensure that patient's journey home was well co-ordinated. Staff reported that this was a valuable addition to supporting discharges. The discharge co-ordinators liaised with social services to ensure those patients requiring care had access to the right support.
- Daily board rounds took place on medical wards to discuss patient discharge arrangements and to plan the next step in a patient's journey home. We found that discharge planning documents were included in patient records.
- Bed meetings occurred regularly throughout the day during the week days to review and plan bed capacity and respond to acute bed availability pressures. We attended a morning bed meeting and found that it was attended by senior staff and found the system to be effective and comprehensive.
- From February 2015 to January 2016, 7499 (25%) of admitted patients moved once during their admission. Only 5% of patients moved twice and only 1% of patients moved three times or more. However a high number of patients were being moved after 10pm. In January 2016, 170 patients were moved after 10pm. This was a reduction on the previous five months where the patient moves had exceeded 200. Eight patients on the frail elderly unit had been moved after 10pm, 16 patients on 7a, 11 patients on 11b, and 10 patients on the stroke unit, had been moved after 10pm. Bed moves after 10pm should be kept to a minimum to ensure that patients get the rest they need whilst receiving care and treatment.
- Medical services referral to treatment (RTT) was generally higher (better) than the England average (90%) from September 2014 to November 2015 with the exception of dermatology that did not meet the standard between September 2014 and August 2015.

Meeting people's individual needs

Medical care (including older people's care)

- The trust used a yellow wrist band to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made. We saw that these were in use at the time of inspection.
- On admission people living with dementia or with a learning disability were given patient health passports to complete supported by carers or nursing staff. This enabled staff to know more about the person including preferences.
- Helping hand stickers were used for patients that required extra assistance from the staff. We saw that the stickers were placed on the patient name board and patient records and any additional support needs required were discussed at the board round and nurse hand over.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the online service. We observed that a translator was being used for a Russian patient on 7b to ensure that his needs were adequately addressed.
- Leaflets were available around the hospital about services that were offered in hospital and in the community. For example we saw information with regards to memory cafés in Sefton were displayed outside of the ward to support those individuals and families living with dementia.
- There was an adult at risk liaison team within the trust which was part of the safeguarding team. External providers were able to contact the team to make them aware that a patient who had additional needs was being admitted to hospital with the support they required. There was a designated phone line so that vulnerable adults could be referred to the team, and daily reports were provided by the bed management team as to patients who required extra support.
- Call bells were available on each ward and for each bed. However, we found on a number of wards that not all patients had access to their call bell. For example, we found 12 call bells out of reach of patients during our inspection of the medical wards. One patient on ward 9a had slipped down the bed and her call bell was out of reach and required assistance. Once staff were alerted they worked quickly to support the patient. On patient on 11b was on the far side of the ward where they could not be observed by staff and did not have a call bell to summon help if required. We found one call bell that did not work on 7b, the patient reported that the ward were aware of this, however no plan had been put into place for the patient to be able to call for assistance if required.
- There were a range of specialist nurses who provided specialist advice to staff, patients and their relatives. These included tissue viability, palliative care and diabetes. We observed a nursing handover and found that for those patients who were at end of life, referrals had been made to the palliative care service for specialist advice.
- There was a chaplaincy team available 24 hours a day and we observed that volunteers visiting wards to offer friendship and support to patients.
- Patients who lived within the area covered by one clinical commissioning group had access to services of a specialist respiratory team. This service was not commissioned by the neighbouring clinical commissioning group. This meant that the respiratory service provided to patients was not equitable.
- In May 2015 the Trust was awarded the Navajo charter mark for their inclusive attitude towards lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

Learning from complaints and concerns

- All patients and staff we spoke with knew how to make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- There were leaflets available on some wards we visited explaining the complaints procedure or the Patient Advice and Liaison Service (PALS). For example we found that ward 9a and ward 10a did not display any leaflets with regards to the PALS service, although information for making a complaint was available in the patient hand book. Managers informed us that they tried to deal with complaints face to face first, but did give out the necessary information to patients and families if it was required.
- Complaints with lessons learnt were disseminated to staff through the governance noticeboard bulletins which were forwarded to all wards for discussion. We found that complaints formed part of the safety huddle handover to ensure that all staff received the information. The governance noticeboard provided information as to how many, any themes and a synopsis of the complaints with lessons learnt. We reviewed the governance noticeboard bulletin for February 2016 and

Medical care (including older people's care)

saw that complaints were highlighted and lessons learnt shared. Wards advised us that these noticeboards had been introduced three months ago, and were a useful addition to ensure that information was disseminated.

- Complaints were monitored by senior staff and formed part of the quality dashboard for each ward. Each ward was aware of how many complaints they received on a monthly basis. This information was collated across all medical wards and filtered into the directorate dashboard.

Are medical care services well-led?

Requires improvement



At the last inspection in November 2014 well-led was rated as requires improvement because the system in place to communicate risks and changes in practice to nursing staff was not robust. There was a culture of 'good will' within the medical directorate, where many members of staff worked considerably beyond their contracted hours to support colleagues and to provide good patient care. The trust was in the worst 20% nationally for overall staff engagement.

We rated well-led as requires improvement because:

- The trust had a vision and strategy for the organisation, however this was not clear to all staff we interviewed and staff were unclear of the direction of the trust. The trust had several interim executive board leaders and so a new change in direction was being developed and had yet to be cascaded to the staff teams.
- In the trust wide 2015 NHS staff survey the trust performed worse than the national average when staff were asked if they would recommend the organisation as a place to work or receive treatment. The trust scored 3.57 out of 5 compared to a national average of 3.71. The trust performed worse in 14 of the 32 key findings of the NHS staff survey and scored higher (better) in 10 of the key findings.
- Although there was a system in place to monitor risks across medical services, there was a lack of response into some of the key areas that needed to be addressed. For example, the lack of a security team potentially placed staff and patients at risk if a visitor or patient displayed violence or aggression. Also there were no formal weekly matron checklists in place that ensured

all policies and procedures of the trust were being adhered to and being monitored by the trust. For example, as part of the matron checklist, medicines management, environment, and documentation would be checked. A new nursing accreditation had been developed, however this did not replace matrons walking the wards to check ward compliance on a daily/weekly basis.

- Managers informed us that there were data errors in recording information. For example, directorate staffing report showed that bed occupancy rates in February 2016 were above 100% occupied. Senior managers reported that this may have been because patients who had left were not discharged from the system. For example ward 7a showed a bed occupancy rate in February 2016 as 111.82%.
- Unsuitable areas of the hospital were being used to provide bedded areas for patients. The GPAU and the discharge lounge were not used effectively to ensure that patients were discharged promptly and added to the access and flow issues of the trust.
- Staff reported that some members of the senior management were visible and approachable, but not all staff knew the interim executive team and did not feel that all senior management were visible on the wards.
- Staff and managers were unclear if there was a system in place for making suggestions and raising issues with the senior management team. Staff reported there used to be a system but were unsure if this was still in place, and so an issues would need to be raised through their immediate manager.

However,

- Staff were clear on the values of the trust and their responsibility of delivering quality care. The values were based upon 5 areas, Supportive, Caring, Open, Professional and Efficient (SCOPE).
- Risks within the medical directorate were discussed regularly at both ward and divisional level and escalated where necessary. We saw that the risk register reflected the concerns of managers.
- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. Ward managers reported that they had good relationships with their immediate matron and would see them often on the ward.

Vision and strategy for this service

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- The trust had a vision and strategy for the organisation, however this was not clear to all staff we interviewed and staff were unclear of the direction of the trust. The trust had several interim executive board leaders and so a new change in direction was being developed.
- Staff we spoke with were clear on the values of the trust and their responsibility of delivering quality care. The values were based upon 5 areas, Supportive, Caring, Open, Professional and Efficient (SCOPE).
- In the trust wide 2015 NHS staff survey the trust performed worse than the national average when staff were asked if they would recommend the organisation as a place to work or receive treatment. The trust scored 3.57 out of 5 compared to a national average of 3.71. The trust performed worse in 14 of the 32 key findings of the NHS staff survey and scored higher (better) in 10 of the key findings.

Governance, risk management and quality measurement

- Risks within the medical directorate were discussed regularly at both ward and divisional level and escalated where necessary. We saw that the risk register reflected the concerns of managers, the risks were reviewed and a level of risk assigned. For example the difficulty in covering the sickness and vacant posts on the medical rota was assigned 'extreme risk' and was reviewed monthly.
- The trust did not have an onsite security team, and so if violence from patients or visitors occurred there was a reliance on the Police to respond quickly if required. We spoke to staff on ward 11b, and they informed us that violence from patients who were on a detox regime was common and had resulted in injuries to staff. In the trust wide NHS staff survey 2015, 17% of staff reported that they had experienced physical violence from patients, relatives or the public in the last 12 months. This is higher than the national average of 14%. Violence to staff and having no security team was not on the medicine risk register as of the 30 March 2016. We reviewed incident reports for January to March 2016 and found that there had been 16 incidents of violence and aggression on the medical wards.
- Data provided by the trust showed that the police had been called out to the trust 76 times between March 2015 to March 2016. There were 35 call outs due to physical abuse/violence to staff from patients and 18 call outs due to verbal abuse to staff from patients. We were informed by the trust that 74 of the call outs had been to the Southport hospital site.
- Senior staff knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- Senior staff were able to tell us how their ward performance was monitored and all ward managers had copies of the ward dashboard performance.
- We saw no formal evidence from July 2015 to April 2016 that daily/weekly matron quality ward round checklists took place to ensure that all areas of the ward were compliant with trust policy and procedure which reported back into the medical directorate performance dashboards. For example we saw no evidence in the controlled drug medicine book that this had been checked by a senior nurse or environmental checks had been completed and ward performance dashboards were not updated with any results of ward compliance. A new accreditation scheme had been started but not all wards had been through the accreditation process. However, this did not provide assurances to the trust that formal procedures were in place for the period of July 2015 to April 2016 and the accreditation process could not replace the need for matrons formally carrying out daily/weekly checks. We were informed on the unannounced inspection on the 29 April 2016 that a new matron checklist was being rolled out across medical wards alongside the nursing accreditation scheme to address the needs for formal checks being completed.
- Ward managers informed us that alignment between the ward dashboard performance did not always match the actual figures of compliance. For example mandatory training and appraisal figures supplied via the dashboard did not match figures that ward managers had collected. We also found that the directorate staffing report showed that bed occupancy rates in February 2016 were above 100% occupied. Senior managers reported that this may have been because patients who had left were not discharged from the system. For example ward 7a showed a bed occupancy rate in February 2016 as 111.82%.

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- In the trust wide NHS staff survey 2015 the trust scored 3.57 out of 5 which was lower (worse) than the national average (3.71) when staff were asked regards to the fairness and effectiveness of procedures for reporting errors, near misses and incidents.
- Unsuitable areas of the hospital were being used to provide bedded areas for patients. The GPAU and the discharge lounge were not used effectively to ensure that patients were discharged promptly and added to that access and flow issues of the trust.
- We saw no formal evidence that all key improvements identified at the last inspection in November 2014 had been acted upon to improve medical services. For example, the percentage of staff completing mandatory training in a timely way was still inconsistent and in some areas below expected levels.

Leadership of service

- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. Ward managers reported that they had good relationships with their immediate matron and would see them often on the ward.
- Staff reported that some members of the senior management were visible and approachable, but not all staff knew the interim executive team and did not feel that all senior management were visible on the wards.
- We saw good leadership at ward level. We observed ward managers working alongside nursing staff providing support and guidance where necessary.
- In the trust wide 2015 NHS staff survey only 21% of staff reported good communication between senior management and staff. This was below the national average of 30%.

Culture within the service

- Nursing and medical staff said they felt supported and able to speak up if they had concerns. Most staff reported that the trust was a lovely place to work, and all the staff helped each other to ensure that patients received the 'best care and treatment'. Staff were proud of the work they achieved, but felt under pressure due to staffing shortages.
- Managers reported that they had an open door policy to ensure that staff were adequately supported. There was no formal one to one supervision, but staff reported that they could speak to their manager at any time they wanted.

- In the trust wide 2015, NHS staff survey, the trust scored 4.08 out of 5 for staff satisfaction with the quality of work and care they were able to deliver. The national average was 3.94 out of 5.
- Staff and managers were unclear if there was a system in place for making suggestions and raising issues with the senior management team. Staff reported there used to be a system but were unsure if this was still in place, and so an issues would need to be raised through their immediate manager.
- Staff were aware of the duty of candour in regards to being open and honest with patients.

Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed that the majority of medical wards scored over 95% of patients who would recommend the hospital to friends or a relative.
- The trust had news releases on its website pages to keep members of the local community up to date with current events. We observed that the news releases on the website were current and up to date.
- The Trust had undertaken a number of events titled "In Your Shoes" where patients and carers were invited to share their journey with the trust. The event highlighted a number of positive aspects of the care and treatment on the wards as well as a number of negative findings. We saw that the positive findings included good support from allied health professionals, openness of staff and good food. Negative findings included slow discharge planning arrangements and lots of chaos around the wards.

Staff engagement

- The trust held a staff engagement programme in 2015, holding 48 sessions with approximately 900 staff to listen to their views.
- Staff we spoke to felt that they were equipped for their role and had clear roles and responsibilities
- In the trust wide 2015, NHS staff survey 90% of staff reported they had an appraisal in the last 12 months which was higher (better) than the national average.

Medical care (including older people's care)

However, the same survey reported that staff scored the quality of the appraisals lower (worse) than the national average, scoring the quality 2.88 out of five compared to the national average of 3.03 out of 5.







- The trust celebrated the achievements of staff at an annual event. At the last event, medical services had a number of staff recognised for their hard work and commitment.

Innovation, improvement and sustainability

- In the trust wide 2015, NHS staff survey, 70% of staff felt they were able to contribute towards improvements at work. This was a similar result to the national average of 71%.

- The trust was improving the quality standards across the wards using Southport & Ormskirk Nursing Accreditation Scheme (SONAS). The accreditation scheme was based on the trust's 'Care as care should be' approach to service delivery and was modelled around the CQC five domains. We spoke to a ward manager who had been through the accreditation process and saw that from the accreditation there were action plans to improve performance.
- Medical wards used an electronic early warning score system to record information as to deteriorating patients.

Surgery

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

Information about the service

We visited Southport and Formby District General Hospital from the 12 to 15 April 2016, as part of our announced visit of Southport and Ormskirk Hospitals NHS Trust. We also carried out an unannounced visit on 29 April 2016.

The hospital provides a range of surgical services including urology, general surgery, ophthalmology and trauma and orthopaedics. There are four surgical wards, 14A Trauma and Orthopaedics, 15A and 15B, general surgery and the Planned Investigation Unit (PIU). There are five theatres which undertake emergency surgery, elective surgery and day case procedures. During the inspection we visited main theatres and all four wards. We also visited pre-operation clinic to inspect the pre-operative procedures.

We spoke with 12 patients and four relatives. We observed the care delivered to patients on the surgical wards and pre and post-operative care in theatre. We spoke with a wide range of staff including qualified nurses, health care assistants, junior doctors, middle grade doctors, consultants, therapy staff, pharmacy staff, matrons, surgical managers and medical managers. We considered comments from relatives through the CQC enquiry process and reviewed performance information provided to us. We reviewed 10 sets of medical notes, 12 nursing notes and 22 prescription charts. We also observed theatre procedures.

The trust provided 18,724 episodes of surgical care from July 2014 to June 2015. Of these, 6,400 were undertaken in Southport and Formby District General Hospital. Surgical services were managed within the division of planned care.

SFDGH was previously inspected in November 2014.

Summary of findings

We found that the surgical service was inadequate for safe and well-led, required improvement for effective, responsive and good for caring. These findings differed from the findings of the previous inspection in respect of the safe and well-led domain, which were previously rated as required improvement in November 2014.

- Safety did not have a sufficient priority across surgical services. Systems and processes were not always reliable to keep people safe. Incidents were not always properly identified and we saw evidence of previous incidents being repeated. Risk assessments were not always completed and mitigation of identified risk did not always take place. Medically deteriorating patients were not always identified promptly, nor did they always receive the prompt medical attention the required, once they were identified. The mortality and morbidity of surgical specialties are not reviewed by the trust board.
- We also found that staffing levels on wards were frequently insufficient and these were not addressed quickly. We looked at rotas and saw that wards were frequently below their planned rates. Staff were distressed at the low staffing levels and the heavy workload. We observed the impact that the low staffing levels had on patient safety and patients' needs being met.

Surgery

- In addition to the above issues, matters identified during the previous inspection remained evident. There were problems with the replacement of theatre equipment and there was still no pager system in place which had connectivity across the entire hospital.
- Surgical services were inadequate for well-led because there was no clear vision about the future of surgical services across the trust. However, decisions about the future of surgical services could only be made as part of a decision in the wider healthcare economy, once there was greater management certainty within the trust. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken. There was also a combative approach to dealing with disciplinary matters across the division for both nursing and medical staff, with long suspensions in place while investigations were conducted into matters of professional competence.
- Surgical services required improvement for effective because there were poor patient outcomes as indicated by high elective readmission rates and poor performance in national audit programmes. We found that nutrition and hydration needs were not always addressed. In addition staff were not implementing trust policy for fasting guidelines prior to surgery, meaning that people were being left longer than recommended without fluids.
- Surgical services required improvement for responsiveness because they experienced significant difficulties with patient flow. Services were not organised efficiently in that there was no surgical admissions unit where patients could attend on the morning of their surgery. This further exacerbated patient flow issues. Surgical services did not always meet the individual needs of patients who had complex requirements. Complaints were not used as a means of improving services.
- In addition to there being no clear vision for surgical services, morale was poor amongst significant sections of clinical staff. Staff reported concern about

the length of time that disciplinary investigations took and that clinical staff were suspended for lengthy periods of time. Staff reported that this approach created a culture of fear.

Surgery

Are surgery services safe?

Inadequate



Surgical services at SFDGH were inadequate because:

- Safety did not have a sufficient priority across surgical services. Systems, processes and accepted operating procedures were not always reliable or appropriate to keep people safe. We saw examples of practices which demonstrated that staff did not recognise concerns, incidents and near misses and the consequent risks presented to patients. There was a repeated failure to comply with trust policy for the checking of controlled drugs. It was accepted practice for patients to be placed on oxygen without it being prescribed or without a target saturation level being identified. Ward entrance doors were left unlocked and unattended even though there were confused, hypermobile patients on the ward who were at risk of absconding and getting lost.
- We saw evidence that incidents were not properly identified or reported and learning from incidents did not always take place. During inspection we witnessed a distressed relative approaching staff to ask why her relative had been given antibiotics when staff were alerted to their allergy on admission. The patient had not been given a red allergy wristband. Our investigations revealed that this was not reported as an incident. Furthermore, it was a repeat of a similar incident that had occurred in April 2015, which demonstrated a lack of learning from incidents and that necessary improvements were not always made when things go wrong.
- We found that staff did not always assess monitor or manage risks to people who use the services and opportunities to prevent or minimise harm were missed. Medically deteriorating patients were not always identified promptly and when they were identified, it was reported to us that out of hours there could be a delay before medical assessment was undertaken. We also saw evidence of a delay in the response time of the critical care outreach team to a patient with a high early warning score. We found that nutritional risk assessments were not always completed for patients who were clearly vulnerable. In addition fluid balance charts were not consistently kept updated on all wards.

- There were frequent staff shortages on some wards, which were not addressed quickly or identified as a problem. We witnessed a lunchtime when there were insufficient staff for the number of patients that required significant support to eat their meal. One student nurse was left to support four patients eating their lunch. This took time to do and the process was still ongoing one hour later. This meant that patients were waiting too long for their lunch. We witnessed a patient about to fall out of bed. Nursing staff voiced concerns to us about staffing levels and were visibly distressed by the issue.

However, we found:

- There was a robust system of infection control monitoring and supervision.
- The environment was visibly clean.
- There was good evidence of medical documentation and senior review in medical records.
- There was a robust system of pre-operative assessment in place.

Incidents

- Four serious and untoward incidents occurred in surgical services at the hospital between January 2015 and February 2016. These incidents included one surgical error, delay in a diagnostic incident, sub-optimal care of a deteriorating patient and a security breach of confidential data. All these incidents were investigated using root cause analysis investigation methodology and action plans were put in place to prevent any re-occurrence of these incidents. We also heard about these incidents from different members of the surgical services team, which demonstrated that they were high profile events for the service.
- The most common type of incident that occurred on surgical wards was falls. One hundred and thirty seven falls occurred on surgical wards but only 4 of these were assessed as causing moderate harm or above. The majority of these falls (67) took place on the trauma and orthopaedic ward. Medication errors accounted for 89 incidents for surgical wards and from the data given it was possible to see the same incidents being repeated, which gave cause for concern about whether there was a robust system in place from which staff could learn from incidents.

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- Incidents that occurred across surgical services were recorded and documented using an electronic incident reporting system. All staff we spoke with were aware of how to report incidents and could demonstrate how to use the system, what constituted an incident and the different classifications of incidents. Most staff we spoke with were able to confirm that they had reported incidents and discuss the type of incidents they had reported.
- On some wards staff reported a robust system of feedback from reported incidents, with feedback being discussed at safety huddles and ward meetings. We observed that on these wards records were kept of discussions and action plans relating to incidents. However, on other wards staff we spoke with reported that they did not receive individual feedback from incidents that they raised and commented that they would appreciate feedback.
- We observed an incident as it occurred on Ward 14A, which was not recorded as an incident. We observed a distressed relative alerting staff to the fact that a patient was being administered antibiotics when it was identified that they was allergic to the medication on admission. This incident echoed a similar incident, on the same ward, which occurred in April 2015 when a patient with an allergy to antibiotics was given an antibiotic. We found that surgical services were not always able to provide assurance that incidents are correctly identified and any learning arising from incidents is not always embedded into the practice of staff.
- Surgical services reviewed mortality and morbidity as part of the regular audit meetings in each specialty. Although minutes were taken of these meetings they were not part of the trust governance structures. We were told that mortality and morbidity was reported at the planned care governance meetings and fed into the mortality surveillance group, but on review of the minutes of the planned care governance meeting, we were unable to identify an agenda item which discussed mortality and morbidity, for each surgical specialty, on a regular basis. There was a trust wide mortality surveillance group which had various task and finish work streams which were ongoing. However, from a review of the minutes of the mortality surveillance group there appeared to be no in-depth review of deaths in

each surgical specialty. We were unable to identify a route by which trust board was informed of in-depth mortality and morbidity issues arising across surgical services.

- All staff that we spoke with were aware of the requirement to be open and honest with patients and their relatives when things go wrong, although not all staff recognised the term duty of candour.

Safety thermometer

- The NHS safety thermometer is an assessment tool which, once a month, measures a snapshot of a range of possible harms. These harms include the incidence of falls, pressure ulcers, blood clots and urinary catheter infections. All surgical services collected data by ward and theatre area and prominently displayed the information at the entrance of the ward.
- The data displayed at the front of all surgical wards showed that there were no infections in the past year arising from urinary catheters. It also showed that incidence of falls, pressure ulcers and blood clots were low. Between the period September 2015 to January 2016 there was one catheter infection on ward 14a and one on ward 15a. We were assured that surgical services were monitoring a range of avoidable harms and that rates of avoidable harm were low.

Cleanliness, infection control and hygiene

- We were provided with very detailed monthly infection control reports. Each monthly report identified the number of meticillin-resistant staphylococcus aureus (MRSA) bacteraemia (blood-born) infections, clostridium difficile (C diff), infections arising from in-dwelling devices, hand-hygiene audits, incidence of contagious infections such as influenza and antibiotic prescribing behaviour. From these reports we were able to see that annual targets were being set and progress towards these targets was monitored on a ward, clinical area basis. Any infectious event was investigated using a root cause analysis methodology and lessons were cascaded across the trust. The reports also identified annual trends and provided monthly performance comparison against last year's infection rates by ward. This monthly reporting process provided us with assurance that there

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were robust systems in place to monitor infection control practices across surgical services. The data provided demonstrated that infection rates across surgical services were very low

- Information provided by the hospital showed that across surgical services there was one case of MRSA bacteraemia, from April 2015 to January 2016.
- One MRSA colonisation acquisition was identified on a surgical ward from a patient who was a planned admission. This case was investigated and key learning points were identified and cascaded across surgical services.
- Surgical services had low rates of C.diff. The data provided to us by the hospital indicated that there were 7 C.diff infections from April 2015 to January 2016. Five of these occurred on ward 14a, one each on wards 15a and 15b.
- The hospital monitored surgical site infection rates on a monthly basis and prepared an annual report for the trust board. Between April 2015 and March 2016 there were four instances of surgical site infections in total hip replacements.
- The hospital monitored each clinical area's compliance with hand hygiene policies. From the six months data that we were given, where surgical wards submitted monthly data to a hand hygiene audit, compliance rates with trust policy were high, between 97-100%. However, surgical wards did not consistently submit monthly hand hygiene audits. For example by January 2016, the planned investigation unit hand only submitted one hand hygiene audit since March 2015. We observed staff complying with hand hygiene policy on all wards we visited.
- The cleanliness of commodes was audited on a weekly basis and compliance with trust policy was high across surgical wards.
- We observed that patients with infections were isolated in side rooms and that staff wore personal protective equipment such as gloves and aprons, when delivering care and treatment to them. Side rooms being used for infectious patients had the appropriate signage outside of the rooms.
- Staff in theatres adhered to gowning policy and all infection control policies and good practice.

- The wards and theatres areas we inspected were visibly clean. There was a cleaning schedule in place, which was regularly monitored. We observed regular cleaning taking place throughout the day.

Environment and equipment

- The environment was not suitably adapted for the high number of patients with cognitive impairment and dementia on surgical wards. On ward 14A signage throughout the ward was very poor. Each bay was identified by a very small piece of paper with a small number on it, placed at top of the entrance to the bay. When inspecting these wards, inspectors had to ask staff which bay they were in and where the number of the bay was placed. A patient with cognitive or visual impairment would not be able to identify which bay they were in or visually locate the bay, after leaving it. Once in the bay, there were no measures in place to assist with orientation for those patients with cognitive or visual impairment and dementia. We observed that the layout of ward 14A did not facilitate regular observation or allow nurses to respond to patients verbally requesting support. We observed that a bay, which could not be observed from the nurses' station, had a number of bed-bound and confused patients in it who would call out for reassurance from nurses. We did not observe any nurses coming into the bay to provide reassurance to those patients requesting it.
- Ward 15A, which also had a number of patients living with dementia on the ward, was not locked at the entrance to the ward. We observed a very mobile patient with an obvious cognitive impairment repeatedly walking towards the unlocked door. On each occasion they were stopped by the same nurse who was working in a nearby single room. When we raised the issue of safety with the nurse, she agreed that it was a concern. Wards 15A and 15B were linked by an unlocked door, which also provided an opportunity for a confused patient to wander off into another ward.
- There was a system in place to monitor the completeness of resuscitation equipment. The resuscitation equipment on all wards was in order and checked daily as verified by the regular signing of documentation.

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- There was a system in place for the servicing of theatre equipment. All theatre equipment that we checked was in date and regularly serviced.
- There was no approved schedule to replace older equipment in theatres. This had been identified on the previous inspection. The issue was identified as a risk for the planned care division in that it was on the risk register but no funds were identified to address the matter.
- There were issues with bleep connectivity and doctors could not be contacted in certain parts of the hospital. This was raised on the last inspection. We were told that new pagers had been purchased two weeks prior to our inspection, but that they had not yet been distributed.

Medicines

- All the wards we visited had appropriate storage facilities for medicines. All wards were visited by staff from pharmacy department on a daily basis Monday to Friday and were available on-call outside of these times.
- Controlled drugs were appropriately stored in a metal, double locked cupboard. There was a system in place to check that controlled drugs were being managed in a secure and safe manner. Night staff were designated to check the controlled drugs on every shift and to sign a booklet verifying that they had been checked. We observed that on one ward, from the week commencing 12 February 2016 to our inspection on 12 April 2016, the controlled drugs booklet had not been signed on 26 occasions. We observed very similar omissions on a second ward, where the checking of controlled drugs was not signed on numerous occasions. We did not see any evidence of audit looking at ward staff compliance with the policy of controlled drug management. The omissions identified and lack of audit of ward compliance with hospital policy did not provide assurance that there was a safe system in place for the monitoring of controlled drugs.
- Medicines that required fridge storage were appropriately stored and we saw evidence that fridge temperatures were being monitored on a daily basis.
- We reviewed 28 prescription charts. All prescriptions were signed, dated and legible, antibiotics were prescribed according to guidelines and medication to prevent VTE was given when indicated. However, two of

the charts reviewed did not have a unit number on the front page. One patient had been prescribed a medication but it had not been administered. We observed that on one ward there were a number of patients on oxygen and only one of these patients had been prescribed oxygen. As oxygen is a drug it requires prescribing in all but emergency situations, with the target level of saturation identified when prescribed. When we raised this issue with ward staff, they commented that it was not prescribed, more often than it was prescribed. The failure to prescribe oxygen and identify the target level of saturation, before administering it to patients does not provide assurance that the prescription and administration of oxygen complied with recommended guidelines.

Records

- We saw evidence of comprehensive pre-operative assessments taking place, which included reviewing patients' past medical history and establishing MRSA status. Staff reported that if any abnormalities were identified at pre-operative assessment the anaesthetist was alerted and the patient further reviewed.
- We reviewed 10 sets of medical notes and found a good standard of medical documentation on all wards and in theatre notes. All medical notes were in good order, legible and entries were signed. Medical notes were kept in a lockable trolley and situated at the nursing station.
- A complex system of documentation was being used by nursing staff. Nursing care plans and communication sheets were held in a large lever arch folder at the nursing station and organised according to ward bay. Other parts of the nursing documentation, such as fluid balance charts, 2 hourly patient comfort checks and records relating to pressure area care, were kept at the end of the patient's bed. There was also a separate, electronic recording of early warning of medical deterioration scores. Staff found this organisation of records confusing and burdensome commenting that the complexity of the documentation led to different parts of it not being completed regularly. We observed that documentation at the end of the bed was not always completed in full and documentation stored in the nursing record was not always updated. Staff reported to us that the system of documentation was implemented by nursing managers without full involvement of the ward nursing staff. We were told that

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initially ward staff were involved in the documentation review task group, but their views were ignored. In addition to the documentation being confusing and burdensome, storing patient information at the end of each patient's bed did not provide assurance that patient confidentiality was maintained.

Safeguarding

- Safeguarding policies and procedures were in place across surgical services. The trust had a safeguarding team, which was available during normal business hours Monday to Friday, to provide advice and guidance to staff if required. All safeguarding policies and procedures were available on the trust intranet and all staff we spoke with knew how to find them.
- The staff we spoke with knew how to identify safeguarding concerns and some staff were able to discuss occasions when they had raised a safeguarding concern.
- The trust had a target of 90% of staff receiving safeguarding training. The trust provided us with information which showed that by March 2016 84% of surgical services staff had completed level 1 safeguarding adults training. The figure for most wards was higher, with between 90-100% of ward staff having completed safeguarding training for adults. The trust information provided for ward 15A indicated that only 81% of staff had completed safeguarding training for adults. However, information we were shown on ward 15A indicated that this figure might have been inaccurate and that over 90% of staff had actually completed the required training.
- The training information rates provided by the trust for children's safeguarding levels 1 and 2 was very low, with only 18-55% having completed their training. Most surgical areas were recorded as less than 50% of staff having completed training. It was reported to us that the trust had recently changed its method of delivering safeguarding training and staff were now required to complete their training electronically. Discussions with ward managers indicated that more ward staff had actually completed their level 2 training, than were reflected by the information supplied by the trust. It was reported to us that apart from long term sickness and maternity leave, all ward staff had completed level 2 safeguarding training.

Mandatory training

- The trust provided annual training for all staff on an annual rolling programme basis. The modules provided by the trust covered a wide range of areas. The trust had recently introduced the prevent module, which is part of the government's counter terrorism strategy.
- Information provided by the trust indicated that the completion of all mandatory training modules was variable according to professional group. Medical staff had low rates of completion for some modules such as moving and handling and fire safety, but better rates for infection control and information governance.
- Ward nursing staff had much higher rates of completion for all modules (85-100%), apart from basic life support training, hand hygiene and conflict resolution. Data provided by the trust indicated that only 33% of nursing staff had completed hand hygiene modules, although ward staff we interviewed disputed this low figure.

Assessing and responding to patient risk

- The trust used an electronic system to record patients' vital observations such as temperature, rate of respirations and pain. This system aggregated each observation to one score, which formed a medical early warning score (EWS). This system was used to alert ward staff when a patient was medically deteriorating and required increased observations and further medical input. If a patient scored above four, this was escalated to medical staff. Nursing staff reported that medical staff responded within 30 minutes, which was trust policy, during office hours Monday to Friday. We were informed that out of hours and at weekends there were delays in responding to wards calls for medical review for deteriorating patients within a 30 minute time frame. This was particularly the case for medical patients outlying on surgical wards. Staff reported that if they were particularly concerned about a deteriorating patient they were able to request support from the critical care outreach team, but we were provided with evidence of an incident where the critical care outreach team was unable to respond to a patient with a EWS of 9 because there were other patients with scores of 10 across the hospital.
- The trust undertook monthly audits to identify whether the EWS observations were being completed in line with trust policy, which is as the early warning score

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increased the frequency of observation should be increased. The information provided to us indicated that none of the surgical wards were recording observations in line with trust protocol on a consistent basis.

- We were informed about a very serious incident where there was delay in responding to the medical deterioration of a patient and the patient died. The root cause analysis identified that there was a failure of nurses and medical staff to escalate the patient's deterioration in line with trust policy.
- We were told that patients with higher EWS were discussed at handover and safety huddles. However, we observed a handover and did not see any EWS being discussed.
- We saw evidence in nursing documentation of risk assessments being undertaken for falls, nutrition and hydration, pressure areas and VTE. The risk assessment tool used for nutrition was the malnutrition universal screening tool (MUST). We were told that if a patient was identified as at risk of malnutrition, further assessment was requested and a red tray was issued. We looked at 10 sets of nursing notes and noted that the VTE risk assessment was not completed on three occasions. We also observed that six patients on ward 15A did not have a MUST assessment completed. When this was raised with staff, we were told that the ward had been too busy to complete them. From these omissions we were not assured that risk assessments were always completed for patients.
- The documentary evidence with which we were provided combined with the results of our observations did not provide us with assurance that surgical wards were always assessing patients for known risks. Nor were we assured that once a patient began to deteriorate on a surgical ward would they receive timely intervention.
- We observed patients being brought into theatre, procedures immediately prior to surgery commencing and the recovery process. As part of the safety procedures we observed theatre staff implementing the World Health Organisation (WHO) surgical safety checklist. The WHO safer surgery checklist is a set of safety checks to improve safety performance at critical points in a patient's surgical pathway. We found that the checklist was performed in the recommended way for

each point of the pathway. We observed junior staff correcting a consultant surgeon regarding the correct procedure for disposal of swabs. Our observations provided us with assurance that risks present for patients during the surgical pathways were being fully considered by all theatre staff. Following surgery, patients' vital observations were recorded electronically, initially at five minute intervals, with lengthening periods as the recovery phase progressed. We were assured that known risks in theatre were fully assessed and responded to in a timely manner.

Nursing staffing

- We were informed that the service undertook a six monthly assessment of staffing requirements according to the acuity and dependency of patients on surgical wards. From the acuity and dependency assessments safe staffing levels were identified for each ward.
- We were provided with monthly data detailing staffing levels on all surgical wards in the hospital for the months of October 2015 to January 2016. The data provided told us about the planned number of staff and the fill rate of staff for the months October 2015 to January 2016. The fill rate for qualified staff was between 87-92%. The fill rate for health care assistants was between 96 – 105%. Using the trust's own monthly performance measures any staffing levels below 95% were considered to fall into a red rating.
- We observed that wards 14A and 15A did not always have the planned levels of staffing or the staffing levels required to provide adequate care and treatment. Ward 14A was a thirty bedded trauma and orthopaedic ward. When we visited at least 10 of these patients had obvious cognitive impairment, with some being very confused and disorientated. These same patients were either bed bound or unable to mobilise independently and required substantial assistance with washing and eating. On the four occasions we visited ward 14A we observed incidents which indicated that there were insufficient numbers of nursing staff for the acuity and dependency of the patients for whom they cared. We observed a morning handover that was divided into two stages, but in all, continued for one hour and five minutes. During this busy time two agency health care assistants, appeared to be providing the care for all of the patients on the ward.

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- Call bells were constantly ringing and were left unattended for an unacceptable amount of time. When this issue was raised with senior staff, it was confirmed there was an awareness of the staff deficit at morning handover and discussions had taken place to identify an alternative way of managing staff during this time.
- On another occasion we observed a meal being distributed at lunchtime. On this occasion in one bay, which contained four people requiring substantial assistance with eating, one student nurse was left unattended to provide the majority of the required support to patients. As she was required to feed each patient one by one, this took over an hour to complete. The student was supported by a health care assistant who was providing care to patients in a separate bay. There were four patients in the bay next door, whom the health care assistant was supporting to eat their lunch. Over this hour we did not observe any qualified member of staff overseeing lunchtime activities. The low level of staffing on this occasion meant that patients could not be supported eating their lunch in a timely manner. These observations were supported during our interview with the ward manager who reported that the ward had received complaints from families who felt that their relatives were not receiving adequate assistance during mealtimes.
- We observed the impact that low staffing levels had upon patient care. Fluid balance charts were not completed for four patients out of six records that we looked at on that ward. We also observed a very frail, confused patient, who was behind a partially drawn curtain and unable to be seen from the door of the bay, about to fall out of bed. There was no obvious reason for the curtain to be partially drawn. This was escalated immediately to a member of nursing staff and the fall was prevented. In addition we observed a medication error relating to a failure to put an allergy wristband on a patient, which was not reported as an incident. All these observations indicated that staffing levels were not adequate for the dependency of the patients for whom the ward was caring.
- We looked at the staffing rotas for the previous three weeks and identified that out of 21 days the ward was fully staffed to the planned levels on only four days. Data provided to us by the trust indicated that there was a vacancy of 1.68 WTE and a sickness rate of 7.69% in January 2016.
- We looked at the staffing levels for the previous 7 days on ward 15A and found that on 6 days there were less staff than planned. When we reviewed the past off duty the same gaps were reflected. The actual nurse staffing levels were below the planned levels for both qualified staff and health care assistants. From March 2015 there were 25 incidents, reported by 15A nursing staff, which related to insufficient staffing levels.
- On two separate occasions staff became tearful during our interactions with them and reported that they couldn't stand the heavy workload anymore. One member of staff reported that she frequently went home and cried because she was so upset by the low numbers of staff and heavy workload. From February 2015 to January 2016 the staff of ward 14A completed incident forms on nine occasions to report insufficient staffing.
- One member of staff from 15A raised concerns about low staffing levels. They reported that they believed it was dangerous for patients because they didn't receive the care they should and the nurses were exhausted. Another member of staff started to cry when we asked if they were happy at work. They responded that they loved their job but the low staffing levels meant that they couldn't do it properly. We observed the impact of the low staff numbers. We reviewed nutritional assessments for patients on the ward and observed that only one had been carried out. We also observed six patients being delivered food on the red tray system, which indicated they needed support or assistance to eat. When we asked staff why there was no nutritional assessment carried out on those patients who obviously required assistance, we were told that staff didn't have the time to carry them out.
- Although we were told that acuity and dependency levels for each ward was assessed on a six monthly basis, when we discussed this with senior ward staff, they appeared to be unfamiliar with the concept of acuity and dependency assessments. We were unable to see any evidence of daily acuity and dependency levels of patients being considered to support daily review of staffing levels.

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- The staffing levels in all other surgical areas were adequate for the needs of the patients.

Surgical staffing

- There was one full-time consultant urologist, two part-time consultants and one locum consultant. This meant that the on-call rota for urology was one in three. The shortage of consultants was compounded by a lack of middle grade doctors for urology. There were two staff grades and one specialist registrar trainee. The continuation of the specialist trainee position was threatened by the difficulties in the on-call rota. A junior doctor reported that there was frequently no urology middle grade cover out of hours and if advice and support was required, it was often provided by middle grade general surgical staff. The trust had attempted to recruit to a consultant post in September 2015, however, no suitable candidates were attracted and the post remained vacant. It was explained to us that it wasn't an attractive urology post as the complex cases had been removed from the caseload following service reconfiguration.
- Medical and nursing staff complained that there was a shortage of orthopaedic consultant medical cover at SFDGH when consultants are operating at Ormskirk.

Major incident awareness and training

- The trust had a major incident policy in place which was available on the trust intranet and a hard copy was kept in each surgical area. All staff we spoke with knew how to access the major incident plan. The ward managers we spoke with understood the role of each ward area in the event of a major incident.

Are surgery services effective?

Requires improvement



Surgical services at SFDGH require improvement for effective because:

- Outcomes for people who use the services were below expectations compared with similar services. The hospital had a readmission rate for elective surgery significantly higher than the England average and performance in national audits was worse than the national average.

- Patients were at risk of not receiving effective care and treatment because hydration and nutrition needs are not consistently assessed, monitored and reviewed. We saw instances where fluid balance charts were not completed for patients and where nutritional needs were not assessed for patients who clearly required assistance.
- Care and treatment did not always reflect current evidence based guidance in that we saw evidence in patient notes that staff were not adhering to the trust policy on fasting prior to surgical procedures.

However we also found that:

- There was a strong local audit programme for each specialty, addressing local and national priorities.
- Enhanced recovery pathways were in place for surgical procedures such as joint replacements.
- Monthly audits were undertaken to assess theatres compliance with World Health Organisation safer surgery checklists and compliance was strong with the first part of the surgical process.
- There was strong evidence of excellent multidisciplinary working with rehabilitation therapists having a strong presence on surgical wards that we visited.

Evidence-based care and treatment

- Patients received care and treatment in line with recommended national guidelines from NICE and the Royal College of Surgeons, which was regularly audited by the trust's involvement in a wide range of national and local audits.
- Each specialty had its own annual audit programme based on national and local priorities. We were provided with the minutes of monthly audit meetings for urology, orthopaedics, anaesthetics and general surgery. These minutes demonstrated that there was a programme of clinical audits in each specialty which was based on national and local policies.
- Enhanced recovery (ER) pathways were in use for surgical procedures such as joint replacements. Enhanced Recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery.

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Evidence has shown that patients on an ER pathway are involved with the planning of their operation, receive smoother rehabilitation and return to normal activities more quickly.

- Monthly audits were undertaken to assess theatres compliance with WHO safer surgery checklists. We reviewed a selection of recent WHO audits from different theatres including dermatology, general theatres and radiology. These audits demonstrated that the WHO safer surgery checklists were being carried out 100%, apart from the de-briefing, which was carried out 75% at SFDGH.

Pain relief

- Staff assessed patients' preferences for pain management pre-operatively. The pain of in-patients was assessed as part of vital sign electronic assessment. There were also 2 hourly intentional comfort rounds. However, surgical services did not use formal pain scoring too to assess pain. In addition, there was no formal tool used to assess pain in patients that had cognitive impairment or were not able to communicate their pain levels verbally.
- There was a dedicated pain team based within the hospital to provide support and advice to staff dealing with patients' complex pain requirements.

Nutrition and hydration

- There was a system in place to assess the nutritional requirements of all patients. The hospital policy required all in-patients to undergo a malnutrition universal screening tool (MUST). Those patients requiring extra support or assessment were either referred to a dietician for further assessment or identified for extra support during mealtimes. There was a red jug and tray system in place to identify those patients who required extra support eating and drinking.
- The system was not consistently followed in that patients did not always receive a MUST assessment. We observed four patients who staff were supporting to eat their lunch and records indicated that no assessment had been carried out.
- We observed that the red jug system, which alerted staff to those patients who required extra assistance with drinking, was not implemented consistently. There were

patients who were identified as requiring assistance with fluids and food but did not have a jug with a red lid. We noted that on four occasions fluid balance charts were not completed.

- We noted that there was confusion around the guidelines for fasting before surgery. We were informed by staff that all patients were fasted of food and fluids for 12 hours prior to surgery. We also confirmed from the medical and nursing notes that this was the fasting regimen adopted. This regimen does not comply with the most up to date national guidelines which advocate fasting from food for six hours prior to surgery, with clear fluids being allowed up to two hours prior to surgery, with some evidence including tea with milk as clear fluids. These guidelines increase the emphasis on the benefits of encouraging fluids up to two hours prior to surgery.
- The trust policy in relation to fasting stated that patients should be fasted of food for a minimum of six hours and that for a patient on a morning list should fast from midnight. The policy allowed for clear fluids to be taken up to two hours prior to surgery. Staff were not adhering to the policy and implementing a pre-operative procedure of 12 hours fasting from solid food and fluids.

Patient outcomes

- The readmission risk at SFDGH for elective general surgery was 165, which is significantly worse than the England average of 100. The readmission risk for the elective procedures in urology and ophthalmology were slightly worse than the England average. The readmission risk for all non-elective procedures was either better than the England average or slightly worse than the England average.
- Surgical services participated in a number of national audits including the national emergency laparotomy audit (NELA), the national bowel and lung cancer audits and the national hip audit. Surgical services had a programme of national and local audits based upon national and local priorities.
- The national emergency laparotomy audit (NELA) uses 11 indicators to assess the care and treatment of patients requiring emergency laparotomy. The trust's performance against these indicators in 2015 was poor. It achieved only three of the 11 indicators. In less than half of cases of emergency laparotomy, the trust did not

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provide consultant support for review within 12 hours of emergency admission, preoperative review by either a consultant surgeon or an anaesthetist and consultant surgeon and anaesthetist being present in theatre. In less than half of cases risk was not properly documented, direct postoperative admission to critical care was not achieved and there was no assessment by a medical care of the elderly specialist in patients over 70 years of age. However, in more than 80% of cases there was a CT scan reported before surgery and arrival to theatre in a timescale appropriate to urgency. There was final case ascertainment in over 80% of cases. We were told that this data was out of date and that a laparotomy care pathway had been recently introduced. It was expected that this pathway would improve the trust's 2016 performance.

- Performance in the national bowel cancer audit was mixed. In some indicators the trust performed better than the national average including the percentage of patients discussed at a multidisciplinary team meeting, case ascertainment rate and reporting of CT scan, but worse for the number of patients seen by a clinical nurse specialist.
- Performance was also mixed in the lung cancer audit where only 74% of patients were discussed at multidisciplinary meeting, compared to a national average of 95%. The percentage of patients receiving CT before bronchoscopy and receiving surgery was the same as the national average.
- The trust participated in the national hip audit, which measures eight indicators related to the care and treatment of patients admitted to hospital with a fracture of their hip. The trust performed worse than the England average in five of the eight indicators. These five indicators were surgery on the day of or after day of admission, bone health medication, falls assessment, mean length of acute stay and preoperative assessment by a geriatrician. The trust performed better than the national average for the following indicators patients admitted to orthopaedic care within four hours, patients developing pressure ulcers and mean total length of stay. The need to recruit an orthogeriatrician was recognised at the time of the last inspection, but the trust reported that it had been unable to recruit to the vacant position.

- Of the 6,400 surgical procedures carried out at SFDGH 57% were emergencies, 22% were elective and 21% were day case. The majority of surgical procedures carried out in Southport were general surgical cases, 15% were trauma and orthopaedics, 14% were urology and 12% were other.

Competent staff

- All staff we spoke with reported that they had undergone a personal development review in the past year.
- We were informed that there was a preceptorship programme in place to support newly qualified nurses to assume the responsibilities of their new role. This programme was also in place for nurses from other countries, including EU countries. This included a period of supernumerary practice, supported by an education programme, which addressed key competencies. We spoke with nurses on this preceptorship programme and they were very happy with the support they received.
- There was a trust induction programme for all staff, but two junior doctors we spoke with said that they had been unable to complete their induction in full.
- All bank, agency and locum medical staff received a ward induction checklist on attending a new ward.
- There was no formal system of clinical supervision in place for nursing staff. Nurses of different levels of seniority commented that they would appreciate clinical supervision.

Multidisciplinary working

- We observed excellent multidisciplinary working on surgical wards. Occupational therapy and physiotherapy staff were highly visible on all wards we visited. Therapy staff were based on the trauma and orthopaedic ward and were an integral part of the ward team. We saw evidence of multidisciplinary liaison in clinical notes. Ward staff reported that members of the multidisciplinary team responded to requests for referrals promptly.
- We saw evidence of multidisciplinary team meetings for different surgical specialities including trauma and orthopaedics and colorectal surgery.

Seven-day services

Surgery

- There were consultant ward rounds for surgical specialities on Saturday and Sunday.
- There was a good medical presence, out of hours, for all surgical specialities apart from urology. It was reported to us by junior medical staff that it was very difficult to get consultant/middle grade urological support out of hours and at the weekend. We discussed this issue with senior medical staff who identified that there were fewer than required urology consultants and middle grades at the trust. There was one full-time consultant, one part-time consultant and one full-time locum. The on-call commitment for urology specialists was one night in three.
- Nursing staff reported that it was difficult to get junior and senior medical staff to visit medical outliers on surgical wards out of hours and at the weekend, with several requests often having to be made before they attended.
- Support from the pharmacy department was available seven days a week. On Saturday and Sunday mornings there was a dispensing service available and there was an on-call pharmacist out of hours.
- Diagnostic services were available for surgical patients seven days a week, apart from histopathology.

Access to information

- Staff had access to the necessary information to make decisions and care appropriately for patients. Staff we spoke with reported that test results and other diagnostic services reported in a timely manner and reports were secured in patient notes.
- We noted that there was evidence in the medical notes of regular senior review and a robust clinical decision making processes.
- All pre-operative assessments were contained within the medical notes, containing risk assessments, allergies and social information about the patients.
- Information boards were visible in staff areas and these displayed audit information, link nurse details and trust wide correspondence.
- Staff had access to the trust intranet and access policies and procedures when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy governing obtaining consent to carry out a surgical procedure from surgical patients. This policy was based upon national guidelines. We saw evidence of consent to surgical procedures being obtained in two stages; during the pre-operative stage prior to admission, and on the morning of admission. However, from our review of medical notes we saw instances where consent was still being obtained on the morning of the surgical procedure. This was confirmed in our discussions with staff who brought the issue up with us as a concern.
- From our discussions with staff, we saw that all but one member of staff understood the issues involved with obtaining consent to treatment from patients both with and without capacity.
- We saw evidence that consent was obtained for a complex orthopaedic procedure by a foundation year two doctor. It was not clear whether this doctor had the requisite skills and experience to be the medical practitioner obtaining the level of consent required for the particular procedure. National guidelines and the trust policy stated that the clinician providing the treatment is responsible for ensuring that the patient has given valid consent. The foundation year two doctor was not the clinician undertaking the surgery in the instance we observed. Trust policy stated that the task of seeking consent may be delegated to another, as long as they are suitably trained and qualified; in particular they must have sufficient knowledge of the proposed treatment and understand the risks involved. We were not assured that a foundation year two doctor had sufficient training to undertake consent in the particular procedure we observed.
- We saw evidence in medical notes of mental capacity assessments being undertaken according to national guidelines.
- In November 2015 the trust audited surgical services compliance with the consent policy and found that full compliance was achieved in only 50% of cases. An action plan was developed to address the shortfalls in compliance but we were not provided with details of a re-audit.

Surgery

Are surgery services caring?

Good



Surgical services at SFDGH were caring because:

- We observed a range of care and treatment activities being delivered to very dependent patients with kindness, consideration and respect.
- Patients and relatives told us that they were happy with the care they received from nurses. They also told us that on most occasions nurses had comforted them when they were distressed and needed emotional support.

However we also found that:

- Although the performance of surgical wards in the Friends and Family Test (FFT) did improve during 2015, the percentage of responses remained low, compared to the national average.
- The percentage of patients who would recommend the wards to friends and family ranged between 80-89%.

Compassionate care

- We observed staff delivering compassionate and caring treatment to patients across all areas of the service. Theatres and recovery staff were observed being kind and reassuring to patients following their surgery. We had the opportunity to observe nursing auxiliary staff, therapy staff and student nurses delivering a range of care and treatment to in-patients and they all delivered this care with kindness and respect. All patient/staff interactions that we observed were positive, caring and respectful.
- The Friends and Family Test is an NHS tool that enables patients to give feedback on their experience of NHS care and is collected at ward level. The England average response rate to the questionnaire was 35.5%. All surgical wards at SFDGH were significantly below this figure, with the planned investigation unit (PIU) response rate the lowest at 16% and ward 14A the highest at 21%. The FFT performance for surgical wards improved through 2015, but performance remained low on all wards other than PIU. Particularly noticeable was

the poor performance of ward 14A in January and February 2015, when only 64 and 70% of respondents replied that they would recommend the ward to friends and family.

Understanding and involvement of patients and those close to them

- We spoke with a number of patients and relatives about their experience of surgical services at SFDGH. In general both patients and relatives were happy with the care they received. There were two instances, however, where a patient and a relative gave examples of where nursing and medical staff did not listen to them about levels of pain, infection and drug allergies. In one of these instances a doctor did not accept that a patient was experiencing severe pain and refused to consider the possibility that the patient had an infection, even though this was strongly suggested by the patient. The patient was left in pain overnight and it transpired that this patient did have an infection in a wound. This is an illustration of a patient not being involved in their own care.

Emotional support

- We observed staff providing emotional support to patients when they were distressed. This was particularly the case for patients who were confused and agitated.
- Clinical nurse specialists were available for trauma and orthopaedics, urology and a range of oncology specialities.

Are surgery services responsive?

Requires improvement



Surgical services require improvement for responsive because:

- The surgical process is not planned to meet the needs of patients. There was no surgical admissions unit or discharge lounge. This impacts on the efficient throughput of patients as it creates unnecessary delays because patients are admitted for surgery one by one and taken down to theatre when a nurse can be spared from the ward. There is no forward waiting area in theatre which adds further to delays.

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- Surgical services at SFDGH experienced difficulties with patient flow. There were high numbers of medical patients occupying surgical beds, which prevented elective surgical patients from having their surgery. There were high numbers of cancellations on the day of surgery and one third of these cancellations were because of lack of a surgical bed or critical care bed. Bed occupancy rates were over 90% for all surgical wards and at some periods over 100%. The percentage of patients starting treatment within 18 weeks of referral was below the national target of 90%.
- Surgical services did not always meet the needs of individual patients with complex needs. We observed that the needs of patients with dementia were not fully considered, even though there was a dementia link nurse on all wards. We observed that the environment and care that was not adapted to the needs of patients with dementia. A patient was moved eight times after admission for the following 48 hours and every time she was moved she missed a meal. She only received sandwiches or toast over the 48 hour period. She commented that she was hungry and had to ask her family to bring food in for her.
- We found that patients were admitted from accident and emergency to recovery on six occasions over the previous weeks, where they were cared for overnight. There were no facilities for hot meals to be taken, there were no private toilet facilities and relatives were not allowed to visit. This practice was escalated whilst we were on inspection and when we visited on the unannounced inspection, it had not been repeated.
- We were also informed that trust management did not fully consider the individual needs of elective colorectal patients when it was decided to admit these patients to Ormskirk hospital the evening before surgery. Patients were transferred on the morning of surgery, after they had received bowel preparation medication. This practice was stopped when a consultant surgeon became aware of what was happening and intervened, but demonstrated that minimal effort was made on the part of managers to understand the needs of this patient group.
- Complaints were not used as an opportunity to learn and improve the service. Even though there were a high number of complaints on each ward, no senior ward staff could explain how complaints had improved services.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of emergency and elective surgical services for the community it served. This included trauma and orthopaedics, ophthalmology, urology, general surgery including colorectal surgery.
- The hospital did not provide specialist or complex surgical services and patients requiring specialist surgery were referred to the relevant specialist centre. There had been a contraction in level of specialist services provided at the hospital, as part of wider health economy planning. An example of this is that urology did not undertake complex surgery, which staff reported had negatively impacted on the hospital's ability to recruit medical staff. The hospital also shared services with Whiston Hospital, which is part of the St Helens and Knowsley NHS Trust.
- Surgical services were not planned or organised to provide efficient access to surgery in that there was no admission lounge for elective surgical patients. Patients were required to sit in line on each ward and change into their theatre gown one patient at a time. The lack of admission lounge created difficulties for staff managing admissions, in that ward staff had to take patients down to theatre and if they were busy, it would delay a patient being brought to theatre. A similar delay was evident for patients in recovery awaiting return to the ward. Once in the theatre area there was no designated forward waiting area, which also created a delay because patients could only come into theatre area when the anaesthetic room was available for them. This organisation of elective surgical admissions created delay at either end of the process.
- At the time of inspection there was no emergency theatre Monday to Thursday morning. We were told that it would be beginning in mid-April of this year.

Access and flow

- Surgical services at SFDGH experienced difficulties with patient flow throughout the service. We saw evidence of this during inspection across surgical services. In addition, the data provided to us by the hospital supported our observations. All surgical wards reported difficulties with high numbers of medical outliers. Wards 15A and 15B and the PIU also reported high numbers of

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outliers from trauma and orthopaedics. During our inspection ward 15A had six medical outliers and four orthopaedic outliers. Senior nursing staff reported that the previous week the same ward reported 14 medical outliers. Ward 15B reported seven medical outliers and four orthopaedic outliers on the day of our inspection. All of the orthopaedic outliers were patients who had diagnoses of dementia and had suffered a fractured neck of femur. Data provided to us indicated that for the month of March 2016 there were 118 medical patients occupying surgical beds. This data did not include the PIU which also reported medical outliers during inspection.

- Nursing and medical staff reported that medical patients occupying surgical beds created problems with surgical elective admissions in that patients were often cancelled the day before or on the day of surgery. One consultant who originally had five procedures planned for the day we spoke with him. Three of these had been cancelled at 4.30pm the previous day. 'In theatres there were 92 reported incidents which related to the cancellation of surgery because of lack of capacity. These reasons included no ICU/HDU or ward bed available or lack of anaesthetist.'
- The trust wide target for percentage of cancelled operations was 0.6%. Over the previous 12 months, this was met on only two occasions which were July 2015 and January 2016. For the months when the target was not met, performance varied considerably, with the highest percentage of cancellations occurring in October 2015, when 2.04% of all operations were cancelled. In February and March 2016 the percentage of operations that were cancelled was 1.23% and 1.57% respectively. Compared to the England monthly average of 1%, the trust's performance was worse. However, for quarter 4 of 2015/2016 the trust performed about the same as the England average of 1.2% because of the trust's strong performance in January 2016.
- We were provided with additional data providing the reason for all operations that were cancelled. Out of 328 operations that were cancelled at SFDGH, 102 were cancelled because of lack of either a ward bed or an intensive care bed.
- However, the high number of cancelled procedures did not translate into poor performance for re-booking

cancellations within 28 days. In 2015/16 the trust's performance against the national cancelled operations target was good, with only two cancelled operations not being re-scheduled within 28 days.

- The bed occupancy rates for surgical wards at SFDGH were high, especially for the last four months of 2015/2016. All wards were above 90%, with some wards being over 100%. The bed occupancy rates of ward 14A were particularly high, with percentage bed occupancy rates for December, January, February and March of 100.9, 98.8, 101.1 and 99.5%, respectively. National guidelines state that bed occupancy rates above 85% can adversely affect the quality of care and increase the risk of harm to patients.
- The average length of stay at SFDGH was around the England average for all elective surgery. There were some differences to the England average when broken down into specialty, with urology and trauma and orthopaedics having significantly higher length of stay than the England average. These lengths of stay were repeated in non-elective procedures.
- The percentage of patients starting treatment within 18 weeks of referral was below the target of 90% for all specialities.

Meeting people's individual needs

- During the inspection we observed, and were provided with, examples of where surgical services were not responsive to patients requiring support with their individual needs. Of particular concern was the failure to adapt how in-patient care was delivered to patients with dementia and other cognitive impairments. Although there was a dementia link nurse on each surgical ward, it was difficult to identify any obvious reasonable adjustments that had been made for these patients. The environment was not conducive to patients with cognitive impairment. There was no signage above beds to indicate to staff that such patients might require adapted communication techniques. No thought had been given to how patients with communication difficulties might communicate pain as indicated by the lack of a pain assessment tool for non-verbal patients. In addition to our observations during inspection CQC had previously received concerns from a relative about the poor standard of care given to a patient with learning difficulties.

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- We were told about a dementia passport for patients living with a diagnosis of dementia. This was completed by the patient or their representative and included key information about the patient, such as important likes and dislikes. We did not see a passport in operation during our visit.
- We spoke with one patient with complex treatment and care needs who told us how her particular needs had been completely ignored. This patient had been admitted to recovery from accident and emergency because there were no beds on a surgical ward. Her husband and small child were unable to visit her in recovery, causing great distress to all the family. This patient was moved numerous times in 48 hours and each time she moved she either missed meals or there was no meal available for her. She was given a sandwich or toast and reported that she had been extremely hungry.
- During our inspection we found out that patients had been admitted from accident and emergency to recovery because there were no beds on medical and surgical wards on six occasions. There were no bathroom facilities in recovery, apart from a commode. Patients were therefore unable to wash or use a toilet in a private and dignified manner. The only meals provided in recovery were sandwiches and relatives were unable to visit. The use of recovery in this manner was escalated immediately to trust management and ceased from the day of inspection. On our unannounced inspection there was no evidence that recovery had been used again for escalation.
- We were also informed of the failure of trust management to fully consider the individual needs of patients admitted for elective colorectal procedures. As a response to winter pressures patients were admitted to Ormskirk hospital to be transferred on the day of surgery to Southport via taxi. These patients had been administered bowel preparation as a necessary part of their forthcoming procedure. An accident that could have been anticipated occurred on route to Southport hospital.

Learning from complaints and concerns

- Between February 2015 and January 2016, 80 complaints were received about in-patient surgical services at SFDGH. These complaints were evenly

distributed across all wards. The majority of complaints related to the standard of care given to patients, for example waiting for buzzers, the treatment of confused patients.

- There were patient information boards, detailing how to make a complaint but they were not in prominent positions and were difficult to find.
- When we discussed complaints with senior ward staff, none of them could identify positive actions that had been taken as a result of a complaint. In addition none of them could give an example of a recent complaint. This was an illustration of a culture that did not take complaints seriously or use them as an opportunity to learn and improve the service delivered.

Are surgery services well-led?

Inadequate



Surgical services at SFDGH were rated as inadequate in the well-led domain because:

- There was no vision or strategy for surgical services at the hospital. Staff were not aware of the vision and values for the service. Staff articulated confusion and anxiety about the future of surgical services.
- The systems for identifying risks did not effectively identify risks, issues and concerns. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken.
- We found a top down directive culture in terms of medical leadership, with medical staff reporting a combative style of leadership dominating management relationships. There was also a combative approach to dealing with disciplinary matters across the division for both nursing and medical staff, with long suspensions in place while investigations were conducted into matters of professional competence. Some staff reported a bullying culture existed.
- Complaints were not used to drive service improvements

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- Staff morale and satisfaction was mixed, with some staff being visibly distressed and expressing that they did not feel listened to and others reporting that a good relationship existed between senior surgical staff and ward staff.

Vision and strategy for this service

- There was no clear vision or strategy for surgical services at SFDGH.
- Staff were confused about the future of surgical services at SFDGH. A number of staff articulated anxiety to CQC about the future of acute surgery at the hospital.

Governance, risk management and quality measurement

- There were structures in place to identify and report on risk and quality measurement. Risks for surgical services were identified and placed on a risk register, but didn't always progress forward. An example of this is the lack of a plan to replace old theatre equipment.
- Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not always taken. Examples of this include the failure to identify the poor staffing levels on wards and the impact these had on the safety of patients; the decision to admit patients from accident and emergency to the recovery area, which had inadequate facilities to care for the patients placed there; and the decision to place colorectal patients in another hospital, when they would have to be transferred by taxi on the morning of their surgery, after receiving bowel preparation medication.
- There was a failure to use complaints as a vehicle to drive service improvements.
- There were regular business and governance meetings throughout the planned care division. Minutes were taken and cascaded throughout the service. Ward meetings took place on a regular basis and minutes were made available for us to review. We saw a good standard of communication from these minutes.

Leadership of service

- Medical staff reported a combative style of leadership, which also influenced how the hospital dealt with disciplinary matters. The same issue was also raised by nursing staff. Clinical staff were unhappy with the length

of time that disciplinary investigations took and that clinicians subject to the investigatory processes were suspended during this time. It was reported to inspectors that this approach led to a culture of fear amongst medical and nursing staff.

- We observed a variable standard of leadership across surgical services. On some wards the ward manager provided clear clinical and organisational leadership on others leadership was not fully established and the manager did not appear to know or understand basic matters about the ward.
- In the 2015 NHS staff survey 21% of staff reported good communication between senior management and staff. This was below the national average of 30%.

Culture within the service

- There was a poor relationship between consultant surgeons and trust management. It was reported by consultants that they had no access to speak with senior management and were not listened to by management.
- Morale was very low across the service for clinicians and managers. We met nurses who were distressed by the low staffing levels and heavy workload. These nurses felt that their concerns were not listened to by clinical managers.
- There was a clear disconnect between clinical staff in all areas and trust management, although some staff reported that this had improved in recent months. This disconnect resulted in management making decisions that were not in the best interest of the patient. The previously cited example of colorectal patients being transferred to SFDGH in a taxi after taking bowel preparation was an illustration of this decision making process. A second example of this was the decision to care for patients in recovery, even though there were no toilet facilities. It was reported to us, by patients, that nursing staff were clearly distressed by nursing in these circumstances.
- Nurses reported that they felt unsupported by the division's clinical nurse leadership, when they tried to raise issues about staffing levels. However, other staff reported that they did feel supported by nursing leadership and could approach them about poor staffing levels and managers responded positively to issues raised.

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- It was reported to us that a culture of favouritism existed amongst nurse leadership and you could only progress in your career if you did not question the nursing leadership.
- Some staff reported that the culture in the organisation was improving since the changes at the top of the organisation but change was very slow.
- It was commented to us by senior staff that the dominant culture was one that tolerated delay. An example of this delay was cited to us with the lack of drive to solve the known problem with bleep coverage in the hospital. New bleeps had been purchased and had arrived in the hospital two weeks ago but had not been distributed. This was frustrating for clinical staff.
- The same delay could be seen in dealing with disciplinary matters, with staff suspended pending investigation for very long periods of time. Staff reported that lengthy suspensions felt unfair and had a negative effect on staff morale. Some staff reported that human resources department was unsupportive and did not appear to understand the need to deal with disciplinary matters swiftly.

Public engagement

- The trust board minutes were available to the public online.
- The trust reported that it had undertaken a number of events designed to understand the patients' experience of its services. These events were called "In Your Shoes"

and patients and carers shared their experience of services. They highlighted good experiences including good support from allied health professionals and good food. They also highlighted negative experiences such as slow discharge planning and lots of chaos on the wards.







Staff engagement

- The trust held a staff engagement programme in 2015, holding 48 sessions with approximately 900 staff.
- In the NHS staff survey 90% of staff reported that they had an appraisal in the last 12 months, which was better than the national average. However, the survey also reported that staff rated the quality of appraisal lower than the national average.
- Staff gave us examples of where they were involved in innovations such as the documentation review, but then their views were ignored and managers proceeded with their own view. This approach undermined motivation to be involved with innovations.

Innovation, improvement and sustainability

- There was little innovation across surgical services at SFDGH as there was confusion about the future development and sustainability of surgical services at this site.
- We were told about an innovative new service being developed for pelvic floor surgery and that preliminary discussions had taken place.

Critical care

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

Information about the service

The critical care services are based at the Southport and Formby District General Hospital. The critical care unit can accommodate up to 15 patients. The unit provides care for five intensive care patients and six high dependency patients. The unit also has a coronary care unit with four patient beds.

The services are consultant-led and provide specialist care and treatment to adult patients with a range of serious life-threatening illnesses in Southport and the surrounding areas. Patients could be admitted to the critical care services via the emergency department or from within the wards and departments across the trust. There were 488 intensive care patients and 746 high dependency patients admitted to critical care between April 2015 and March 2016.

We visited the Southport and Formby District General Hospital as part of our announced inspection during 12 to 15 April 2016. As part of our visit, we inspected the critical care unit.

We spoke with the relatives of seven patients. We observed care and treatment and looked at seven care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, a pharmacy technician, the pharmacist, the practice based educator, the practice development nurse, nursing assistants, outreach specialist nurses, a dietitian, physiotherapist, the unit manager, the

matron for critical care and the consultant lead for intensive care. We received comments from people who contacted us to tell us about their experiences. We reviewed performance information about the services.

Critical care

Summary of findings

We gave the critical care services at Southport and Formby District General Hospital an overall rating of good. However, we rated the services as Requires Improvement for responsive.

This was because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients were supported with the right equipment. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating.
- The staffing levels and skills mix was sufficient to meet patients needs and staff assessed and responded to patients risks. The consultants covering the critical care unit during out of hours were also responsible for other areas, such as providing anaesthetic cover for the surgical and maternity services. However, there was a second on-call consultant to provide additional cover and support.
- Patients received care and treatment by multidisciplinary staff that worked well as a team. A consultant-led ward round took place twice a day on the critical care unit. Staff carried out a daily assessment of delirium (acute confusion) in patients using the Confusion Assessment Method for intensive care (CAM-ICU) guidelines.
- The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Patients relatives spoke positively about the care and treatment they received. They were supported with their emotional and spiritual needs. Feedback from surveys showed patients relatives were positive about the services. There were systems in place to support vulnerable patients.
- There was effective teamwork and clearly visible leadership within the services. Most staff were positive about the culture within the critical care

services and the level of support they received from their managers. Key risks to the services, audit findings and quality and performance was monitored though routine departmental and divisional quality and governance meetings.

However, we also found that: -

- The critical care services were previously rated as requires improvement for responsive following our last inspection because we had concerns around delayed discharges and the provision of single sex accommodation.
- During this inspection, we found that significant improvements had been made to reduce the number of delayed discharges. However, further improvements were still needed to ensure patients received appropriate care.
- The number of patients with delayed discharges had improved from 487 during 2014 to 294 during 2015. However, recent capacity issues across the hospital meant there was a worsening trend and there had been 111 delayed discharges between January 2016 and March 2016. There were 86 mixed sex breaches on the unit between April 2015 and March 2016.
- This meant a significant number of patients were still affected by delayed discharges and patients privacy and dignity was affected as a result of mixed sex breaches.
- The majority of staff had completed their mandatory training and appraisals. However, this was below the hospitals target of 90% training completion.
- There was one speech and language therapist across the hospital during weekdays. This meant staff on the unit occasionally experienced a delayed response after referring patients for this service.

Critical care

Are critical care services safe?

Good



We rated the critical care services at Southport and Formby District General Hospital as 'Good' for being safe.

This was because: -

- The critical care services were previously rated as 'requires improvement' for safe in May 2015 following our last inspection. This was because we had concerns around the management of medicines and the presence of pseudomonas in the tap water within the critical care unit.
- During this inspection, we found that improvements had been made. We found that medicines were stored, handled and managed appropriately and remedial actions had been taken to address risks associated with pseudomonas in the tap water.
- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients were supported with the right equipment.
- Patient records were legible, complete and up to date. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. Staff were aware of how to access guidance in the event of a major incident.
- The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. The consultants covering the critical care unit during out of hours were also responsible for other areas, such as providing anaesthetic cover for the surgical and maternity services. However, there was a second on-call consultant to provide additional cover and support.

However, we also found that: -

- The majority of critical care staff (74.6%) had completed their mandatory training. However, this was below the hospital's target of 90% training completion.

Incidents

- The Strategic Executive Information System data showed there was one serious patient safety incident reported by the critical care services between February 2015 and January 2016.
- The incident was reported in November 2015 in relation to a delayed diagnosis and delayed treatment. The incident was investigated and learning was shared in order to improve patient care.
- Records showed there were 459 patient safety incidents reported across the critical care services between March 2015 and March 2016. The majority of these incidents (97%) had resulted in no or low patient harm.
- The most frequently reported incidents were in relation to transfer delays and delayed discharges. We saw evidence that incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to identify learning and prevent reoccurrence. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron or lead consultant.
- Incidents and complaints were discussed during monthly staff meetings so shared learning could take place. Learning from incidents was also shared during staff handovers and through hospital-wide alerts and critical care newsletters.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. The incident reporting system provided prompts for staff to apply duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Patient deaths were reviewed by individual consultants. These were also reviewed during weekly and monthly critical care mortality and morbidity meetings.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).

Critical care

- The critical care services had low levels of falls with harm, infections and pressure ulcers. Safety Thermometer information showed there were no catheter urinary tract infections, one fall with harm and two pressure ulcers reported in relation to critical care between September 2014 and September 2015.
- Information relating to the safety thermometer outcomes was clearly displayed on notice boards within the critical care unit.

Cleanliness, infection control and hygiene

- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) and five cases of Clostridium Difficile (C.diff) infections reported between March 2015 and March 2016 across the critical care services.
- We looked at the investigation report and action plan for two C. diff incidents from November 2015. These showed the incidents had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trusts infection control team.
- The overall infection rates were within expected levels for the size of the hospital. Intensive Care National Audit and Research Centre (ICNARC) data also showed that unit acquired MRSA infection rates were within expected levels compared to the England average.
- All patients admitted to the critical care unit underwent MRSA screening procedures. Patients identified as at risk were also screened for C.diff and Carbapenemase-producing Enterobacteriaceae (CPE) infections.
- There were no cases of ventilator-associated pneumonia (VAP) identified in the critical care unit between February 2015 and September 2015. Patients at risk of acquiring VAP received safe and appropriate treatment through the use of a recognised ventilator care pathway. Staff also used recognised care pathways for patients with sepsis (blood poisoning).
- The critical care unit was clean, tidy and maintained to a good standard. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels.

- The intensive care beds were located in single rooms, so patients identified with an infection could be isolated if needed. The unit also had a dedicated isolation room with negative air pressure flow to minimise the risk of spread of infection. We saw that appropriate signage was used to protect staff and visitors.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.
- Hand hygiene audits were carried out on a monthly basis across the unit. Audit results showed staff consistently achieved hand hygiene compliance scores of 100% from April 2015 to February 2016.
- During our previous inspection, we found that the service was investigating the presence of pseudomonas in the tap water affecting several areas of the critical care unit. During this inspection, we found that all remedial actions had been implemented and the risks associated with pseudomonas in the tap water had been addressed.

Environment and equipment

- The environment and equipment in critical care unit was visibly clean and well maintained. The clinical areas were tidy and free from clutter.
- Each patient bed area had an equipment trolley containing all the equipment required to treat the patient. Bed spaces were equipped with the right equipment, such as ventilators and intubation equipment (for placement of tube in patients airways).
- Equipment was appropriately checked and cleaned regularly and the majority of equipment we saw had service stickers displayed and these were within date.
- Equipment was serviced by the hospitals maintenance team under a planned preventive maintenance schedule. Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- The unit had three older ventilators that were no longer supported by the manufacturer since January 2016. There was a plan in place to purchase new ventilators and these were expected to be in place by July 2016. The matron for critical care told us there was sufficient stock of ventilation equipment to ensure patient safety was not impacted until the purchase of the new equipment.

Critical care

- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- During our previous inspection, we had concerns that the management of medicines on critical care did not always protect patients from risks associated with the unsafe use or management of medicines.
- We reported this as a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. We told the services to take appropriate actions to address our concerns.
- During this inspection, we found that the previously highlighted issues had been addressed and medicines, including controlled medicines, were securely stored. Staff carried out daily checks on controlled medicines and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. A pharmacy technician was responsible for maintaining minimum stock levels and checking medication expiry dates.
- We saw that medicines that required storage at temperatures below 8C were stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- The critical care services had a dedicated pharmacist based on the unit during weekdays. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication records for seven patients and found these to be complete, up to date and reviewed on a regular basis. We also found the use of oxygen had been prescribed and documented correctly on the medication charts of patients receiving oxygen treatment.

Records

- We looked at the records for seven patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for venous thromboembolism (VTE), pressure care or nutrition and these were completed correctly.
- The records showed timely assessments by nurses and daily consultant reviews took place.

- Standardised nursing documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 92.5% of critical care staff had completed safeguarding adults (level 1) training and 100% had completed safeguarding children (level 1) training. However, only 56.6% of staff had completed safeguarding children (level 2a) training, which was below the hospitals 90% target for training completion.
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report safeguarding concerns was displayed in the critical care unit.
- There were safeguarding link nurses in place. Staff could also seek advice and support from the hospital-wide safeguarding team.
- Safeguarding incidents were reviewed by the matron and also by the hospitals safeguarding committee, which held meetings every two months to review incidents and to look for trends.

Mandatory training

- Staff received mandatory training, which included key topics such as infection control, information governance, dementia care, mental capacity act, consent, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling, conflict resolution and resuscitation training.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- The overall mandatory training completion rate for all staff across the critical care services was 74.6%. This showed the majority of staff had completed their mandatory training but the hospitals target of 90% training completion had not been achieved.

Assessing and responding to patient risk

- Critical care staff carried out routine monitoring based on the patients individual needs to ensure any changes to their medical condition could be promptly identified.

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- Patient records showed that staff escalated concerns correctly, and repeat observations were taken within necessary time frames to support patient safety.
- Ward staff across the hospital used early warning scores. If a patient's health deteriorated, staff were supported with medical input and could access the critical care outreach team.
- The critical care outreach team followed up all critical care patients that had stayed on the unit for at least 72 hours and had been discharged within the past 24 hours. Records between April 2015 and January 2016 showed 98% of patients discharged from critical care received a follow up review by the outreach team within 24 hours of discharge.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards and acuity was based on Intensive Care Society (ICS) guidelines. The expected and actual staffing levels were displayed on a notice board in the unit and these were updated on a daily basis.
- Nursing staff handovers occurred three times a day and included discussions around patient needs and any staffing or capacity issues.
- During our inspection the critical care services had sufficient numbers of qualified nursing and support staff with an appropriate skill mix on each shift to ensure that patients received the right level of care.
- The unit provided care for up to five level 3 (intensive care) patients and six level 2 (high dependency) patients. All intensive care (level 3) patients were nursed 1:1 and all high dependency (level 2) patients were nursed 1:2 in accordance with ICS guidelines.
- The critical care unit also included a coronary care unit (CCU) that could accommodate up to four level 2 (high dependency) patients. The CCU was staffed by nurses from the critical care unit. The staffing levels for the CCU were maintained to allow 1:3 nurse to patient ratio for routine coronary care patients and this was increased to 1:2 when patients with higher dependency levels were admitted to the CCU.
- The staffing establishment across the critical care unit was for at least 11 trained nurses and two nursing assistants during each shift.
- The matron for critical care told us staffing levels were flexible and based on the dependency of patients. Where patients with increased dependency were

identified, staffing levels were increased through the use of additional nurses or assistant practitioners to ensure patients received appropriate care. We saw evidence of this during the inspection.

- The matron for the critical care services was responsible for the ward staff and was supported by the critical care unit manager. There was a nurse coordinator on each shift that was supernumerary (i.e. additional to the staffing establishment) as recommended by ICS guidelines.
- There were two vacancies for band 5 nurses across the unit and recruitment for these was on-going. There were no nursing assistant vacancies.
- The matron for critical care told us they did not routinely use external agency. The majority of cover for staff leave or sickness was provided by the existing nursing team.
- Records between March 2015 and February 2016 showed the monthly average for agency staff use in the unit ranged between 2.7% and 7.3%. The use of agency staff was within levels recommended by ICS guidelines (less than 20% agency staff on any one shift).
- The critical care outreach team included a whole time equivalent (wte) band 7 nurse and a 0.4 wte band 7 nurse as well as three 0.6 wte band 6 nurses from the critical care unit.

Medical staffing

- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skills mix to ensure that patients received the right level of care.
- There was a designated lead consultant for intensive care as set out in the ICS standards.
- There were 17 critical care consultants on the critical care rota with approximately seven consultants that had daytime sessions on the critical care unit during the week.
- The medical rota showed consultants alternated during the week which meant there may be a lack of continuity of care for patients.
- During weekdays, at least two consultants were based on the unit in the mornings from 8:30am to 1pm and at least one consultant from 1pm until 5pm. During out of hours there was at least one on-call consultant during weekdays.

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- At the weekend, on-call consultant cover was available over 24 hours. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- The existing on-call consultant rota included a combination of critical care specialist and surgical consultant anaesthetists. The on-call consultants covering the critical care unit outside of normal working hours were also responsible for other areas, such as providing anaesthetic cover for the surgical and maternity services.
- The associate medical director for planned care told us it was difficult for the services to provide a separate consultants rota for critical care. This was because the service configuration was based on the recommendations from the Shields report (Assessment of Acute Hospital Clinical Services in West Lancashire and Southport and Formby", report by Sir Robert Shields, May 1999).
- The implementation of the Shields report recommendations meant emergency out-of-hours anaesthetic services were provided across two acute hospital sites that were 10 miles apart. There had been a reduction in the number of trainee doctors made available to the trust from Health Education North West. The consultants team was also not large enough for the provision of a separate critical care rota.
- The risks to patient safety were minimised through the use of a second on-call consultant to provide additional support for the first on-call consultant and to provide cover for the Ormskirk and District General Hospital. Consultant-led ward rounds also occurred twice a day, seven days per week so that patients received appropriate care and treatment.
- The consultant to patient ratio in the critical care unit did not exceed 1:8 during weekdays and 1:15 during out-of-hours service in line with ICS standards.
- The consultants were supported by a team of specialty grade doctors (including anaesthetic / critical care trainees).
- There were least two specialty grade doctors present on the unit from 8am to 5pm each day. However, one of these doctors was required to support a trauma list for three Saturdays each month. This meant there was one doctor on the unit during the day on Saturdays. The specialty doctors we spoke with told us this impacted their workload on Saturdays but they were able to manage and provide appropriate care for patients.
- There were least one specialty grade doctor based on the unit from 5pm until 8am over seven days. They were supported by the operating theatre anaesthetist or the on-call consultant when needed.
- There were no consultant vacancies. Locum doctors were used to cover for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospitals policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handover.

Major incident awareness and training

- Staff received mandatory training in resuscitation, fire safety and health and safety.
- There was a documented major incident plan within the critical care services and this listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident.

Are critical care services effective?

Good



We rated the critical care services at Southport and Formby District General Hospital as Good for being effective.

This was because: -

- The critical care services were previously rated as requires improvement for effective in May 2015 following our last inspection. This was because we found that not all patients were reviewed by a consultant within 12 hours, and the service did not have twice daily ward rounds in line with the national standards. We also did not see evidence of the daily use of a critical care delirium scoring tool.
- During this inspection, we found that improvements had been made. We found that patients received care and treatment by multidisciplinary staff that worked well as a team. A consultant-led ward round took place twice a day on the critical care unit.

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- Staff carried out a daily assessment of delirium (acute confusion) in patients using the Confusion Assessment Method for intensive care (CAM-ICU) guidelines. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for most performance measures in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- The majority of nursing staff (67%) had completed the post registration award in critical care nursing, which exceeded the intensive care society standard for 50% of staff to have completed the training.

However, we also found that: -

- Most of the ward-based staff had completed their appraisals (79.7%), but the hospitals target for 90% completion had not been achieved by the nursing and support staff.
- Staff were supported by pharmacists, dietitians and physiotherapists as well as diagnostic support such as for x-rays and scans. However, there was one speech and language therapist across the hospital during weekdays. This meant staff on the unit occasionally experienced a delayed response after referring patients for this service.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE), National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations as well as guidance published by the relevant medical bodies such as the Royal Colleges and British Medical Association.
- Staff used care pathways that were based on national best practice guidelines and carried out care 'bundle' audits to check adherence to national standards. The results from the nutrition, skin care, and ventilator care, renal care, sepsis care and tracheostomy tube care bundle audits from 2015 showed the critical care services achieved 100% for most of the applicable standards. Action plans were in place where standards had not been achieved.

- The urgent care divisional audit plan 2016 showed the critical care services planned participation in seven national and local clinical audits.
- Findings from clinical audits were reviewed for any changes to guidance and the impact that it would have on practice was discussed during consultant meetings and audit meetings that took place at least every two months. Audit findings were also shared with the to look for improvements to the service.

Pain relief

- The critical care staff had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice and treatment when required.
- Patient records showed that patients were prescribed pain medication when needed. Patients told us their pain symptoms were suitably managed and the staff treated them in a way that met their needs and reduced discomfort.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements. Where patients were identified as 'at risk', there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff to ensure patient safety. A dietitian was available to provide support for staff during weekdays. The medical staff also carried out swallow assessments where patients had difficulties with their eating and drinking.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that staff used the red tray system so patients living with dementia could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- ICNARC audit data from April 2015 to December 2015 showed the risk-adjusted acute hospital mortality (for

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patients with a predicted risk of death less than 20%) was 1.40 and the overall risk-adjusted acute hospital mortality was 1.18. The expected mortality ratio was 1.0, which meant the actual deaths on the unit were slightly higher than the anticipated number. However, the data showed the intensive care unit was still within the expected range for the ICNARC (H 2015) model mortality ratio when compared with similar units nationally.

- The ICNARC data up to December 2015 showed the critical care unit performed better than other similar units for unplanned readmissions within 48 hours, non-clinical transfers out and the proportion of patients admitted to the unit with severe sepsis.
- The data also showed that performance was within expected levels for unit acquired MRSA, unit acquired C.diff and unit acquired infections of the blood. The unit performed worse than other similar units for out-of-hours discharges and delayed discharges greater than four hours.
- ICNARC data showed that the mean length of stay for ventilated admissions, patients with severe sepsis, pneumonia and elective and emergency surgical admissions was higher than other comparable units nationally.
- The mean length of stay on the unit for admissions with trauma, perforation or rupture was shorter than other comparable units during 2015.
- Staff carried out a daily assessment of delirium (acute confusion) in patients using the Confusion Assessment Method for intensive care (CAM-ICU) guidelines.

Competent staff

- The critical care service had a practice educator and a clinical nurse educator based in the unit. They oversaw training processes and carried out competency assessments based on national critical care competency guidelines.
- Newly appointed staff had an induction and their competency was assessed over a period of six weeks before working unsupervised. During the induction period, the new starters were supernumerary (i.e. in addition to the staffing establishment). This was followed by further training during the first two years of employment after which they were placed on a post graduate critical care course.
- Records showed 67% of nursing staff had completed the post registration award in critical care nursing, which exceeded the ICS standard for at least 50% of staff to

have completed the training. The matron for critical care told us training for five additional staff was on-going and they expected 74% of staff to have completed the post registration training by August 2016.

- Staff told us they routinely received supervision and annual appraisals. Records showed the personal development review (PDR) completion rate was 79.7% for ward based staff. This meant the majority of staff had completed their PDR although the trust target for 90% completion had not been achieved by the nursing and support staff. The records also showed 94% of medical staff in critical care had completed their appraisals.
- Records showed 79% of all eligible medical staff in the critical care services had been revalidated with the General Medical Council. The records also showed 15% had their revalidation deferred and 6% were not yet due for revalidation.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services. Staff handover meetings took place during shift changes and safety huddles were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- A consultant-led ward round took place twice a day with input from nursing, pharmacy and physiotherapy. A daily microbiologist ward round also took place separately on the unit. The nursing staff told us they had a good relationship with consultants and unit-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Patients could be referred for speech and language therapist (SALT) support when required. There was only one SALT therapist across the hospital during weekdays. Staff told us this meant there was sometimes a delayed response.
- Staff told us they received good support from pharmacists, dietitians and physiotherapists as well as diagnostic support such as for x-rays and scans.

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- The critical care outreach team provided cover across the hospital over seven days between 8:30am and 4:30pm. Outside of these hours the hospital at night team nurse practitioners received handover from the outreach team. Staff spoke positively about the support they received from the outreach team.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients' needs.
- We found that sufficient out-of-hours medical cover was provided to patients by specialty grade doctors as well as on-site and on-call consultant cover. Patients admitted to critical care were seen daily by a consultant.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The physiotherapy on-call service was provided by the hospital-wide physiotherapy team. Pharmacy support was available on the unit during the day on Saturdays and Sundays. The dispensary was also open for a limited number of hours on Saturdays and Sundays.
- Staff received support from social workers (for complex discharges), tissue viability nurse and dietitian support during weekdays but there was limited availability and limited on-call arrangements for these during weekends.
- The critical care staff told us they received good support outside normal working hours and at weekends.

Access to information

- Staff used paper based patient records that contained detailed patient information from arrival to the critical care unit through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.
- Staff told us the information about patients they cared for was easily accessible. This included information such as test results, patient risk status and nursing and medical records.
- We saw that information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the hospital's intranet.

Consent and Mental Capacity Act

- Staff understood how to seek consent from patients and understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS)
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- We saw evidence that best interest meetings took place in the records we looked at. We also looked at one patient record where a DoLS application had been made and this had been completed correctly.
- Staff followed guidelines on the appropriate use of restraints such as the use of 'mitts' (equipment used to prevent a patient pulling out intravenous lines while unconscious).
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

Are critical care services caring?

Good



We rated the critical care services at the Southport and Formby District General Hospital as 'Good' for being caring. This was because: -

- The relatives of patients receiving care in the critical care unit spoke positively about the care and treatment provided by the nursing and medical staff. They told us they were treated with dignity, empathy and compassion. Patients or their relatives were kept fully updated and were given opportunities to have all their questions answered.
- We spoke with the relatives of five patients. They spoke positively about the attitude and behaviour of the critical staff. They told us the staff were kind, pleasant and helpful.

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- Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.
- Patients' relatives told us the staff supported them with their emotional and spiritual needs. Patients had an allocated nurse who was able to support their understanding of care and treatment. There were facilities to provide overnight accommodation for the relatives of patients.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. The patients we saw were well positioned and their dignity was maintained.
- We observed staff providing care in a respectful manner. We saw that patients bed curtains were drawn and staff conversations about patient care and treatment were conducted discreetly to maintain privacy and confidentiality.
- We spoke with the relatives of five patients. They told us the staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that patient dignity was maintained. The comments received included "fantastic care, staff do everything for you"; "staff couldn't be better" and "cannot fault the staff".
- Patients relatives were very positive about staff attitude. The relative of one patient commented all the staff are pleasant and helpful, treated with kindness and understanding.

Understanding and involvement of patients and those close to them

- Patients relatives told us they had been kept fully updated and the nursing and medical staff clearly explained the patients condition and progress to them. The comments received included "the nurses and doctors explain everything that's going on" and "consultants kept me informed".
- Due to the nature of the care provided in critical care, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.

- Staff prepared patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.
- The critical care outreach team managed the patient diaries. These were not given to patients upon discharge from the unit but were given to patients during their outreach follow up session.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Patients relatives told us they were supported with their emotional needs. The relative of one patient told us a nurse put their arm around and hugged their loved one and gave them reassurance when they were upset and this was really helpful.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that the patient or their relatives were able to voice any concerns or anxieties.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Staff could seek support from the palliative care team if a patient required end of life care. Staff were also able to provide overnight accommodation for relatives of patients.
- Staff provided relatives of patients with bereavement leaflets. Information about chaplaincy services and spiritual support was also displayed in the unit.

Are critical care services responsive?

Requires improvement



We rated the critical care services at Southport and Formby District General Hospital as 'Requires Improvement' for being responsive to patient's needs.

This was because: -

- The critical care services were previously rated as 'requires improvement' for responsive in May 2015 following our last inspection. This was because we

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found the services had issues with regular delayed discharges both in hours and out of hours and faced challenges in the provision of single sex accommodation for high dependency patients.

- During this inspection, we found that significant improvements had been made to reduce the number of delayed discharges and 'mixed sex' breaches through daily reviews and an increased consultant focus to facilitate discharges. However, further improvements were still needed to ensure patients received appropriate care.
- The number of patients with delayed discharges had improved from 487 during 2014 to 294 during 2015. However, recent capacity issues across the hospital meant there was a worsening trend and there had been 111 delayed discharges between January 2016 and March 2016. There were 86 'mixed sex' breaches on the unit between April 2015 and March 2016.
- This meant a significant number of patients were still affected by delayed discharges and patient's privacy and dignity was affected as a result of 'mixed sex' breaches.

However, we also found that: -

- Bed occupancy levels between January 2015 and January 2016 were similar to or slightly higher than the England average.
- Patients were routinely admitted to critical care within four hours of making the decision to admit them. Patients were routinely seen by a consultant within 12 hours of admission because consultant ward rounds were conducted twice a day on the unit.
- There were 17 instances where patients were stabilised in the theatre recovery area between January 2016 and March 2016 and only one instance where a patient was kept in recovery longer than four hours.
- There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There had only been three formal complaints relating to critical care services between March 2015 and March 2016. The services also received 81 compliments during this period.

Service planning and delivery to meet the needs of local people

- The unit provided critical care services for adults over the age of 16 years. There were 488 intensive care and 746 high dependency patients admitted to critical care between April 2015 and March 2016.
- The critical care unit could accommodate up to 15 patients. The unit had five intensive care beds and six high dependency care beds. The unit also had a coronary care unit with four patient beds.
- We found the allocation of beds was flexible depending on the type of patients requiring admission to the unit. For example, there were six intensive care patients and five high dependency patients on the unit during the inspection. The staffing levels were adjusted to ensure patients received appropriate care.
- The theatres recovery area was occasionally used to accommodate patients that were transferred from the wards or emergency department requiring stabilisation or from the operating theatres with complications following surgery and were awaiting a critical care bed.
- Records showed there were 17 instances where patients were stabilised in the theatre recovery area between January 2016 and March 2016. There was only one instance where a patient was kept in recovery longer than four hours during this period. The theatre recovery area had appropriate equipment and patients received 1:1 care by trained nurses with support from the critical care consultant and outreach nurses.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was daily involvement by the matron to address and manage these risks.
- There were three daily meetings with the bed management team to ensure patient flow was maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff used a passport document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patients likes

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and dislikes. The additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.

- Staff could contact the hospital-wide team for advice and support for dealing with patients living with dementia or with learning disabilities.
- There were defined visiting hours for relatives. However, relatives could arrange to visit patients at any time during the day depending on the patients condition.
- Staff could access appropriate equipment to support the moving and handling of bariatric patients (patients with obesity) admitted to the critical care services.

Access and flow

- NHS England records showed bed occupancy levels between January 2015 and January 2016 were similar to or slightly higher than the England average.
- Hospital records between April 2015 and March 2016 showed average bed occupancy was 93% for intensive care beds and 73% for high dependency beds. This was reflected during the inspection as we saw that intensive care beds were fully occupied but a number of the high dependency beds were unoccupied.
- The critical care unit operated a closed admission policy with all admissions needing to be discussed between the referring team and the critical care consultant. Unplanned admissions to the unit required consultant to consultant referral prior to admission.
- Patients were routinely admitted to critical care within four hours of making the decision to admit them. Records for the three months of December 2015, February 2016 and March 2016 showed there were 124 admissions and only two occasions where patients were not admitted to the unit within four hours.
- Intensive Care Society (ICS) guidelines recommend that all critical care patients are assessed by a consultant within 12 hours of admission. The matron and lead consultant told us they did not routinely collect data on the number of patients assessed within 12 hours. However, they were confident that most patients were seen by a consultant within 12 hours of admission because consultant ward rounds were conducted twice a day on the unit.
- NHS England data between April 2015 and March 2016 showed there were 17 urgent surgery cancellations due to a lack of critical care beds at the hospital.
- ICNARC data showed the unit performed better than other comparable units nationally for non-clinical transfers out. NHS England data showed there were four instances where patients were transferred out of critical care for non-clinical reasons between April 2015 and March 2016.
- ICNARC showed the unit performed worse than other comparable units for out-of-hours discharges; however, the rate of out-of-hours discharges was within an acceptable statistical range. Patients were reviewed by a consultant and only discharged if it was clinically safe to do so.
- ICNARC data showed the unit had consistently performed worse than other comparable units for delayed discharges between January 2010 and March 2015. However; since April 2015, there had been improvements and the unit was performing better than average between April 2015 and December 2015.
- Hospital records showed there were 487 delayed discharges during 2014. There were 294 delayed discharges during 2015, which showed some improvements had been made. The main reason for delayed discharges was due to a lack of available ward beds across the hospital.
- Records showed that during 2014, 23.9% of patients were discharged from the unit within four hours of the decision to discharge them. During 2015, the proportion of patients discharged from the unit within four hours had improved to 40.9%.
- The proportion of delayed discharges that took between 24 and 48 hours was 15.6% during 2014 and had improved to 8.3% during 2015. Similarly, the proportion of delayed discharges longer than 72 hours was 16.8% during 2014 and had improved to 5.2% during 2015.
- The matron for critical care told us actions taken to reduce delayed discharges included a daily review to identify patients that could be discharged and an increased consultant focus to facilitate discharges.
- Patients with delayed discharges were clinically safe as they were still in the care of the staff on the unit. However, the presence of these patients on the units meant there was an increased likelihood of mixed sex breaches (i.e. occurrences of unjustified mixing).
- Records showed there were 86 mixed sex breaches on the unit between April 2015 and March 2016.

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- The matron for critical care told us they had a discussion with each patient that experienced a delayed discharge to fully explain the situation and to address any concerns the patient may have.
- Additional steps taken to minimise the impact to patients privacy and dignity included ensuring curtains were drawn and locating patients next to same sex patients where possible. The unit also had sufficient bathroom and toilet facilities.
- The matron for critical care told us that although they had made significant improvements during 2015, there was a worsening trend in delayed discharges since January 2016 due to increased bed capacity issues across the rest of the hospital. Records showed there were 111 delayed discharges between January 2016 and March 2016.
- During our previous inspection we found that the critical care service had issues with regular delayed discharges both in hours and out of hours. The unit also faced challenges in the provision of single sex accommodation for high dependency patients.
- During this inspection, we found that significant improvements had been made to reduce the number of delayed discharges and mixed sex breaches. However, further improvements were still needed to ensure patients received appropriate care.

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care unit and included contact details for the Patient Advice and Liaison Service (PALS).
- The matron for critical care was responsible for reviewing and investigating complaints. Information about complaints was discussed during routine staff meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The hospitals complaint policy stated that formal complaints would be acknowledged within three working days and investigated and responded to timescales mutually agreed with the complainant.
- Records showed there were only three complaints relating to critical care services between March 2015 and March 2016. These complaints were appropriately investigated and responded to in a timely manner.
- The matron for critical care told us any minor issues or concerns raised by patients or their relatives were addressed immediately by staff. Records showed there

were two informal concerns / information requests made in relation to critical care between March 2015 and March 2016. The critical care services also received 81 compliments during this period.

Are critical care services well-led?

Good



We rated the critical care services at Southport and Formby District General Hospital as Good for being well-led. This was because:

- The critical care services were previously rated as requires improvement for well-led in May 2015 following our last inspection. This was because we were not assured that the critical care service had robust effective systems in place to ensure that key risks were escalated and addressed in a timely manner to ensure the safe delivery of high quality care.
- During this inspection, we found that improvements had been made. The critical care risk register listed the key risks to the service and this was reviewed and up to date. Key risks to the services, audit findings and quality and performance was monitored through routine departmental and divisional quality and governance meetings.
- The hospitals vision and values had been cascaded across the surgical services and staff had a clear understanding of what these involved. There was effective teamwork and clearly visible leadership within the services. Most staff were positive about the culture within the critical care services and the level of support they received from their managers.
- There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the services and how to resolve these.

Vision and strategy for this service

- The hospitals vision was based around the slogan Excellent, Lifelong, Integrated Care. This was underpinned by a set of five values including; supportive, caring, open and honest, professional and efficient (SCOPE).
- There was no strategy document specifically for the critical care services. However, the strategy for the critical care services had been incorporated into the

Critical care

corporate strategy 2014-17, which included specific performance objectives relating to the provision of lifelong and integrated care, excellence in treatment and care, performance delivery, to empower and develop staff and to maintain organisational stability.

- The vision, values and objectives had been cascaded to staff across the critical care unit and staff had a clear understanding of what these involved.

Governance, risk management and quality measurement

- There were monthly quality and governance meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Within the critical care unit, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. The critical care risk register listed risks relating to services and this was reviewed and updated during monthly governance meetings.
- We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards and newsletters.
- The critical care services were routinely peer reviewed through the Cheshire and Mersey Critical Care Network to assess compliance against best practice standards.

Leadership of service

- The critical care services were incorporated into the urgent care division at the hospital. There were clearly defined and visible leadership roles within the critical care services. There was a designated lead consultant for intensive care that oversaw the critical care services.
- The nursing staff were managed by a coordinator on each shift, who reported to the unit manager and the matron for critical care.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were highly motivated and positive about their work. They described the senior nursing and medical staff as approachable, visible and provided them with good support.
- All the nursing and support staff told us there was a friendly and open culture. Trainee medical and nursing staff told us that they felt supported.
- We spoke with five middle grade critical care doctors. Two of them told us they had experienced some form of bullying or discrimination in their role. The remaining three doctors were positive about working in critical care and told us they received good support from the consultants.
- Records showed staff sickness levels of 5.67% for ward nursing staff and 11.53% for specialist staff (such as outreach nurses) between April 2014 and March 2016. Sickness rates for medical staff based in the critical care unit were below 1% during this period.
- The sickness levels were higher than the national average during this period. The matron for critical care told us the sickness levels were affected by staff on long term sickness. Cover for sickness or unplanned leave was provided by the staff within the existing team or through the use of agency staff.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Patients that had previously stayed on the unit and their relatives were invited to attend follow up clinics up to eight or 10 weeks after discharge to discuss and share their experiences.
- The critical care services did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment.
- Staff sought feedback from the relatives of patients by asking them to complete a feedback survey. The survey covered key areas such as the environment, facilities and staff communication.
- The survey results for the period January 2016 to March 2016 was displayed in the unit and based on 12 responses from patients relatives. The survey results showed that feedback was mostly positive (83% to 100%) across most areas covered by the survey. However, there were negative responses relating to the amount written information provided (67%) and the quality of the relatives room (50%).

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- The information from the surveys was used to look for improvements to the services. For example, the relatives room had been updated and a new information leaflet had been created following feedback from the survey.

Staff engagement







- Staff told us they received good support and regular communication from their managers. Staff routinely participated in team meetings. The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards.
- The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The trust had 10 positive findings and 14 negative findings within the NHS staff survey of 2015. The matron

for critical care confirmed the findings from the survey were discussed with the critical care staff and any ad hoc staff concerns through individual discussions or during routine team meetings.

Innovation, improvement and sustainability

- The critical care services carried out collaborative work with the Cheshire and Mersey Adult Critical Care Network. There was participation in quality audits and information was shared with the care network to look for improvements to the service.
- The critical care services planned to participate in the Southport and Ormskirk Nursing Accreditation Scheme (SONAS). The accreditation scheme was based on a number of care and service delivery standards.
- The lead consultant and matron for critical care were confident about the ability of the service to meet patient needs in the future. Staffing issues and equipment maintenance were identified as the key risks to the critical care services.

End of life care

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

Information about the service

We visited Southport and Ormskirk NHS Foundation trust as part of our announced inspection on 12, 13, 14 and 15 April 2016 where patients with end of life care needs are cared for on the general wards and in the community.

The integrated specialist palliative care (SPC) team is within the community and continuing care clinical business unit and works across the acute hospital and community settings within West Lancashire and Southport and Formby. End of life care (EOLC) is the shared responsibility of all staff within the trust and the team works closely with all departments to support the delivery of EOLC wherever the patient is. They are part of the wider integrated SPC services which include Queenscourt Hospice, situated adjacent to the SDGH site.

Between April 2014 and March 2015 for adults over the age of 16 there were 885 deaths at Southport and Formby district general hospital (DGH) and four deaths at Ormskirk DGH. In the same period there were 363 referrals made to the hospital SPC team members and 748 to the community part of the SPC team.

Due to the very low numbers of deaths at Ormskirk hospital we have not written a separate report as EOLC was directed by the same team. There is a mortuary on site, however mortuary services are provided by a neighbouring trust.

During this inspection we visited 11 inpatient areas at Southport and Formby DGH and spoke with DNs from the West Lancashire and Southport and Formby community

teams. We observed a multidisciplinary team (MDT) meeting and visited the Oasis roomunit, prayer room and Queenscourt hospice. We met with the SPC service leads and the director of nursing.

We observed care, looked at records for 18 people, 15 prescription charts and spoke with 29 staff across all disciplines, including doctors, nurses and health care professionals. We spoke with 15 patients and nine carers, some face to face, and others on the telephone.

End of life care

Summary of findings

At the last inspection in November 2014 we found EOL services to be good in all five domains of Safe, Effective, Caring, Responsive and Well Led. At this inspection we found good EOL services across all the domains with the exception of Effective which we found requires improvement. They were rated as good overall because;

- Incident reporting systems were in place and actions were followed up following investigation.
- Anticipatory EOL care medication was prescribed appropriately in hospital and in the community. Hospital staff were knowledgeable about responding to deteriorating patients and hospital care records reflected this with appropriate evidence or establishment of ceilings of care documented. There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) of those thought likely to be dying which was well embedded in community services. EOL services were adequately staffed and as well as the SPC team which was clinically led by a consultant in palliative medicine, there was a Transform team which promoted advance care planning, the amber care bundle and provided EOLC training.
- The delivery of EOLC was planned in accordance with the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People including the introduction of the IPOC. Actions were being taken to meet the national framework, Ambitions for Palliative and End of Life Care, including cross boundary working to coordinate care and the generation of data via national and local audits to review and improve services. Patients had comprehensive assessments of their needs which included pain assessments and in hospital, nutrition and hydration assessments. There was good evidence of multidisciplinary team working and seven day services were in place. There was a rapid transfer process in place which the team were working to improve.
- EOL care services were provided by compassionate, caring staff who were sensitive to the needs of

seriously ill patients. The service was delivered by staff who were committed to providing a good service and there was good clinical leadership from a consultant in palliative medicine. Community services in particular, were highly regarded by patients and families. In the hospital staff were mindful of prioritising EOL patients for side rooms when the situation allowed and the Oasis room unit provided space for relatives to stay. Accommodating people's preferred place of care (PPC) was important to staff and their success rate at achieving this was over 80% in the year to December 2015. There was a clear strategy in place and all the EOL and palliative care staff we spoke with understood what the service was setting out to achieve and how their role fitted in. Staff were positive about EOL care and felt well supported.

However there were areas for improvement:

- Conversations between district nurses and GPs around the commencement of the IPOC to support patients at the end of life were not always documented. The service should ensure that all GP involvement is documented in the IPOC when the decision is made for this to be commenced.
- Completion of mental capacity assessments was not consistent, even when indicated on the DNACPR. The trust was not using the unified DNACPR process and hospital DNACPR forms did not travel with the patient when they left hospital. There was no audit of DNACPR forms or decisions despite the system for reviewing these forms being identified as an area for improvement in the last CQC inspection in 2014.
- The complaints process and governance processes around monitoring incidents required improvement. The trust should ensure the new incident monitoring system includes dissemination of feedback and lessons learned to all relevant areas, including the mortuary.
- Syringe drivers were not being checked four hourly in line with hospital standards. The service should continue to educate and audit this process.

End of life care

- Prior to our inspection there had been no-one actively taking the part of executive lead for EOLC and there was no non-executive director with responsibility for EOLC.

Are end of life care services safe?

Good



We rated safe as good because:

- Staff understood their responsibilities to raise concerns and report incidents and we saw examples of how actions had been taken to address these and improve practice. Systems were being implemented to improve the quality of monitoring and reviewing incidents.
- Good systems were in place for ordering syringe drivers which were readily available.
- Records were stored securely and entries in the notes were legible and up to date.
- Staff were aware of safeguarding procedures and knew who to contact. The SPC team met the trust target for mandatory training and all had completed safeguarding training.
- Hospital staff were knowledgeable about responding to deteriorating patients and hospital care records reflected this with appropriate evidence or establishment of ceilings of care documented.
- Use of the individual plan of care (IPOC) of those thought likely to be dying was embedded in the community and was in place in all the patient records we reviewed.

However:

- Conversations between DNs and GPs around the commencement of the IPOC to support patients at the end of life were not always documented. The service should ensure they are following their own policy and document clearly the involvement of the patient's GP.
- The improved incident monitoring system did not include the dissemination of feedback and lessons learned to all relevant areas, including the mortuary.
- Medication delivered via syringe drivers was not being checked four hourly in line with hospital standards.

Incidents

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- There were systems and processes in place to report incidents and staff told us they were encouraged to do so. Incidents were graded using a risk scoring matrix with criteria for the likelihood of the incident recurring and the severity of the harm caused.
- Between February 2015 and January 2016 there were 143 datix incidents related to EOLC and the mortuary. Of these, 22 related to discharge of EOL patients. Five of these were beyond the control of trust staff, for example delays in continuing healthcare (CHC) funding. However, the other 17 related to issues such as poor quality discharge summaries, lack of understanding of the rapid EOL transfer (REoLT) process and omitted referrals to the district nurses. Five incidents dating back to March 2015 were still being reviewed.
- Two incident actions included a recommendation for further REoLT training for staff, which had been acted upon.
- The trust's quality improvement strategy (2016-2020) described the successful identification of learning from incidents and the dissemination and embedding of learning as a key focus in 2016. It reported that processes will be developed to provide contemporaneous feedback on lessons learned from incidents and structures will be developed to ensure learning from incidents is understood at a local level throughout the organisation. We did see evidence of plans to address this in the EOL service, but at the time of inspection it was not yet fully in place. However the service confirmed that all EOL incidents were now copied to the consultant in palliative medicine at the time of reporting.
- Service leads told us incidents were discussed at the monthly EOL strategy steering group. We saw minutes from November and December 2015, and January 2016 which only made limited reference to incidents. It was documented in the January 2016 minutes that incidents needed to be discussed but that no record was available and an invitation was to be sent for a member of the risk department to attend future meetings. There were plans for a monthly report of all EOL incidents to be taken to this meeting.
- Some generic problems had been discussed in the meetings, for example some issues with 111 services

alerting the emergency services when someone had died, even when the death was expected. This had been causing distress to families and staff but the services had worked together to resolve this.

- Incidents were a standing agenda item on the monthly community and continued care clinical business unit (CBU) governance committee. Minutes from the January 2016 meeting identified that members needed to look at the learning from incidents, and there was a plan to re-format the documentation to support this.
- We reviewed a selection of incidents reported relating to EOL services and found they were appropriately followed up. The trust provided evidence of incident reviews with recommendations and actions in place as required, for example 88 trust staff have had training in REoLT since the incidents in 2015 in addition to the 147 already trained. There had been no further REoLT incidents regarding documentation.
- Mortuary staff told us they reported incidents as required, but received little or no feedback or learning. Despite mortuary services being provided by a neighbouring trust, staff need to work closely with EOL services at Southport which should ensure feedback from incidents is disseminated appropriately.

Medicines – hospital site

- We reviewed seven patients' prescription charts and saw good evidence of appropriate prescribing for EOLC, including anticipatory medications. All seven were legibly written.
- We saw documented evidence in at least one set of notes that an information leaflet had been provided to a patient commenced on opioid treatment.
- The prescription charts included a pre-printed page for anticipatory medications for EOLC and a page of guidelines for symptom control at the end of life. Staff said they found this very helpful.
- The drug midazolam was pre-printed on the chart with one check box to indicate treatment for agitation or breathlessness therefore it was not possible to differentiate between the two. For opioid prescribing the indications were separate and there were two boxes, one for pain, and one for breathlessness, which meant

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the indication for its prescription was clear. Separate boxes, one for the indication of agitation and one for breathlessness when prescribing midazolam would provide clarity.

- Syringe drivers were ordered via the trust intranet or telephone from the electrical and biomedical engineering (EBME) equipment library. Out of hours there was an electronic job ordering system and they were collected by the porters. The service had identified an issue with incomplete central records of syringe driver maintenance and training due to long term sickness in the EBME. An action plan had been introduced in March 2016 and the service provided us with evidence that the issues were being addressed.
- In one set of records the monitoring chart for a syringe driver showed it was checked six hours after it was initially commenced, then not repeated for a further 12 hours. The chart indicated it should be monitored every four hours. Information provided by the service showed an audit in 2016 found none of the seven patients audited had four hourly syringe driver checks. A new checklist was piloted on one ward and a further three patients were audited, but the number of daily checks had only increased from three to three and a half per 24 hours when it should be six. Auditing was ongoing, with targeted education in specific areas.
- Lock boxes are lockable clear plastic covers placed over the syringe driver to prevent damage, activation of the boost button or tampering with the rate control. Lock boxes were already in use in the community and were in the process of being introduced in the hospital following an incident where a syringe driver caught on something resulting in a leak.

Medicines – community

- We reviewed eight patients' prescription charts and saw good evidence of appropriate prescribing for EOLC, including anticipatory medications. All eight were legibly written.
- Medicines were the patient's property for community patients but district nurses (DNs) said they always advised that controlled drugs be kept securely and they checked the stock on visits.

- We saw accurate stock reconciliation records for drugs kept in patients' home, however they were documented on a variety of different forms rather than a designated template.
- DNs were using a yellow form entitled 'controlled drug record sheet', however we saw more than one example of these being completed with details for non-controlled drugs used in the syringe driver such as levomepromazine and glycopyrronium. When we spoke with DNs about this they showed us a white drug administration form which was available for routine drugs, however it was not always being used. In another set of notes the drug administration records were documented in the case notes rather than on a form. The records themselves were appropriate, but the method of documentation was inconsistent.
- This meant drug records were not as clear as they could be in those cases.
- We saw a completed GP prescription sheet in the chart for the syringe driver and anticipatory medicines and evidence that the syringe driver was checked twice daily when the district nurse visited.
- Syringe drivers for the community were ordered from the hospice. District nurses had their own stocks of syringe drivers which were kept at their bases.
- We looked at syringe driver records at the DN Ainsdale (Southport and Formby) base. There was a book for logging them in and out and stickers to indicate when they had been calibrated. When calibration was due they were sent off to EBME at the hospital.

Records

- The service used an electronic health records system to record their interventions and data, and gold standards framework (GSF) patients were also tracked through the generic trust patient administration system. Medical and nursing documentation was recorded in paper format.

Records – hospital site

- We reviewed ten sets of care records for EOL patients in the hospital, two of which included an individual plan of care (IPOC) of those thought likely to be dying. The IPOCs were mostly completed although the spiritual and cultural sections were blank for both patients. One

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set of notes contained a sticker showing that the chaplain had visited, but there was no narrative. Ward staff said this should have been in the IPOC once it had commenced.

- The paper medical records were stored in lockable trolleys at the nursing station where they were under direct vision of healthcare staff at all times.
- Nursing records were stored together in large lever arch files which were not very secure as pages tended to fall out. If pages fell out without being noticed by staff there was the potential for a breach of patient confidentiality. Some other records, for example fluid balance sheets, were at the patient's bedside.
- There was one medical entry with no designation or GMC number provided by the doctor but the majority met expected documentation standards. Eight had evidence of discussion with family.

Records – community

- We reviewed eight sets of care records for patients who had recently died in the community. All had the names and appropriate designations for medical and nursing staff clearly documented. Five of the eight had evidence of discussion with family. All were signed and dated.
- All eight records included the IPOC which were mostly completed although at least two had no details recorded in the spiritual and cultural needs section.
- All district nursing interventions included documentation for cleaning hands and obtaining consent.
- Patient records were stored in the patient's home unless there were particular issues preventing that, in which case they were stored securely in the office.
- Carbon copies of the initial assessments were stored in locked filing cabinets in the office.

Safeguarding

- Hospital and community staff knew how to contact the vulnerable adults team if they had safeguarding concerns for a patient, and there was also a safeguarding helpline.
- If a staff member had a safeguarding concern they would discuss with their team and complete a datix incident form.

- All members of the SPC team were up to date with Safeguarding Adults and Safeguarding Children (level one for clerical staff and level two for clinical staff) training.

Mandatory training

- There was a mandatory training programme in place which included elements such as fire safety, information governance and hand hygiene as well as different levels of safeguarding dependent on staff role. The SPC team were 93% compliant with mandatory training prior to our inspection and were actively addressing the gaps to bring the team fully up to date. This met the trust target of 90% compliance.
- The monthly induction course included a two hour session on EOLC for new staff, and a slightly longer session for junior doctors.
- All members of the SPC team with patient contact had completed their advanced communication skills training.

Assessing and responding to patient risk

- When the possibility of dying was recognised and reversible causes of deterioration excluded, an individual plan of care (IPOC) of those thought likely to be dying was developed with the patient and those important to them. The trust policy for care of those likely to be dying was clear that this process should involve both medical and nursing staff.
- There was a section on the form for the doctor to sign and record their general medical council (GMC) number. This was to confirm that the multi-professional team of at least a doctor and nurse agreed that reversible causes for deterioration had been considered, they recognised that the patient was likely to be dying / ill enough to die and this had been documented in the patient's clinical record.
- In the hospital this decision was made by the multidisciplinary team (MDT) and was discussed at the board rounds which took place Monday to Friday at 8.30am and at the weekend with the team members on duty. The doctors would then review the patient and would usually agree with the decision as generally it would have been discussed in the preceding days. Staff said they always involved the SPC team, time allowing.

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- In the community the decision was made by the district nurse in close liaison with the GP. The decision would be discussed with the patient where possible, and with the family. After 6.30pm the decision would be discussed with the out of hours doctor.
- We reviewed 10 sets of hospital care records for patients at the end of life. Of these, all had appropriate evidence or establishment of ceilings of care documented. Two patients had IPOCs in place with input from medical and nursing staff.
- Staff we spoke with were experienced in discussing end of life with families, including the delivery of supportive care rather than aggressive treatment.
- Of the eight sets of community care records we reviewed, only two included documentation referring to evidence or establishment of ceilings of care. All eight patients had been started on an IPOC but only one had been signed in the relevant section by the GP and five had no evidence of a discussion with the GP. Two of these five had entries in the notes indicating GP agreement and a further one had been faxed to the GP.
- Most of the district nursing staff we spoke with said they would only start a patient on the IPOC following discussion with a doctor and this was reiterated by the SPC team clinical lead and the Transform clinical lead. One DN said the GP did not sign it and tended to regard it as a nursing document and another said that DNs could start patients on the IPOC themselves. There were good relationships between GPs and DNs and staff said the GPs would not commence an IPOC without prompting from the DNs.
- It would appear therefore, that discussions with GPs were usually taking place, but they were not always being documented by the DNs. This meant the service was not following its own policy which required a GP to sign the IPOC in the relevant section.
- Once the IPOC was started the district nurse sent a fax to the patient's GP and to Queenscourt hospice to register that the patient was recognised as being at the end of life so that the emergency services would not be sent out for an expected death.
- Nursing staff on the wards had good knowledge of the ceilings of treatment, for example that there would be no escalation to critical care. One ward manager we

spoke with demonstrated good knowledge of the protocols for patients at the end of life including liaison with the SPC team and the Transform team where appropriate, for example if a patient needed to be placed on the gold standards framework (GSF) register.

- Two patients complained to us about their treatment in the emergency department and said they were not prioritised and that staff did not know about the GSF despite them being told by their GPs it was flagged on the system.

Nursing staffing

- The SPC team included 11.4 whole time equivalent (WTE) palliative care nurse specialists (2.2 WTE hospital based, 9.2 WTE community including 0.6 WTE vacancy since March 2016). These nurses were also known as clinical nurse specialists (CNSs).
- In the community the CNSs were aligned to the district nurse (DN) neighbourhood teams which in turn were linked to GP practices within a geographical area. There was 1 or 1.5 WTE CNS per DN team.
- The CNSs were flexible with their caseloads and would cover and support each other where necessary.
- There was also a Transform team staffed by 4.4 WTE facilitators funded until April 2017 to promote advance care planning, the amber care bundle and provide EOLC training. There were clinical leads within the team for the hospital, community and care home settings, although all team members worked across all areas supported by the SPC team and the two consultants in palliative medicine.

Medical staffing

- The SPC team included 1.6 WTE (2 x 0.8 WTE) consultants in palliative medicine, one of whom was the lead palliative and EOLC clinician.
- There was a 24 hour a day consultant on call, supported by a first on call medical rota consisting of specialty doctors from Queenscourt Hospice.

Major incident awareness and training

- There were documented major incident plans in the hospital with action cards on the wall which could be

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followed by staff in the event of a major accident. Staff were aware of the actions to take in the event of an emergency and knew how to find the trust policy and access key documents and guidance.

- DNs in the community gave examples of the types of adverse events they have to deal with, such as adverse weather and IT issues. All staff carried mobile phones and there was a list updated every week, detailing those patients with priority status, which included those at the end of life and patients with diabetes. DNs said even without the list they knew from day to day who their priority patients were. The West Lancashire team were more rural and had access to 4x4 vehicles when required.

Are end of life care services effective?

Requires improvement



We rated effective as requires improvement because:

- There was no audit of DNACPR forms or decisions despite the system for reviewing these forms being identified as an area for improvement in the last CQC inspection.
- Completion of mental capacity assessments was not consistent, even when indicated on the DNACPR.
- The trust was not using the unified DNACPR form and process and hospital DNACPR forms did not travel with the patient when they left hospital. Formal pain assessment was inconsistent and we did not see pain care plans in use.
- The assessment of nutritional and hydration status was variable in the community.
- There was no Electronic Palliative Care Co-ordination System (EPaCCS) in place.

However:

- The delivery of EOLC was planned in accordance with the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People including the introduction of the IPOC.

- Actions were being taken to meet the national framework, Ambitions for Palliative and End of Life Care, including cross boundary working to coordinate care and the generation of data to review and improve services.
- Patients had comprehensive assessments of their needs which included pain assessments and in hospital, nutrition and hydration assessments.
- The SPC team had completed a range of post registration training relevant to EOLC. The Transform team delivered a comprehensive programme of training across the trust in both acute and community settings.
- There was good evidence of multidisciplinary team working and seven day services were in place.
- The service participated in national and local audits, and implemented action plans to improve the delivery of care where appropriate.

Evidence-based care and treatment

- The IPOC introduced by the service was an individual plan of care which included food and drink, symptom control and psychological, social and spiritual support in line with Priorities of Care for the Dying Person Duties and Responsibilities of Health and Care Staff (Leadership Alliance for the Care of Dying People from One Chance to Get it Right, June 2014).
- There was a comprehensive palliative care and EOL audit programme in place with a range of audits ongoing. There was a forward plan which was red, amber, green (RAG) rated to indicate whether or not the status of the audits were on target with their planned timescales. This programme was a standing agenda item on the monthly EOL strategy steering group where audit status was discussed.
- There was a specialist palliative care services cross boundary audit programme held four times a year and we saw four sets of minutes from these which summarised the results from audits and identified discussion points.
- We saw evidence of suggestions, recommendations and action plans in place following the completion of audits, for example the audit for patients achieving their preferred place of care.

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- The Transform team reviewed as many hospital deaths as possible by visiting the mortuary daily. 75% of deaths between March 2015 and April 2016 were reviewed, 48% of which were people who had been recognised as dying. Of this 48%, 82% had an individual plan of care (IPOC) for the care of those thought likely to be dying.
 - Where there was no IPOC in place, the Transform team reviewed the records to identify whether one should have been commenced. The team were auditing all IPOC documentation between April 2015 and April 2016 and at the time of our inspection had just completed the data collection.
 - The gold standards framework (GSF) is a tool used across hospital, community and care home settings to support the identification of patients who may be approaching the last six to twelve months of life. Once this is recognised staff are able to assess, plan, and communicate about patient care and preferences. Intended benefits are improved cross boundary coordination, avoidance of unnecessary hospital admissions and rapid discharge for those whose preferred place of care is their home or care home.
 - The trust took part in the GSF acute hospitals pilot in 2010 alongside 16 other trusts and was the only whole hospital with participation from all hospital wards. Annual audits had been undertaken to monitor performance and make improvements. In 2015 one district nursing team from West Lancashire and one from Southport and Formby audited ten sets of case notes each, for recently deceased patients. Improvements had been made from the previous audits, with 19 standards met for 100% of patients, compared with 16 in 2014 and only one in 2013.
 - Areas requiring improvement included discussion about the patient by the district nurse at the GP led GSF meetings and the recording of GSF discussions in the nursing notes. There was also only 65% compliance (compared with 80% in 2014) with the standard for a bereavement assessment made by contact or visit at 8-12 weeks post death and referral on to other services if required. An action plan was in place to address these issues.
- Pain relief**
- All ten hospital records we reviewed included evidence of assessment documentation for pain, although this was completed as part of intentional rounding rather than a formal pain score tool. Pain assessments were also recorded on the electronic national early warning score (NEWS) vital sign assessment tool which included prompts to record pain scores, and on the IPOC.
 - There was a patient profile sheet in the notes which prompted the use of a care plan for pain where indicated, however we did not see these in use, even for one patient who was described as having uncontrolled pain on movement and/ or rest for seven consecutive days during the first week of April 2016.
 - The 2015 Cheshire and Merseyside palliative and EOLC network care of the dying evaluation (CODE) showed that 92% (23 of 25) of relatives felt doctors and nurses did enough to help relieve the patients' pain during the last two days of life some or all of the time. In the community this figure was 100% (23).
 - The staff we spoke with were unaware of a formal tool for assessing pain in patients who were unable to clearly articulate their needs, for example dementia patients. In one set of notes we saw a copy of the Abbey pain scale which is used to assess pain in patients who cannot communicate, however it had not been completed. Staff observed for non-verbal signs and liaised with the next of kin to assess pain in these patients.
 - Information leaflets about understanding opioids for pain in palliative care were available for patients and family.
 - Patients we spoke with said they were asked about pain regularly. A patient on the spinal unit said they asked him every four hours when they completed observations and patients on wards 7B and 14B also said their pain was assessed frequently.
 - In the community notes we also saw evidence in the case note entries, rather than a formal tool, of pain being assessed and treated. For patients on the IPOC there was good documentation around pain issues and one patient had been advised to keep a pain diary.
 - Where patients were not on the IPOC we did not see pain care plans in place, despite this being a recommendation on the gold standards framework (GSF) care plan. This meant that the pain status of the patient may not be immediately clear to different nurses visiting the patient at home.

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Nutrition and hydration

- All ten inpatient records we reviewed included assessment of nutritional status, and nine included assessment of hydration status.
- One patient was receiving subcutaneous fluids. As artificial hydration is regarded as a medical treatment, it should only be offered to a patient at the end of life if it is considered to be in the patient's best interests however we were unable to find any assessment documentation or details of the reason for this.
- We saw evidence that mouth care had been initiated where appropriate.
- One member of staff gave examples of what needed to be considered in terms of nasogastric (NG) intubation and intravenous (IV) fluid therapy. There was good awareness of the different factors that had to be considered, for example the intrusive nature of an NG tube.
- In the community records the assessment of nutritional and hydration status was variable. Four of the eight records had evidence of hydration status and five had nutritional status information.
- An audit of eating and drinking at the end of life using 20 case notes each from the hospital and community was presented in June 2015. Completion of initial assessments for food and drink was good but 25% (five of 20) of hospital notes and 15% (three of 20) of community notes had no documented initial plan for food and drink.
- Actions from this audit were to continue to support and educate all health professionals with assessments and plans, encouraging a full description for both. Training around eating and drinking had been added to the care of the dying programme and at the time of our inspection 97 hospital staff and 21 community staff had completed this element of the training.

Patient outcomes

- The latest national EOLC Audit: Dying in Hospital was published in March 2016. This was the second round of the national audit of care of the dying in hospitals in England. As with the last audit published in 2014, there

were two elements: an organisational review of services and protocols; and a clinical case note based audit depicting the end of life care of patients who died during May 2015.

- 34 sets of case notes from patients who died at Southport hospital between 1-31 May 2015 were reviewed. For three of the five quality care indicators the hospital achieved the same or higher (better) percentage than the national average.
- For the presence of documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days the hospital achieved 82% (the national average was 83%). If sudden or unexpected deaths were excluded then this result was revised to 90%, still slightly lower (worse) than the national average of 93%.
- For documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care the hospital achieved only 50% (the national average was 66%).
- The hospital achieved all but one of the eight organisational indicators. The exception was the appointment of a lay member on the trust board with a responsibility/ role for EOLC which was achieved by only 49% of hospitals nationally.

Competent staff

- The 13 CNSs had completed a range of post registration qualifications in health and social care and were all educated to or working towards degree level in subjects related to their specialist area of practice. All but one had completed their clinical examination skills and eight were qualified in non-medical prescribing.
- At the time of our inspection all members of the SPC team were up to date with their annual appraisals.
- The CNS members of the team had access to group supervision provided by a clinical psychologist who facilitated two, one and a half hour, clinical supervision sessions per month. Information provided by the service showed these were mostly well attended when they took place but between April 2015 and February 2016 the sessions were cancelled for six of the eleven months.

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- Both the Transform and the SPC team delivered a range of training relevant to caring for people at the end of life thus providing staff with the knowledge and skills to provide appropriate care for this patient group. This included formal and ad hoc training.
- There was a six day palliative care education course for senior nurses which had been completed by 31 community district nurses and 22 hospital registered general nurses since 2014.
- Training delivered by the SPC team included advanced communication skills (completed by 174 staff) and a communications simple skills in-house training session (599 trust staff and another 36 at intermediate level). They also trained staff in symptom management, pain, and eating and drinking at the end of life.
- There was an EOL skillset challenge where staff were awarded a bronze, silver or gold award dependent on the level of training they had completed.
- The Transform programme aims to improve the quality of end of life care within acute hospitals across England, and
- These key enablers formed the core of the education provided by the Transform team who delivered a broad range of training in these areas. They provided their training figures which showed several hundred staff, both hospital and community, had received this training, with the highest attendance being for their care of the dying training which had been completed by 477 community staff (93% of district nurses) and 1247 hospital staff (75% of all clinical staff).
- Other training delivered by the Transform team included future care planning, rapid end of life transfer (REoLT) and genogram training. Each district nursing team was allocated a member of the Transform team who spent one day per week with them to support with new documentation and provide opportunistic training.
- The service provided us with the content of the REoLT training and it was clear, comprehensive and relevant. Further delivery of this training was identified as an action in a piece of reflective practice written by a member of the SPC team and as an action following two incidents. All of these recommendations cited a lack of understanding from staff around the REoLT processes.
- We spoke with the service leads about the provision of REoLT training and were told it was included in the six day course, was part of induction training and was delivered on an ad hoc basis on the wards, as and when required. This meant there was flexibility and staff could access support and training in their working environment and learn 'on the job'; however, as the training was not being systematically rolled out to everyone there was the possibility that some existing staff would not receive it.
- A 'training the trainer' programme had taken place to ensure each ward and community team had their own syringe driver trainer. All qualified nursing staff were trained to use syringe drivers.
- A small number of the district nurses had completed training which enabled them to verify a patient's death. There were some restrictions to when this could happen, including the patient having an IPOC in place, they must have been seen by their GP within the fortnight prior to their death and they could not be subject to deprivation of liberty safeguards (DoLS). However, when it did happen it meant the family had someone known to them to verify the death and did not have to wait and call a doctor out.

Multidisciplinary working and coordinated care pathways

- We saw good documented evidence of multidisciplinary working. At least two sets of the ten hospital records included input from speech and language therapy (SALT), physiotherapy and occupational therapy and we saw evidence of comprehensive holistic assessments.
- In other notes we saw documented evidence of equipment requirements ordered for the patient's home, with discharge planning including reference to the discharge planning coordinator, the district nursing team and the SPC team.
- The SPC team crossed over between hospital and community as and when required, for example at weekends when one CNS from the team covered both community and hospital patients.
- There was a weekly multidisciplinary team (MDT) meeting where new referrals and ongoing complex patients were discussed, as well as any recent deaths. We attended this meeting and observed discussion of

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approximately 20 patients and 20 recent deaths. The meeting had representation from the SPC team, the hospice, chaplaincy, social work, allied health professionals (AHPs) and Transform. It was chaired by the clinical lead of the SPC team. We observed good discussion of individual cases and plans to follow up where things had not run smoothly, eg Transform to provide further education. The records system demonstrated good holistic assessment and care provided by the CNSs. Wider multidisciplinary discussion, ie with the AHPs, was not observed, although our presence may have impacted on this.

- The CNSs maintained good relationships with the local GPs and attended all GSF meetings where the status of patients was discussed, including their condition and situation, key symptoms and how they were coping at home.
- There was no Electronic Palliative Care Co-ordination System (EPaCCS) in place. The service used an electronic health record for recording information about patients on the GSF register including referrals to the SPC team, people's care preferences and key details about their care at the end of life. This enabled them to audit their processes and performance against objectives, for example referral to contact time. We saw evidence in two sets of patient hospital records that a GSF notification had been sent to the patient's GP due to them being identified as being at the end of life.
- An alert flagged up on the generic hospital patient administration system when patients already registered on the GSF were admitted. Daily reports were generated from this system to identify GSF patients in the hospital. These patients were supported by the Transform team which considered whether the admission could have been prevented, organised prompt referral to the SPC team where necessary and liaised with the community teams.
- Ward staff described close links with palliative care and community services. All patients with a DNACPR order in place were discussed at handover and nursing staff reported good team working with the medical staff, discharge team and SPC team. The Transform team were supportive with GSF patients and would also help with organising night sitters through Queenscourt hospice when required.

Referral, transfer, discharge and transition

- The referral, admission and discharge criteria for specialist palliative care services were set out in a document adapted from the Merseyside and Cheshire palliative care clinical network group.
- The SPC team accepted referrals from all sources via telephone or a referral form which could be faxed or posted. The referrer specified on the form which service they were requesting, for example nursing, medical or Queenscourt hospice. Routine referrals for pain or symptom management, or psychological support had a target contact time of three days. Urgent referrals for uncontrolled pain or symptoms were requested to make telephone contact with the SPC team. There was a clear referral form pathway on the reverse of the form to direct people to the correct contact details.
- Between March 2014 and April 2015 there were 363 hospital referrals and 748 community referrals to the SPC team. The integrated hospital and community SPC team responded to urgent referrals within 24 hrs, often the same day, and non-urgent within 3 working days. 91% of referrals met these targets.
- Community and hospital staff were expected to register all those recognised as approaching the end of life on the gold standard framework (GSF) register held by GP surgeries. The register was shared by GPs with the SPC team who flagged patients on their own register and the hospital databases.
- Between March 2014 and April 2015 there were 853 new West Lancashire and Southport and Formby GSF registrations during the year, 180 (21%) of whom were recognised as approaching end of life while in hospital, with registration requested from there.
- The standards for REoLT were agreed amongst the team, including an arrangement with pharmacy for take home medicines to be ready within two hours, equipment to be delivered on the same day and the ambulance service to attend for transport within two hours. These standards all relied on REoLT being clearly indicated. There was a folder in each ward and department outlining the process so that every staff member had access to detailed guidance; however, there was no specific policy in place.

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- Staff spoke with us about a successful REoLT undertaken the week before our inspection. This transfer had been pre-empted by staff who had prepared for it in advance by establishing the patient's preferred place of care (PPC), what new equipment would be needed at the residential home and inviting the staff from the home in for a meeting. Once the discharge was agreed the discharge planner on the ward made contact with the district nurse to arrange delivery of a syringe driver from the community. Syringe drivers were always renewed just before discharge so the district nurse had one less thing to do on the first visit to the patient at home. In this case the pharmacist organised the anticipatory medicines within the time frame and the only delay was 45 minutes due to transport not arriving within the agreed time frame.
- The clinical lead told us ambulance transport for a REoLT sometimes let the process down by not being able to transfer in an appropriate timescale. This led to disappointment and frustration for patients, relatives and staff and sometimes meant the PPC was not achieved despite everyone's best efforts. There was agreement that a private ambulance could be ordered in circumstances where the ambulance could not transfer in time, however the delay was not always anticipated.
- As described earlier in the report there had been a number of incidents related to confusion over the REoLT process. One ward manager said it "instilled panic" in the staff, partly because there were time pressures to make it happen, but the district nurses complained if it was too rushed. She felt better integration with the community matrons would make the process smoother. However good support was provided by the SPC team who were working hard to improve the process, including actions from an audit such as working on a carboned booklet to keep all the REoLT paperwork together and enable a complete copy to be filed in the clinical record after discharge.
- Other reasons described by staff as to why transfers were sometimes delayed included the time taken for continuing healthcare (CHC) decisions to be made around funding and medical staff not identifying the patient as 'for discharge' on the electronic system. Staff reported no issues with obtaining equipment or obtaining medication. If a patient was for CHC funding the documentation and checklists were completed by discharge planning.
- There had been changes to the CHC process which included an assessment team being employed by the trust and working collaboratively with the local clinical commissioning group (CCG) to coordinate packages of care. This role had previously been undertaken by the district nurses. The palliative care leads explained there could be a delay with the commissioning support unit (CSU) on a Friday afternoon when waiting for a CHC decision but in an emergency the community emergency response team (CERT) would step in if this enabled a patient to go ahead with a rapid transfer home. The problems in the process were recognised by the service leads who described "an improving situation with ongoing dialogue".
- Each ward had a member of the discharge team allocated to them as a discharge planner and DN referrals or equipment would be discussed with them. Prescriptions for the DN teams would travel with the patient. This meant that even if the patient was not seen by the GP for 24 hours there was no delay in obtaining medications, for example syringe drivers needed replacing every 24 hours.
- Discharges were discussed at the daily board round, attended by the MDT and the discharge planner.
- There was an electronic system in place which generated letters to GPs when patients were discharged.
- Staff told us they tried to transfer EOL patients from the emergency department within two hours but this could be difficult as sometimes doctors wanted them to wait in the department until they had been seen.
- When a patient died on the ward the relevant paperwork was completed and photocopied. One set went with the patient notes, and the other was sent for auditing. Two wrist bands were attached to the patient and a job would be logged on the electronic system for the porters to come and transfer to the mortuary. Staff told us they always received a prompt response from the porters and they usually arrived within 20-30 minutes.

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- The trust policy for care after death required the deceased be transferred from their hospital bed to the mortuary within two hours of verification of death as far as possible (without exception transfer of care should not exceed 6 hours as this will breach requirements for tissue donation). The most common reason for delay was awaiting verification of death obtaining the medical certificate of cause of death (MCCD), particularly if the patient died during medical handover between 7am and 8am, however staff reported no problems with meeting the two hour target and there were no associated incidents reported between February 2015 and January 2016.
- Within the community the deceased were transferred to the undertakers of the next of kin's choice. Staff reported no problems with these processes

Seven-day services

- A 9am to 5pm seven day a week service was provided by the SPCT with support provided by the Transform team.
- Staff told us that out of hours (OOH) there were two telephone lines at the hospice, one for professionals and a generic line for members of the public including patients and their families. At weekends both of these lines were covered by the CNS on duty. Two patients told us they had called at weekends and left a message on an answer phone and their calls had been returned.
- There was 24 hour palliative medicine advice available from on call consultants in palliative medicine and medical staff at Queenscourt hospice.
- The OOH DNs picked up messages from their answerphones at base throughout the night via their mobile phones. They worked closely together and were flexible so that if one DN had to suddenly stay with an EOL patient a team member would pick up some of the other visits. There were evening shifts between 4.30pm and midnight, and night shifts between 11.00pm and 8.00am.
- Urgent referrals to the SPC team were reviewed at weekends and contact was made where necessary. The SPC team told us there was always someone available for them to phone and they felt well supported.
- Equipment could be obtained between 5am to midnight, including weekends, for patients transferring

home. Several staff from different areas were very positive about the equipment delivery drivers and said they had regularly received equipment within the hour. Basic equipment was kept on the vans at weekends.

- There were specified pharmacies where medicines could be obtained out of hours and delays in anticipatory medicines had been improved due to the CNSs completing the non-medical prescribers (NMP) course. There was a pharmacist on call at the hospital OOH.
- When a patient died OOH in the community there was a telephone number to the on call GP for health professionals only. Some of the senior DNs had completed verification of death training which meant that it was not always necessary to call the GP out for an expected death.
- The chaplaincy team shared the on call duties to provide cover twenty four hour cover seven days a week.
- There was little provision for the issuing of MCCD OOH. Bereavement officer and mortuary services were provided by a neighbouring trust. If "absolutely necessary" the on call anatomical pathology technician (APT) could issue the certificate.

Access to information

- Electronic patient information systems on the wards and in the emergency department showed alerts that flagged up when a patient was on the gold standard framework register or was identified as EOL.
- There was a nursing page on the trust intranet where staff could access document templates such as pain care plans, the GSF information including the registration form for the GP, and policy documents providing guidance, for example the procedure for care after death.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- DNACPR audits were not included on the forward plan submitted to us by the service.
- We reviewed nine do not attempt cardiopulmonary resuscitation (DNACPR) records in the hospital. Five included evidence that the patient required a capacity assessment but of these, only two were completed.

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- All nine forms had a summary of why CPR was not in the patient's best interest.
- Hospital DNACPR forms did not travel with the patient when they left hospital. Unified DNACPR (uDNACPR) forms were used in the community and these did travel with the patient. uDNACPR forms in the community notes were mostly completed by GPs and therefore not part of this inspection.
- Staff had fed back to specialist palliative care services that they found it difficult having a conversation about the resuscitation decision in a way that included the patient and family, took note of the patient's wishes, and yet did not make them feel it was the family's responsibility to make the decision if the patient lacked capacity. Following discussion at the patient safety collaborative on the deteriorating patient a leaflet with prompts for health professionals was produced by SPC services and was being piloted for junior staff.
- When a staff member needed to initiate a DoLS referral they discussed it with their team and complete a datix incident form. The matron had traditionally completed the DoLS documentation but staff were starting to do this themselves, particularly OOH, with support from the matron. Ward staff would start the process on the computer and work their way through it until they reached a point where they needed support. They were positive about this, and one nurse said it helped with continuing professional development and reflective work for revalidation with the Nursing and Midwifery Council (NMC).

Are end of life care services caring?

Good



We rated caring as good because:

- Feedback from people who used the service was largely positive, particularly with community services.
- Where issues were identified, the service had acted to address these and make improvements.
- The service had introduced person-centred initiatives to try and make people feel more comfortable and cared for, such as comfort packs and syringe driver bags with the creators name on them.

- Open visiting was in place for families of EOL patients to enable them to spend as much time as they needed with their relatives.
- There was a chaplaincy team who offered emotional and spiritual support, regardless of faith.

However:

- There was some negative feedback from hospital patients and a survey had shown that 12% of respondents were extremely unlikely to recommend the hospital to friends and family.

Compassionate care

- The service participated in the Cheshire and Merseyside palliative and EOLC network care of the dying evaluation (CODE). This was a regional survey undertaken with bereaved relatives to seek their perspective of the quality of care and support provided to people and their families in the last days of life.
- Surveys were sent to the next of kin for patients who died between 1 May and 30 November 2014, excluding those who did not meet the criteria. The final report was published in November 2015.
- Results showed that 74% of relatives were happy with the help available to meet the patients' personal care needs, such as washing, personal hygiene and toileting needs in hospital. In the community 100% of relatives who responded were satisfied with this. 87% felt there was enough help in hospital with nursing care, such as giving medicines and help with finding a comfortable position in bed and again, 100% relatives were satisfied with this in the community. 78% were satisfied that the bed area and surrounding environment in hospital provided adequate privacy.
- Confidence and trust in nursing and medical staff was good. 77% of families felt adequately supported in hospital during the last two days of their relative's life, and this rose to 100% of families in the community. 88% were either likely or undecided about recommending the hospital to friends and family but 12% were extremely unlikely to recommend. In the community 100% of families were extremely likely, or likely to recommend the service.
- An action plan was developed in March 2016 to address areas for improvement. The target date for

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improvement was March 2017 but there was already evidence of progress in some areas, for example ensuring that at least one person from every ward team and community neighbourhood had completed the spiritual care awareness course.

- Several local groups, including schools, create comfort packs and syringe driver bags, labelling them with their name, for example “this was made just for you by Ruby”. Comfort packs were for family members who wanted to stay at the hospital to be with their relative.
- Open visiting was in place for families of patients at the end of life. When a patient died on the ward the staff allowed the family as much time as they needed with their relative. If there was no family present a member of staff would stay with the patient; they were not left alone.
- Free parking was available to families collecting a medical certificate of cause of death (MCCD) from the mortuary manager. Weekly car park passes were available to buy for regular visitors to the hospital.

Understanding and involvement of patients and those close to them

- One patient we spoke with said they had received marvellous care and described the nursing staff in hospital as “absolutely brilliant”. They felt involved in their treatment and knew all about what results they were waiting for, and why.
- Another patient said they saw the doctor every day and felt that the staff were personal friends. They had been attending the hospital for nine years and described the staff as loyal and part of the family. They had no complaints about their treatment and said staff came promptly when they rang the call bell.
- In the community the home visits and palliative services were described as excellent and reliable.
- One patient described a lack of information and support from the hospital for two weeks following discharge but since community staff were involved, and links with the hospice established, care had been “brilliant”. This patient had experienced a number of issues during admission to hospital and said when they asked a doctor how to complain they were told there were no

forms and they should go online. Two other patients also described a problem with complaining, and one said they had no response to their complaint until their local member of parliament intervened.

- One patient described CHC as the biggest help over the past ten months. They said the hospice staff made them feel they were personal friends and were excellent. “Nobody could have had any better treatment from the GP, district nurses, palliative care nurses and the hospice and to think I didn’t want to be there.”
- Two patients confirmed that when they left messages on an answerphone out of hours, the calls were returned promptly.
- Staff went through the bereavement booklet with the family, when they were ready, following a death on the ward. We saw the booklet which included information about the steps to take following death such as contacting a funeral director, collecting the medical certificate cause of death (MCCD) and registering the death. One ward manager said they put an asterix next to the key points and told the families they could ring with any concerns. They offered families the opportunity to speak with the doctor who had cared for their relative, particularly where there had been an emergency or sudden death.
- Last offices were usually carried out after the family had left, unless they wanted to help. Last offices included tidying the patient, ensuring dentures were in, washing, hair care, dressing in a shroud and wrapping in a sheet. Relatives could accompany the patient to the mortuary if they so wished.

Emotional support

- There was a chaplaincy and spiritual care team which offered support to patients and families, regardless of their faith. There was an ablutions room and prayer room available where people could pray and leave prayer intentions or thoughts for the chaplains to read as part of their monthly meeting. The team included a full time ecumenical chaplain, part time Roman Catholic chaplains, bank chaplains who supported the on call service, and chaplaincy volunteers. The team had contacts with all the major faiths and church denominations.

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- The chaplaincy and spiritual care team contributed to the individual plans of care by offering traditional prayers, bible readings and personal spiritual support as required. The team delivered training to staff throughout the trust as well as an induction session for all new nurses.
- A GSF audit had identified bereavement support as not meeting the required standard and one of the actions being implemented from this was the introduction of an assessment and care plan for the main carer of all GSF registered patients. It was recognised that looking after the carer's own needs was an important part of caring for those at end of life and had a significant impact on bereavement, as well as on satisfaction with the care provided.
- CNS and DN staff offered follow-up bereavement support to families, usually a single contact. If further support was required the family was referred to the GP or the hospice.
- The bereavement officer (two people job sharing for one WTE) service was provided by a neighbouring trust.

Are end of life care services responsive?

Good



We rated responsive as good because:

- Staff were mindful of prioritising EOL patients for side rooms when the situation allowed and the Oasis roomunit provided space for relatives to stay in the hospital.
- Accommodating people's preferred place of care (PPC) was important to staff and their success rate at achieving this was over 80% in the year to December 2015. Plans to improve this process were implemented following audits.
- There was a REoLT process in place which was being monitored and staff were working on the issues identified.
- Genograms had been introduced to try and gain a better understanding of patients' family situations as an alternative to the traditional medical history taking.

However:

- There were no facilities for relatives to stay with their family member on the wards.
- The complaints process required improvement. Steps were being taken to address this.

Service planning and delivery to meet the needs of local people

- The wards we visited had female and male bays, and a small number of side rooms. EOL patients could be moved to a side room, provided there were no patients with infection prevention and control needs as these took priority over everyone else. On some wards there were beds that were quieter, for example on Ward 14B two of the bays had beds in a recessed area which were more private than other beds, so these would be used for EOL patients when necessary. Sometimes EOL patients were moved to a different ward to use a side room if one was available and that is what the patient and family wanted.
- There were no facilities for relatives to sleep in fold up beds on the wards, although they could stay in a chair by the bed. Ward staff did their best to make relatives comfortable and provided pillows, drinks and toast. There was provision for relatives to stay in the Oasis roomunit near Wards 11A and 11B. This unit had two rooms and was furnished with an electric recliner chair bed, a sofa and two chairs so there was just enough space for members of two different families. There were facilities to make drinks, a fridge, television and a stocked bookshelf. There was also a comments book where families were able to leave messages.
- There was a recently refurbished relatives' room in the emergency department, funded by a community link foundation. There was an isolation room and a secondary triage room which could be used for deceased patients if required, but usually they were left in a resus bed unless it was needed by another patient.
- In the community EOL patients had access to night sitters from the Queenscourt at home service where necessary. Patients entitled to CHC funding may receive other services dependent on their level of need.

Meeting people's individual needs

- When a patient from another faith (other than the Christian belief) died staff knew how to contact the

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relevant religious leader. There were 'cultural awareness in bereavement' posters on display on the wards and staff said the mortuary team were very good and gave advice when needed.

- There had been at least one occasion where a deceased bariatric patient was too large for the trolley when being transferred to the mortuary. Staff were able to adapt a bed for transfer, with the use of a special cover to ensure privacy and dignity.
- Alternative therapy such as acupuncture was available through the hospice and the DNs said they could refer to occupational therapy at the hospice and they would visit the patients at home.
- The service had introduced the use of a genogram to record family information in a pictorial format. This included information about family members over at least three generations including basic family structure, family relationships and details about individual members. Details may include demographic, emotional, behavioural or medical factors and it was designed to help staff quickly assess and understand the family situation using an alternative to the medical model of assessment.
- Inclusion of the genogram in patients' records had been audited annually three times since 2014 and by June 2015 was present in 74% of the 50 records audited across all palliative care services. DNs said they were trying to start the genogram on early visits with end of life patients before the IPOC was implemented. They described the genogram as very time consuming and said the process was not yet fully embedded but they did understand it.
- A telephone interpreter service was available via the switchboard.

Access and flow

- Staff were mindful of considering a person's preferred place of care (PPC) and were doing their best to accommodate this. In December 2015, 100 sets of case notes for people who had died during the preceding 12 months were audited. 82% chose home as their PPC, 10% identified a hospice or hospital and for 8% the PPC was not documented. 100% of those identifying a PPC that was not home (10 patients) achieved this. 19

patients did not achieve their PPC but there was good documentation of the reasons which were discussed at the quarterly palliative care audit meeting in March 2016.

- Advance care planning (ACP) was in place in the community. An audit was undertaken in early 2014, which looked at 20 sets of DN notes and compared with 20 electronic records. Further education was provided to the teams and followed up with a re-audit in July 2014 which looked at 10 sets of DN and electronic notes. There were also pre and post audit questionnaires for the DN team to measure knowledge, skills and confidence in ACP.
- The re-audit showed that for 100% of patients their PPC was discussed and documented, and a named spokesperson was documented in both electronic records and case notes. Similarly, the patients' and carers' wishes and preferences were reviewed and discussed in 100% of all records, and the likelihood of dying was recognised, acknowledged and discussed with patient, carer and other health professionals involved in 100% of all records.
- In the re-audit, 100% of staff audited had some, good or high level of knowledge, skills and confidence in recording and supporting a patient's wishes regarding ACP. Questionnaires were completed by one DN team and one CNS.
- Actions from these audits included the Transform team focusing on ACP education in 2015-2016. DNs we spoke with confirmed they received regular ongoing support from the Transform team with ACP which was started well in advance for the patients.
- There was a REoLT checklist available on the wards, within the EOL information folders. This provided staff with prompts for different stages of the process, for example ordering any necessary equipment and take home medicines. Each stage had a time next to it, which enabled the process to be audited. The process had been audited twice. The second audit in March 2015 identified that none of the 35 cases audited had a copy of the REoLT checklist, Transit letter, uDNACPR or IPOC in the case notes. The service had an action plan in place and was continuing to monitor the documentation.

Learning from complaints and concerns

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- The EOL complaints and compliments report from February 2016 was provided to us by the service. While it listed the complaints related to EOL it did not provide enough details to determine what had happened, whether or not the complaint was upheld and whether or not there were any actions to be implemented or learning to be disseminated.
- We raised this with the service leads who acknowledged this was an issue they were aware of and they were taking steps to improve their complaints reporting and management.
- There was a monthly community and continued care clinical business unit (CBU) governance committee where complaints were reviewed. Minutes from December 2015 and January 2016 recorded that the format for reviewing complaints was being addressed to provide better clarity of the level of complaints received, more team involvement and a focus on embedding lessons learned. EOL complaints were also reviewed at the monthly EOL strategy steering group.
- While there was separate coding for EOL within the trust's formal complaints system the 2015 Cheshire and Merseyside palliative and EOLC network care of the dying evaluation (CODE) showed no named person with responsibility for dealing with complaints received, either at the hospital or in the community. Of the seven hospitals from the region that participated, five had a named person in place. Three of the five participating community trusts had a named person in place.
- CODE showed the SPC team were not routinely notified of any complaints received; four of the seven participating hospitals had this in place, as did four of the five participating community trusts.
- The service leads explained that EOLC complaints were often part of a wider more general complaint, dealt with in the CBU where the incident arose.
- Information provided by the service showed that the SPC team engaged in reflective practice and invested time in considering how they could learn and improve from patient and carer feedback.. This was consistent with what we found when speaking with the wider team, including the district nurses who were reflecting on how or whether they could have done things differently following a recent complaint from a bereaved family.

Are end of life care services well-led?

Good



We rated well-led as good because:

- There was a clear strategy in place and all the EOL and palliative care staff we spoke with understood what the service was setting out to achieve and how their role fitted in.
- There were challenges to the strategy, particularly the loss of provision of one of the community service teams. Staff were aware of the potential consequences of this, and risks were being managed and updated on the risk register.
- Quality was monitored at meetings and plans were in place to improve this process.
- Performance information, such as audit progress, was discussed at the monthly community and continued care clinical business unit (CBU) governance committee.
- Staff were positive about their roles and felt supported by their managers.

However:

- Prior to our inspection there had been no-one actively taking the part of executive lead for EOLC and there was no non-executive director with responsibility for EOLC.

Vision and strategy for this service

- There was a current strategy in place which included the role of the end of life enablers and processes, such as advance care planning and the individualised plan for the care of those thought likely to be dying. The strategy included details regarding communication, spirituality, bereavement and education and set out the aims and outcome indicators. The service leads, SPC team and Transform team members we spoke with were all clear on what they were trying to achieve, and on their roles in the strategy.
- There was a monthly EOL strategy steering group chaired by a consultant in palliative medicine and attended by representation from a number services of including nursing and quality, audit, community, mortuary, pharmacy and spiritual care. We saw the

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three sets of minutes from November 2015 to January 2016 which included an update on the Cheshire and Merseyside palliative and EOLC network which sets the priorities and areas of work to develop and improve services in the region.

- The provision of local community services was subject to a procurement tender process, for which the first stage was a pre-qualification questionnaire (PQQ) used as a means of shortlisting the potential providers. At the time of our inspection the trust had been unsuccessful in clearing the PQQ for West Lancashire community services, but the process for Southport and Formby was ongoing.
- The separation of West Lancashire services was described by the SPC team, as “devastating”. West Lancashire commissioned part of the SPC team services into the hospital so there was a great deal of anxiety and uncertainty about the potential impact on the team of this reorganisation of service provision.
- Due to changes at senior management level there had been some confusion regarding who was the executive lead for EOLC and there was no-one taking active responsibility for this role at the time of our inspection. However, we met with the director of nursing who was going to take on this role, and was positive about joining the strategy steering group and formalising meetings with the clinical lead for the service. There was no non-executive director with responsibility for EOLC.
- Although there was a mortuary on site at Southport, the mortuary services had been provided by a neighbouring trust since October 2014. This had provided some challenges to the mortuary staff who felt the service they now offered was less person-centred and flexible. Staff said they had not been consulted about the changes and although they supported each other, felt unsupported by management and somewhat isolated from both trusts.

Governance, risk management and quality measurement

- There was a community risk register in place with actions and review dates completed. There was a separate risk register to monitor the impact on sustainability of services following the community tender process detailed above. The service leads were all aware of the risks to the service and described the

loss of West Lancashire services as “the disintegration of an integrated service”. Actions included a series of workshops with representation from the senior management team aimed at updating and supporting staff.

- There was a monthly community and continued care clinical business unit (CBU) governance committee attended by the senior management team where incidents and risks were reviewed. This included information about new risks, such as patient safety alerts, and updates on existing risks. Progress against the clinical audit forward programme was discussed on a standing agenda, along with the status of any guidelines and policies which may be due for updating.
- We saw the minutes for this meeting from December 2015 and January 2016 which showed discussion around improving the process for lessons learned from incidents and complaints. Documentation was to be re-formatted to facilitate this.

Leadership of service

- There was an enthusiastic and committed consultant in palliative care who was the clinical lead for the SPC team. She knew the service inside out and staff in different areas (hospital and community) described her as approachable and supportive.
- Staff on one of the medicine wards described the matron as “fantastic – very supportive”. A ward manager said there was always someone they could contact if the matron was on leave or out of hours and the other matrons would always help and support.
- There was a monthly senior nurse advancing practice (SNAP) meeting led by the deputy director of nursing open to all band 7 nurses so included the ward managers. If the ward manager was on leave, a band 6 could attend in their place, and two or three of the matrons also attended. A full day was allocated for these meetings with a set agenda that included discussion around governance, finance, safeguarding, DoLS, mandatory training, vacancies and new initiatives. There would be a 60 to 90 minute session from a speaker, such as a pharmacist, dietician or speech and language therapist and sometimes a more unusual professional, for example pest control.

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- There was also an 'open floor' session at the SNAP meeting when staff could raise any issues or concerns and share information. At the previous meeting the director of nursing attended and spoke to the staff about the forthcoming inspection and local changes around bed pressures. The meetings usually finished by about 1pm and staff then had protected time for administration such as emails or rotas. Staff were positive about these meetings when they took place as they provided an opportunity to communicate with their peers, and also with the deputy director of nursing.
- The deputy director and the director of nursing were described as approachable and the head of nursing for urgent care was regularly visible to staff.

Culture within the service

- We saw evidence of staff being proud of their provision of EOLC. Nursing staff in the hospital and the community told us they felt caring for patients at the end of life was what they did best.
- District nurses said that capacity was their only issue but they never felt unsupported. They said gaps in the service were filled by good will, for example working flexibly to cover each other but the support between colleagues "keeps us all going".

Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.

- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment.
- The trust had up to date news releases on its website to keep members of the local community up to date with current events.







Staff engagement

- The trust held annual pride awards where there were 12 categories for people to vote for, such as team of the year, health professional of the year etc. This was described by staff as a good, positive celebration.
- Some of the staff we spoke with had arranged a team building event for their ward, booked and paid for by themselves.

Innovation, improvement and sustainability

- Building on the best is a national quality improvement initiative seeking to build on the transforming EOLC in acute hospitals programme in England. It will develop new areas of focus including making information more accessible to patients and their families, to enable more shared decision making; taking the opportunities offered by outpatient appointments to discuss advance and anticipatory care planning; improving the handover of information and records as people move between acute and secondary care; and improving pain and symptom management. The transform team made a successful application to become one of only ten acute trusts across England accepted to take part.

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

Information about the service

Southport and Formby General Hospital is approximately two miles from the town centre of Southport, a seaside town in the North West. The hospital serves a population from Southport, Formby, Sefton and West Lancashire of approximately 250,000 people.

The hospital provides a range of outpatient clinics including 23 specialist clinics and includes pain management, ophthalmology, ear nose and throat (ENT), trauma & orthopaedic, maxillofacial, pre-operative assessment and a treatment centre (for day case surgery and endoscopy, not reported under this core service). Approximately 25,000 patients visit these hospital departments each year.

The radiology department at Southport provides x-ray services along with x-ray Computerised Tomography (CT), Magnetic resonance imaging (MRI), Interventional radiology (IR), bone density imaging (Dexa) and non-obstetric ultrasound imaging. Combined with Ormskirk Hospital, 18,000 x-rays, 8,000 CT, 8,800 non-obstetric images were performed annually.

Most clinics were open from 8am to 5pm Monday to Friday, though some also offered early evening and weekend appointments. Radiology offered a 24 hour service to inpatients and Accident and Emergency (A&E) departments and late night and weekend appointments for non-urgent investigations.

Most clinics were on the ground floor of the hospital. They were well sign-posted and had easy access from the car park.

We visited the outpatients and diagnostics departments during the announced inspection between the 12 and 15 April 2016 and the unannounced inspection 29 April 2016. During our visits, we spoke with 27 staff and 10 patients and their relatives. We visited general outpatients, Eye/Ear, Nose and Throat (ENT), medical day unit, colposcopy clinic and phlebotomy. We inspected x-ray, CT, MRI and interventional radiology.

We looked at the care and treatment records for eight patients. We gathered information at a 'share your experience' event in the main entrance prior to the inspection. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Outpatients and diagnostic imaging

Summary of findings

The hospital was previously inspected by the Care Quality Commission in November 2014 and outpatients and diagnostic imaging received a rating of 'requires improvement' for safe and good for the other domains of caring, responsive and well-led.

At this inspection, we gave the outpatient and diagnostic services a rating of 'good' overall, however we rated the services as 'requires improvement' for safe. This was because:

The previous 'requires improvement' rating was due to safety incidents not being communicated with the trust board. This has since been addressed, however other issues of concern were found.

We had a control of infection issue in the eye clinic that was raised during the inspection. The trust responded quickly and an action plan to improve was put in place; however, some issues were not addressed.

At this inspection, we found the hospital performed well against national targets. Waiting times for appointments were better than average with 50% of patients receiving an appointment within five weeks of referral. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment.

There were a large number of appointment cancellations that had a variety of causes including IT issues and patients receiving multiple appointments in error. However, managers were gathering evidence and had set improvement targets

A large number of audits were performed to ensure patients received treatment in line with best practice guidance and there was evidence of collaborative working with neighbourhood trusts.

Some areas of mandatory training showed poor results and managers acknowledged that work was needed. When something went wrong, the outpatients and diagnostic departments responded well to patients and investigated the causes to make sure errors did not reoccur.

The outpatient improvement project was still progressing from 2014; changes had been made to the environment, clinical coding and staffing ratios. Phase four had been suspended due to staffing issues, which was to address the high cancellation numbers.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated the service as requires improvement for safe because:

- There had been a serious incident involving radiology, where a breakdown in communication processes had caused a delay to a patient's treatment. Analysis of the event concluded that an electronic coding system would prevent reoccurrence. The IT department not implemented what was required. An interim system had been developed using read receipt emails to ensure safety.
- We had concerns about a particular piece of equipment used in eye clinic and questioned the cleaning and storage methods in place. Following the inspection, the department revised the cleaning procedure; however we had no assurance that the equipment remained clean during a clinic session.
- Staffing in several areas of outpatients and diagnostics was an issue. There was a number of vacancies in medical posts, including two radiologists that had been highlighted on the risk register since 2014. Physiotherapy had an average shortfall of 23% in a four month period prior to the inspection, and there was a shortage of ultra-sonographers. There was no plan in place to continue the work of a key member of staff in the eye department, who had a period of long term sickness. Nursing staff sickness levels in the outpatient department averaged 6.99% over the last 12 months.
- We found in four sets of patients health records that patients allergies were not prominently displayed on the front of the records, only in the body of the notes which is a potential risk to patient safety

However:

- Communication had improved since the last inspection and radiology issues were now escalated to the assistant Medical Director for analysis and action, if required.
- We were assured that the hospital outpatients and radiology departments and equipment were clean and

kept people safe. All areas were visibly clean and clutter free. There was sanitizing gel available at entrances and in clinical areas and staff hand hygiene audits were excellent. The hospital's infection prevention team regularly monitored and performed random spot checks in areas and confirmed the departments were clean.

- Equipment used in radiology was regularly maintained with daily checks and a service level agreement with a third party provider ensured that imaging devices were accurate and safe. The most recent annual report from an independent medical physics department had raised some small issues and all had been addressed.
- Radiology had good systems in place for ensuring the safety of unwell patients in their department. Patients were assessed prior to and during the procedure, and staff were trained to assess and respond to a patient who deteriorated. Appropriate medication was available, including resuscitation, anaphylaxis and sepsis medication.
- Safety checklists adapted from the World Health Organisation 'five steps to safer surgery' were used in the eye clinic and in radiology. We saw the document in interventional radiology and a completed document in a set of health care records. The use of the checklist was regularly audited and a high level of assurance was gained.

Incidents

- The hospital provided an electronic system for recording incidents and staff of varying grades were able to identify its use and how to access the system.
- There was one serious incident recorded at Southport Hospital between February 2015 and January 2016 related to diagnostic services. We spoke to a member of the review panel, who explained the issues and actions taken following analysis of the incident. We examined the root cause analysis report and found that tangible actions have still to be done, in that no electronic coding system was in place. The department had developed an interim procedure to prevent reoccurrence.
- Since the last inspection in November 2014, the radiology department at both hospital sites had introduced regular staff meetings to encourage sharing

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of information and improved learning. Discrepancies were fed back to the assistant Medical Director and actioned as required. This process meant that important safety information now received appropriate analysis.

- The radiology department explained that staff and patients could be transferred between sites if an incident occurred that would affect appointments. Examples given included the equipment failure that was seen during the Ormskirk site inspection where both departmental image readers failed and x-rays could not be performed.
- Duty of candour training had only recently been included in regular mandatory staff training; therefore, at the time of the inspection, only new starters had received this training. The hospital had sent a global informative email and duty of candour was included in planned care's divisional risk governance notice board. Staff we spoke with were able to explain what was meant by duty of candour and gave examples when this may be used. We saw duty of candour information for staff displayed on a notice board. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Cleanliness, infection control and hygiene

- All areas we visited in the outpatients and diagnostics areas were visually clean. Patient areas and store-rooms were mainly clutter free.
- The trust provided evidence of cleaning schedules, some completed checklists and a curtain changes schedule. Domestic staff had regular cleaning schedules to follow, but we saw no evidence of completed work checklists at the time of the inspection. We requested information and received copies of cleaning schedules from the hospital but not signed, dated documentation of cleaning that had been completed. We spoke to a member of the domestic team who said they did not fill in a cleaning checklist
- Radiology rooms had up to date daily checklists for equipment checking and cleaning, when the room was in use.
- Sanitizing hand gels were visible and in suitable locations at clinic entrances, we saw both staff and patients using the gel.
- We saw personal protective equipment available for staff, where required, such as gloves and aprons. Examination couches were covered with clean paper. Hand sanitizer and wash lotion were available at all sinks.
- The facilities management team displayed the previous month's environment and cleanliness audit results at the entrance to each clinic. We saw figures of 100%, 98% and 88% displayed for eye, electrocardiogram (ECG) and outpatient clinics respectively for March 2016. The figure for outpatients was lower than recorded for the previous 12 months. From February 2015 to February 2016 the average result was 96.9%. This is evidence that continuous monitoring was performed and gave patients' assurance.
- The infection prevention and control team produced a monthly report which reported on performance across both hospital sites. The hand hygiene audits submitted from outpatients, x-ray, fracture, ENT/Eye were all 100% from June 2015 to January 2016. This was confirmed on departmental dashboards. The team also performed unannounced observational audits, checking staff compliance with the hospital's uniform policy of 'bare below the elbows.' There were no reports of non-compliance from either outpatient clinics or diagnostics.
- The phlebotomy room was bright, clean and had both hand washing and sanitizing gel available. The staff told us the room was cleaned at the end of each day. However, the patients' chair, used when taking blood, had a rip in the fabric of the armrest. The tear was not covered during patient appointments and could be a potential infection hazard
- During glaucoma eye clinics, patients may require the use of a gonioscope to assess their condition. A gonioscope makes contact with a patient's eye and must be cleaned after use. We examined the process for cleaning the instruments. There was no written procedure available at the inspection either on display or in a file when requested. The process was described by staff and included preparing three solutions in containers with lids and using the solutions throughout

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the day to clean, sterilize and rinse the instruments. Multiple use of the solutions could lead to a cross infection and using paper tissues for drying the surface could add paper debris to the gonioscope. We raised our concerns to the staff at the time of our inspection and the infection control nurse sister was informed. The process was reviewed and an action plan prepared. A new procedure was subsequently written and had a target date to be introduced as soon as suitable cleaning products were available, which had been ordered.

- There was also an issue with the use of the gonioscope lens during a clinic session. We observed that the dirty and clean instruments were placed next to each other on a plastic A4 wallet in the patients' waiting area. There was potential for the instruments to become mixed and for contamination from passers-by. This was brought to the attention of staff and we were told the process would be reviewed. On return to the clinic, three days later, the same procedure was in place.
- A member of nursing staff told us when a patient attended with a known infection risk, such as Methicillin-resistant Staphylococcus aureus (MRSA), then the patient was given the last appointment of the day and the examination room used was deep cleaned following the appointment. The process was the same in diagnostic areas.

Environment and equipment

- All visible electrical equipment was checked for evidence of portable appliance testing and any service due dates. Where stickers were not evident, on larger equipment in radiology for instance, staff assured us with up to date service documentation that ensured the equipment safety and we saw bar coded stickers relating to the servicing of equipment.
- The radiology department had a long-term contract with a supplier of imaging equipment to service, maintain and replace equipment on a rolling programme. This included equipment in plain film x-ray, CT, MRI, Ultrasound and Interventional radiology (IR) and Dexa.
- An annual report from Christie Medical Physics and Engineering (CMPE) was presented to the trust radiation protection committee in January 2016. This report covered the period January 2015 to December 2015 and

detailed all equipment calibration and testing performed for the trust. CMPE is recognised by the Health and Safety Executive as a Radiation Protection Adviser Body under Regulation 13 of The Ionising Radiation Regulations. Equipment in dermatology, ophthalmology and radiology was included as well as personal protective equipment, policies, procedures, and assessment of patient exposure safety. There were four recommendations from this report and all the points had been addressed.

- Because of this report, the lead aprons used had been included on the daily safety checklist. Aprons were examined for cleanliness and damage. If the visual inspection identified damage or areas of concern, the apron would be checked using a mobile fluoroscopy machine and actioned as appropriate. The aprons appeared visibly clean and stored appropriately
- The radiology department were in the process of replacing their gonad protectors, a specially designed shield used to protect the gonadal area of a patient from the primary radiation beam during radiographic procedures, as they were showing signs of age and starting to split. There was a local agreement in place that protectors were used for all pelvic X-rays of male patients under 70 years of age. Usage compliance was regularly audited
- We saw evidence of health and safety information available to staff in the Eye and Ear, Nose and Throat (ENT) clinic. A noticeboard contained procedures and checklists to help keep people safe including fire safety checklists, safeguarding processes, medicines risk assessments and weekly audits.
- Resuscitation equipment was available in outpatient areas and staff knew where their nearest one was located. Daily checks were made on equipment and expiry of medicines. A logbook accompanied each trolley and these were found to be up to date. Daily defibrillator tests were done and oxygen cylinders were checked, dated and stored appropriately.
- Fire exits were clearly marked, we saw break glass alarms and fire extinguishers, with appropriate service dates, in the x-ray department
- Sharps bins that were in use in clinical areas were secured to walls and were safe.

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Medicines

- During our inspection, we looked at the safe and secure handling of medicines in a variety of clinic and outpatient settings. Medicines were kept locked in secure cupboards and the keys were held by a senior member of staff. None of the clinics we inspected used controlled drugs; however there were suitable arrangements in place to store and prepare controlled drugs for administration in radiology. Stock balances of controlled drugs were correct and all medicines were in date. Radiology contrast media was securely stored in a key coded room.
- Medicine was supplied to clinics by the hospital's on-site pharmacy. Most clinics had a member of pharmacy staff that visited the clinic to check stock quantity and expiry dates and to top up medication, as required. A medicines management weekly audit sheet was evident on the eye clinic noticeboard. The sheet had been signed to indicate that medicines had been checked.
- We found two out of date medicines in the fridge in the eye clinic. A paediatric eye drop used for diagnosis and an ENT antiseptic paste. The nurse immediately removed the items and contacted pharmacy.
- We saw copies of the medicines optimisation policy for the trust in several departments with procedures for prescribing and risk assessments in place.
- Anaphylaxis kits were available in the CT and MRI areas of radiology. The kits were made up of injections required should a patient have a contrast induced reaction.
- Medicines requiring storage between two and eight degrees centigrade were kept in locked fridges. Temperatures were monitored daily to ensure the temperature remained within the recommended range.
- There was evidence of monitoring individual patient's medication safety within the health records we reviewed. Patients were given information leaflets and discussions about side effects had been recorded.

Records

- Patient's health records were stored on site at the hospital. Clinics requested the records days in advance of a patient's appointment and record clerks in the clinic ensured the notes were available as required.

Historically, missing case note audits were undertaken, however the number was so low that a decision to record any missing records as an incident was taken. Between January 2015 and December 2016, there were no incidents of late or missing records reported. Clerical staff confirmed there were very few issues when notes did not arrive prior to the appointment.

- During the inspection, we examined eight sets of health care records. They were generally legible and up to date, though many entries had been dictated and not retrospectively signed. Patient identification stickers matched the notes. However, we found four sets of records that stated the patient had known allergies recorded in the body of the records but not marked in the alert box on the front of the folder. Three of these patients had penicillin allergies. This could be a potential risk to the patient. We did see a fully completed WHO checklist from a previous surgery.
- We observed a doctor updating clinical information on the electronic case notes, by dictation, immediately after the patient's appointment. This meant the patient's records were immediately up to date.
- We saw three sets of health records in a clinic that were front facing and accessible to the general public. Staff were in attendance in the area; however patients passed by regularly and patients' names were not protected.

Safeguarding

- The trust had a policy for safeguarding which informed staff who the named professionals were that could be contacted for advice. The trust wide target for safeguarding training was 90% for level one and 80% for level two in adults and children. A report from October 2015 stated the trust was compliant in all areas apart from safeguarding children level two, which was 61% of appropriate staff were trained. We saw actions to increase compliance and general outpatients staff had reached 87.5% by December 2015. E-learning for this training was no longer available and staff must attend a face to face session.
- We found staff were aware of the policy and who to contact if they had safeguarding concerns.
- We saw evidence of WHO (World Health Organisation) surgical safety checklists (which aims to decrease errors and increase communication in any theatre setting)

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used in interventional radiography when non-surgical procedures were performed. A recent compliance audit gave full or significant assurance across a range of procedures that the checklist had been used.

Mandatory training

- Comprehensive corporate and local inductions were in place at the hospital for all new starters. Staff were expected to undergo mandatory training within three months of commencing work.
- Mandatory training was delivered face to face and via an e-learning package on the hospital intranet. Learning included health and safety, manual handling, basic resuscitation and infection prevention and recently duty of candour. Subjects were repeated either annually or every two or three years, dependent on the subject area.
- The trust target for completion of mandatory training was 90%. The outpatients and diagnostics departments managed staff attendance locally. At the time of the inspection, 95% were up to date with health and safety training. However in February 2016 only 76% had undertaken recent basic life support training, the manager we asked stated this was being addressed. We were told that the database was inaccurate and that the actual compliance figure was higher. We were told in outpatients that all nursing staff were trained in intermediate life support, though evidential data was not supplied.

Assessing and responding to patient risk

- Controlled area illuminated warning signs were evident next to all x-ray facilities. Doors had yellow radiation danger warning signs.
- There were designated staff in each area who were trained to advise on safety. Radiation protection supervisors (RPS) were present in radiology and trained laser protection supervisors (LPS) were employed in the Eye clinic. The radiation protection advisor was external to the trust and staff could access information from them via telephone, email or during the annual inspection.
- We asked staff how they would manage a patient whose condition deteriorated during their appointment. Staff were confident in their response and knew how to act appropriately and where the nearest resuscitation trolley was stored. Staff in both general outpatients and

x-ray were able to give us examples of actual events. The staff in phlebotomy regularly dealt with patients prone to fainting and were able to give a good account of the steps to take.

- In radiology, staff were able to explain the trust policy regarding pregnancy and radiation, and showed us a form signed by a patient. Signs were evident in the waiting room and camera rooms informing patients to let staff know if they may be pregnant.
- We saw interactions with a patient prior to undergoing MRI imaging. The patient was advised what to expect, and safety precautions were undertaken appropriately.
- Examples were given of assessment of patients prior to interventional procedures. The radiographer explained that not all patients were suitable for treatment and a project to introduce a pre-operative appointment was under way.
- A sepsis pack had been introduced to the radiology department in February 2016 to provide rapid access to sepsis medication. A radiographer told us of an incident where sepsis had been identified in a patient undergoing an interventional procedure, so a decision was taken locally to stock medication in the department to improve patient outcomes.

Nursing staffing

- The outpatients department was managed by a part time matron and a full time deputy matron. There was a nursing sister responsible for managing separate areas, such as general outpatients or ophthalmology. A number of outpatient staff had been able to rotate through the department and learn new skills, increasing flexibility in staffing.
- A review of the staffing was being undertaken as part of an outpatient project. At the last inspection, we were told that additional staffing grades were being introduced, this work was still ongoing and the outpatients project plan provided showed target dates had been exceeded and many objectives not yet achieved.
- Sickness levels in the general outpatients was reported as 7% for the period February 2015 to January 2016. For seven out of the last 12 months the sickness figure was

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higher than the trust target and peaked at 16% in March 2015. The sickness/absence rate for radiology staff in the same period was 3%, which was below the trust target of 5%.

- We were informed of difficulties in the diabetic eye screening clinic. The manager had a long term period of sickness and staff told us they had no replacement line manager. This had presented difficulties with equipment, patient management and care. We were told appointments had been cancelled as a locum had not started. Data supplied by the trust stated 122 appointments had been cancelled in the optometry department in February and March 2016 due to staff sickness. There had only been 16 appointments cancelled for this reason in the previous nine months. We were told approximately 30 patients were seen each day. Staff felt unsupported and were under pressure to provide a service. We raised the issue with the matrons and were told they were unaware of the absence or disruption. There were also no entries on the risk register regarding this issue.
- There was a shortfall in establishment of physiotherapists reported to us. Across the specialities, over a four-month period, there was an average of 23% vacancies/absences on the established staffing numbers. From 38 whole-time equivalent (WTE) staff, in February 2016 there was a 13.5 WTE shortfall, the largest from the musculoskeletal clinical assessment service (MCAS) where instead of 10.8 staff there were only three in post. Locum staffing and extra hours ensured the service was maintained.

Medical staffing

- Medical staff were present in speciality clinics as necessary. Some clinics were run by consultants from other trusts, or patients were referred to attend other hospitals when a speciality was not offered such as initial breast screening referrals.
- There was a total of 27 medical vacancies throughout the trust including consultants in a number of specialities, namely urology, dermatology and ophthalmology at the time of the inspection. The urology clinic was experiencing appointment delays as

they were funded for three additional lower grade urology doctors who were also not in post. A consultant ophthalmologist, urologist and trauma and orthopaedic specialist had been appointed but not yet commenced.

- The radiology department across the trust was challenged with a shortage of two substantive consultant radiologists. This issue had been highlighted on the risk register in 2014 and was still not adequately resolved. Additional reporting radiographers were utilised to report extremity plain film images; however, for abdomen and chest x-rays and CT reports the department were relying on external third party reporters to make up the shortfall in staff. We were assured that all images had been reported in time for the patients' next appointment even if there were instances where the five day target was breached. The addition of a second MRI scanner had increased the use of agency reporting as output had increased but the staffing numbers had not.

Major incident awareness and training

- Senior nursing staff had good knowledge of emergency planning procedures. Plans were available on the intranet and a hard copy in the nurse base in main outpatients.
- We asked staff what they knew about the hospital's major incident policy. We were assured that staff knew how to access the policy and what role they took in the plans. The general continuity plan was that staff would be utilised at the acute site.
- A member of staff showed us the major incident procedure on the hospital intranet. We asked three staff if they knew how to access the policies and what to do in the event of an incident and all were able to demonstrate good knowledge

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate



Outpatient and diagnostic services are not rated in the effective domain but during the inspection we found:

- There was a multitude of clinical audits performed in line with best practice and results frequently shared at a

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regional and national level. Results were monitored to ensure consistency and improvement. Good patient outcomes were evident as a result of assessments and evidence based treatments.

- The pain management team demonstrated coordinated care from a range of specialists and had good outcomes.
- Education of staff was important to the service and competencies in specialist fields were seen as a priority. Staff were supported to develop their professional skills.
- Many clinics offered a late, evening or Saturday service.
- Care records were in a process of transition to electronic records, some minor incidents had been recorded, but this had not affected appointments or clinical decisions.
- There was evidence in health care records that consent had been sought, when required, to carry out procedures. Patients had agreed to treatments.

Evidence-based care and treatment

- A large number of audits were in place across the planned care directorate to ensure the care and treatment provided was relevant and current. There was a comprehensive internal audit programme where standards were measured against national guidelines. The trust participated in regional group audits including, oncology regional projects, orthopaedic coding in foot & ankle fractures and national audits including the National Prostate Cancer Audit, National Ophthalmology Audit and participation in the National Joint Registry (NJR).
- Radiology ensured continued quality and best practice with a number of audits including assessment of CT adult head injury compliance with National Institute for Health and Care Excellence (NICE) guidance, reporting accuracy of lung cancers, audit of voice recognition reporting and quality of imaging for neonatal chest x-rays for example. Peer assessment was undertaken among the reporting radiographers.
- Radiology assessed the completion of their World Health Organisation (WHO) checklists for interventional procedures over a period of six months. Three hundred and sixty eight records were reviewed and the results showed a significant improvement since the previous audit. Areas for further improvement were identified

- Ophthalmology used a version of the WHO surgical checklist to improve patient safety in the perioperative environment. The use and completion of the checklist was sample audited in November 2015 and compared with the previous year's audit. The results gave a significant assurance level.
- We saw a number of standard protocols on display in clinical areas to remind staff of national guidelines and best practice, for example, the blood collection process in phlebotomy. However, in the eye clinic two of the procedures had not been reviewed within the given period and were due August 2015, for example the Eyelash Epilation procedure.
- The diagnostic reference levels were monitored and assessed during the annual radiation protection advisor inspection. Discrepancies between sites and equipment were highlighted and discussed.

Pain relief

- If oral pain relief were to be given to a patient in the clinic, we were shown the process that the medicine, for example paracetamol or ibuprofen, would be prescribed on an inpatient prescription sheet which would then be attached to the health records prior to administration. The outpatient's nursing sister told us this did not happen often and it was more likely the patient would be given a prescription to take away.
- A team of eleven staff operated a pain management clinic which had approximately 80 outpatient referrals per month. The clinic followed the Faculty of Pain Medicine's Core Standards for Pain Management (2015), by having more than two consultants and a pain specialist nursing sister in the team and holding multi-disciplinary team meetings to discuss individual patient treatments.
- Pain relief was available for patients attending the colposcopy clinic for procedures.

Patient outcomes

- We saw evidence in team meeting minutes that patient quality issues including waiting times were discussed and actions were included, where possible. The physiotherapy department undertook multiple sclerosis and ear, nose and throat patient audits in order to monitor patient outcomes.

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- A service review to evaluate patient satisfaction with the spinal musculoskeletal clinical assessment service (MCAS) was in progress, the results would be used to monitor and improve outcomes.
- The maxillofacial department participated in a patient experience audit and used results to improve patient outcomes.
- In interventional radiology, observational audits in the use of the WHO checklist were performed. Six procedures each month were audited and the results supplied for January and February 2016 demonstrated 100% adherence to protocol.
- The audiology department was in the development stage, leading towards accreditation with the Improving Quality In Physiological Services (IQIPS) programme. The IQIPS programme is professionally led with the aim of improving service quality, care and safety for patients undergoing physiological diagnostics and treatment. The department had undertaken a number of self-assessment audits, the most recent being October 2015, where they measure against 26 standards required for accreditation. The department action against the standards and plan to re-assess themselves in April 2016
- The ECG department did not participate in IQIPS, however, the four band seven Clinical Physiologist's were all British Society of Echocardiography Accredited and registered with the Royal College of Clinical Physiologists which ensured competency.
- Radiology had worked with the orthopaedic department to audit the quality of shoulder radiographs so that the best evidence and treatment was ensured.
- The pain clinic team used an evidence based pain management programme to treat patients, which included therapeutic support groups. A local patient focussed assessment tool was developed to measure outcomes
- The pain team gave an example where therapeutic network support could improve patient outcomes. The development of a choir by, and for, patients demonstrated both qualitative and quantitative benefits for patients.
- We spoke with a pain clinic patient who was extremely pleased with the management and treatment she received. She did, however, state that it was difficult to

get an appointment when needed. We were told that the clinic tried to follow up patients in a timely manner and the current wait was four weeks from request. A second pain clinic patient stated she had a two month delay in her treatment due to lack of available appointments

Competent staff

- All trust staff were expected to have a regular annual personal development review in line with trust policy. The trust target was 90% and data for January 2016 ranged between 87.5% and 100% across the outpatient and diagnostic divisions. The review was an opportunity for staff and their line manager to discuss learning needs and opportunities.
- All staff that we asked said they had received a review within the last 12 months. In the 2015, national staff survey the trust scored 2.88 out of five for staff response to the quality of the staff appraisal. This was below the national average of 3.03 which shows some dissatisfaction with the process The issue was raised and actions in place to improve.
- Radiographers are registered with the Health and Care Professions Council (HCPC) and as such maintained professional competency and audited their practice. We spoke with the radiology clinical tutor who was responsible for staff education on both hospital sites. She was responsible for student radiographers and as such attended a 'Preparing to Teach' course herself. Staff in radiology were encouraged to learn and attend the UK Radiological Congress, an annual three day conference.
- Radiography students told us they wished to continue their career at Southport and Ormskirk hospitals as they had opportunities to develop in technical areas such as CT or MRI.
- The hospital had clinical nurse specialists in a variety of specialities including oncology, diabetes and dermatology. We met a health care assistant who had specific training and worked independently in a dressing and suture removal clinic. She had attended a tissue viability and wound care course.

Outpatients and diagnostic imaging

Multidisciplinary working

- There were many examples of multidisciplinary team working within outpatients and diagnostic services, for example the cancer pathway group and the pain management team meetings.
- Cancer performance meetings were held weekly, and included other trusts, if appropriate. Telephone dial in meetings were used to facilitate efficient working.
- The pain management team had weekly educational and case conference sessions, monthly performance and operational meetings, and half-yearly service strategy afternoons. These included psychologists, physiotherapists, physician, occupational therapist, nurse, pharmacist, therapy assistants and clerical support.
- Physiotherapy and other support services worked in conjunction with many specialties, for example the trauma and orthopaedic team, urology and the spinal unit, giving the patient options for treatment and care.

Seven-day services

- The physiotherapy and pre-operative assessment departments regularly operated clinics until 8pm to allow greater flexibility for patients who worked.
- Diagnostic services were available seven days per week. Outpatient appointments were available for non-urgent plain film imaging six days per week. MRI appointments were available three evenings per week. CT scanning was performed 24 hours a day for inpatients.
- The matron explained that increased demand for clinic services could only be met with out of hours appointments due to limited accommodation availability. Any new substantive nursing staff would have out of hours working included in the job description. Staff in general outpatients told us that some Saturday clinics were in operation.
- The specialist oncology nurse told us that additional colposcopy clinics were arranged in the evenings when the demand for the service required it.

Access to information

- All staff had access to the most current policies and procedures via the trust intranet, which could be accessed at any computer terminal.

- We saw evidence in health care records of information being shared between specialties caring for an individual. Referrals to other professionals had taken place and responses received.
- All diagnostic images were reported in time for the patient's next appointment, which meant there were no delays in treatment decisions. This was achieved by using external reporting providers and radiologists working additional hours.
- The radiology department were in regular contact with referring general practitioners (GP's) to ensure current practices and information was known. The service did not have an electronic communication service with referring GP's and patients had to access appointments either by phone or in person. Imaging and reporting details were shared including current patient attendance numbers and number of patients who did not attend their appointment. GP's were also informed of any future known delays in service, for example during holiday periods.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with had a good understanding of when consent would be sought, and were able to explain guidance from the Mental Capacity Act. We were shown a copy of the Best Interest Decision Record and given an example when this might be used.
- At the time of our inspection, approximately 60% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards as they had been a recent addition to mandatory training, managers told us this was being addressed. Staff knew whom to contact to seek advice.
- We were given an example in interventional radiology, where the written consent to a procedure, by a palliative patient, was questioned. The staff felt that the patient was not fully informed to make a decision. She counselled the patient and returned them to the ward to consider the options.
- We saw two patient consent forms completed appropriately for patients undergoing CT.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good



We rated the outpatients and diagnostic services as Good for caring because:

- During the inspection, we saw staff interacting with patients in a caring and compassionate manner. The service had a relaxed but efficient atmosphere and staff made time for patients. We heard staff offering patients' drinks during their wait.
- We observed staff interacting with patients in radiology, eye clinic and general outpatients. All patients were treated with kindness and compassion. Staff assisted patients, when required, and we spoke to a patient who had been helped from the corridor who was having mobility issues.
- Three patients praised the staff in the medical day unit. Patients said staff were friendly and on first name terms, and nothing was too much trouble.

Compassionate care

- A patient gave us an example of a member of staff providing excellent compassionate care. The patient had parked a considerable distance from the clinic and had mobility problems. He had stopped en-route and a nurse had stopped to offer assistance. She found a wheelchair then phoned the clinic as the patient was late for his appointment. She then took the patient to his clinic and informed staff he had arrived.
- We saw a doctor approach a patient in the waiting area and accompany the patient to the examination room. She checked the patient's name and gently guided the patient to the room interacting in a kind and caring manner.
- In the general outpatients area, it was possible to speak with the receptionists without being overheard. The staff had arranged a queuing area away from the desk that allowed people to approach the desk individually.
- An oncology patient told us that they were on first name terms with the staff and nothing was too much trouble for them.

- We observed a member of the nursing team offer patients a drink in general outpatients; however, a pain clinic patient told us this had never happened on her previous visits.

Understanding and involvement of patients and those close to them

- The phlebotomist gave good examples of how to manage and reassure a patient with special needs who required a blood test.
- We observed staff interacting with a patient requiring eye drops before seeing the doctor. The nurse was kind but thorough in her explanation throughout the process. She escorted the patient to the waiting room and ensured she was comfortable. Her communication and interactions were excellent.
- We spoke with a mother of a 15 month-old patient. She told us the staff in the clinic were kind and caring and she felt she had received sufficient information during the clinic visit and been involved in her daughter's care.
- We saw staff interacting with patients in the radiology department in a respectful and compassionate manner. The department was busy; however staff took time to talk to patients during their appointment. Patients were given clear instructions and told what to expect.

Emotional support

- The colposcopy team were small and got to know their patients quickly. They understood the impact the outcome could have on the patient and helped them cope emotionally. We were told the health care assistant used distraction techniques to calm patients during uncomfortable procedures.
- NHS Friends and Family feedback forms were visible in clinic waiting areas; however no information was supplied regarding outpatients comments. We spoke to a number of patients who were happy with the care they received.
- Patients who had attended the medical day unit were extremely complimentary about the staff who cared for them. Patients attended for chemotherapy and told us that staff 'couldn't do enough for them'. They helped them cope emotionally, arranged complimentary therapies and were responsive to their needs.

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- We saw a number of quiet rooms available for patients receiving bad news or were anxious about their appointment. Staff said they utilised the rooms for patients with special needs and sought privacy

Are outpatient and diagnostic imaging services responsive?

Good



We rated the services as good for responsive because:

- Services were planned with thought for the needs of local people. Many outpatient clinics were available on both hospital sites for the convenience of patients and had good access once in the hospital.
- The time it took from referral to appointment was better than the national average. The 18 week target was exceeded and 50% of patients received an appointment within five weeks. Patients have a legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.
- All national cancer targets were also met by the hospital.
- In radiology, 99% of patients received their appointments within 6 weeks of referral. This was better than the national target.
- Outpatient and radiology facilities were good. The needs of different people were considered and accessibility was good. Hearing loops and interpreters were available, if needed. Patient information was available in large print, other languages and on-line.
- Staff explained that usually patients who were unhappy with the service would discuss their issues informally at the time. If the problem could not be resolved and the person wished to make a formal complaint the staff provided details of how to do this. We saw information regarding the Patient Advisory Liaison Service in many clinical areas. The number of complaints received was low and we found that they all had been appropriately managed.

However:

- There was no transport service between sites, which patients told us could lead to difficulties with multiple appointments.
- There were a high number of cancelled appointments recorded by the trust. This was something the management were aware of and a piece of work was planned to look at causes and make improvements.
- The diabetic screening accommodation was a little cramped for the number of patients visiting the clinic and the corridor was not wide enough to accommodate wheelchair users.
- We saw two rooms in the eye clinic that were both patient consult rooms and office space.

Service planning and delivery to meet the needs of local people

- All areas inspected were noted to be visibly clean and clutter free. Access to departments from the car park and main entrance was clear and well sign posted.
- Many outpatient clinics were available in both Ormskirk and Southport hospital sites, which offered patients a degree of flexibility in terms of where they preferred to attend.
- There was no transport link between the two hospital sites. This was a disadvantage for patients who had multiple appointments. Three staff who had cross site roles mentioned this issue.
- The radiology department waiting area was spacious and visibly clean. There were separate areas for each imaging speciality. Plans were in place to improve the flow of patients from the accident and emergency department. An operational excellence project had been undertaken and work-flows had been examined. An area was being created for patients in beds waiting for transfer.
- Work was also ongoing to reposition the changing rooms used for the plain film x-rays as they had been identified as a privacy and dignity risk. The rooms opened onto the main entrance corridor to the department rather than into the imaging area.
- Large television screens had been installed in the main outpatient waiting area. The matron explained that these should enable specific information to be displayed along with the current clinic wait time. This is

Outpatients and diagnostic imaging

an enhancement on using hand written whiteboards; however, since their installation there had been a problem with the IT in that all screens displayed the same waiting time, which was inappropriate as waiting areas were shared by different clinics. During the inspection, the screens were switched off and waiting times were displayed on whiteboards.

- The toilet facilities, we inspected in the eye clinic, were visibly clean, though no checklists were present. They were signposted in large print, were wheelchair accessible and had a pull cord alert system. The ladies toilet also had a baby change facility which again appeared clean.
- The Eye/ ENT clinics had a separate area to the general outpatients with a large waiting room and central reception desk. The clinic was very busy at the time of the inspection and the waiting area was short of space. Patients waited on chairs in the corridor leading to the diabetic screening area and restricted the access to the clinical rooms. The screening staff told us that this was a common problem and wheelchair users experienced difficulty getting to the room for their appointment.
- There was a paediatric orthoptist and adult cataract eye clinic taking place simultaneously during the inspection. Children and adults shared a waiting area and there were a small number of toys available. The orthoptist room was used as an office as well as an examination room. The room had children's wall decorations and toys used for attracting attention; however, it was quite cluttered and could not be used as an office during clinic sessions.
- A clinical room used by the optometrist was very untidy. It was a dual-purpose room and served as an office as well as assessing patients for glasses, contact lenses and low visual aids. The room had poor natural light and surfaces were cluttered with equipment and stationary. The nurse told us that the optometrist had been off sick and that currently no patients were being seen.
- An audit had taken place over a two month period, November and December 2014, examining the factors affecting efficiency of the CT department during the day. Three particular issues were found to cause delays and a plan was developed to reduce the issues.

- Rapid access colposcopy clinics were available for patients whose results showed a potential malignancy. Clinics were available at both trust hospitals including two week 'see and treat' appointments if high grade results were seen.
- A patient, who regularly attended for chemotherapy treatment was unhappy about the car parking fees. He told us the fees were higher than the town centre shopping area, and became a big expense.

Access and flow

- Almost 176,000 appointments were made at Southport Hospital between September 2014 and August 2015 according to Hospital Episode Statistics. The number of patients who did not attend was similar to the national average. In several departments, we were told of methods used to improve the numbers of patients not attending.
- The trust provided rapid access clinics for dermatology, ENT, colorectal, upper GI, urology, gynaecology and respiratory patients. Emergency clinics were also available for trauma and ophthalmology conditions.
- Waiting times for suspected and diagnosed cancer patients at Southport and Ormskirk were better than the national average. The urgent two- week referral target, the 31 and 62 day targets were all exceeded.
- The incomplete referral to treatment targets for England is that 92% of patients have an appointment within 18 weeks. Between April 2015 and January 2016, 97% of patients had received an appointment within 18 weeks. The trust also performed better than the England average for 2015 for incomplete patient pathways. Targets were met by waiting time initiative clinics, in addition to planned clinics run by staff over their normal working hours.
- Diagnostic waiting times for the hospital were excellent. Less than 1% of patients waited six weeks or more for an appointment within the previous 12 months for all tests. This is much better than the national average of 2%. In x-ray, CT, MRI, ultrasound, Electrocardiogram (ECG), Audiology, DEXA scans and gastroscopy, no patients waited more than six weeks for an appointment. The only tests that required any wait was Urodynamics and Cytoscopy due to staffing issues. However, all patients were given an appointment within 10 weeks.

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- The figures supplied for cancellation of appointments was double the national average. According to the Hospital Episode Statistics supplied, fifteen percent of outpatient appointments at Southport were cancelled by the hospital. We asked for clarification regarding numbers and reasons for cancelled appointments, and were told that between July 2015 and April 2016, twenty two clinics had been either cancelled or reduced due to doctors being required to cover wards. This was due to vacancies, either locums not turning up or no success in filling shifts and gaps in trainee rota. Fifteen of these were in March 2016. This was confirmed by the staff in the outpatients department who told us that patients were contacted by phone over the Easter period to cancel their appointment.
- Work had been undertaken to identify the causes of the cancellations as part of the outpatient project. It was found that a large number were due to IT errors, for example a patient had received duplicated appointments and therefore one cancelled. Some were due to lack of medical cover as annual leave and study leave had not been coordinated. A review of case notes and discharge of appropriate patients, also contributed. The deputy matron explained that project work was ongoing to improve the efficiency and targets had been set. Administrative staff were working on a 'task and finish' project that focussed on appointment letters. There were no outcomes and the work was incomplete.
- The radiology receptionists were proactive regarding cancellations. The staff explained that they would call patients on the diagnostic waiting lists, for example bone density tests, to fill appointment spaces made by cancellations. Efforts were made to see patients who attended the department with a referral but no appointment.
- The length of time a patient waited once they had arrived in clinic was not regularly recorded; however during our visit we saw a range of waiting times, with some patients being seen immediately and some waiting up to one hour.
- Of the ten patients we spoke to, one had a negative experience to share. Their appointment had been changed three times by post prior to their arrival. We were shown the appointment letter, which stated

'unforeseen circumstances' as the reason for the change. The patient told us that the clinic was always late by at least 30 minutes and they had not received an apology or offered a drink.

Meeting people's individual needs

- Patients attending outpatients for the first time were always given a longer appointment time in order to make assessments and to allow the patient to ask questions.
- We saw patient information leaflets readily available throughout the areas we visited. Information regarding specific conditions was available along with additional contacts and assistance information such as Macmillan advice. Trust leaflets gave details of how to access the information in other languages. In the radiology waiting area there was a range of information leaflets that explained procedures and help patients know what to expect.
- Services had been planned to allow access to clinics for patients with individualised needs. Hearing loops were available to assist people with hearing difficulties. Wheelchair access was good and there were additional load bearing beds that could accommodate larger patients. Larger scanning trolleys were available in x-ray if needed.
- Pain management patients who required no further input from the service were offered an open appointment, which enabled self-referral for flair management rather than discharge. Two patients independently told us that there was always a long wait for appointments and their pain had usually returned before their next visit.
- The pain management clinic at Southport was held in the general outpatients area. There were no hot or cold drinks available in the area and the seating was in fixed rows. A patient told us she always experienced long waits for her appointment, up to 90 minutes, and the seating was very uncomfortable
- The trust had a website that provided patients with practical information about appointments at the hospital and additional information about their condition. For example, the MCAS provided links to websites that provided self-help information for specific conditions such as whiplash or ligament strains.

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- There was information about low vision aids in the waiting area in the eye clinic. There were photographs of what was available and where to access them.
- Complimentary therapies, such as reflexology, were offered to patients attending the hospital for chemotherapy treatments.
- One patient, attending the medical day unit, told us they had been contacted when there had been a cancellation, and they were able to attend an earlier appointment.

Learning from complaints and concerns

- We saw information leaflets in several locations that offered guidance on how to make a complaint and who to contact if unhappy with the service.
- We saw evidence in team meetings that incidents and complaints were discussed with staff in order to learn from experiences and improve service delivery.
- Numbers of complaints were visible on outpatient dashboards and were regularly monitored and assessed by management teams. There were 33 complaints recorded between February 2015 and January 2016. Eight of these related to staff attitude/behaviour and nine were related to clinical treatment. Issues and themes were identified and the number of complaints over the 12month period had decreased.
- The hospital had a Patient Advice and Liaison Service (PALS) team who were the main contact for the patient or relative who wished to complain.

Are outpatient and diagnostic imaging services well-led?

Good



We rated outpatient and diagnostic imaging services as good for well-led because:

- A lengthy programme of improvement was underway at the time of the inspection. Results were evident with better facilities and good referral rates, further phases of improvement were planned. There were well-defined objectives and plans in place for improving quality.
 - Local level leaders had a good understanding of factors affecting the performance of the directorate and quality was assured with regular monitoring.
 - Staff were complimentary about their managers and had good relationships and communication with the heads of department. Safety huddles within teams ensured good communication.
 - Staff engagement was good, with regular surveys and involvement in projects along with awards for recognition of service. Continuous learning was promoted and staff felt supported to continue their education.
- However:
- The outpatient improvement project was behind schedule, staffing restructures and appointment cancellations had not been addressed.

Vision and strategy for this service

- At local level, the staff were conscientious and were proud of the care they provided. However, there was little knowledge of the strategy and future vision of the hospital. The lack of information regarding the future trust board was evident. Managers were focussed on the team and the service they provided.
- Strategies were seen with analysis of services and potential direction of the planned care directorate. These had been developed by the management team to provide a sustainable service

Governance, risk management and quality measurement

- Risk assessments were recorded on the trust risk register. Equipment that was unique or old was identified and assessed for its impact on patient care should the equipment fail. The impact of reduced staffing numbers and effects on patient care was also assessed and recorded on the register.
- Since the last inspection in November 2014, the radiology department at both hospital sites had introduced regular staff meetings to encourage sharing of information and improve learning. Subsequently discrepancies were fed back to the assistant Medical Director and actioned as required.

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- There was an effective governance framework in place at directorate level and there was a clear definition of roles and accountability.
 - Service performance was measured using dashboards and actions were taken to improve performance.
 - There were working arrangements in place with third party providers in radiology regarding service and maintenance of equipment and reporting radiologists. Providers were used that assured quality and met service level agreements.
 - The radiology department were in regular contact with referring general practitioners (GP's) to ensure current practices and information was known. Imaging and reporting statistics were shared including current patient attendance numbers and number of patients who did not attend their appointment. GP's were also informed of any future known delays in service, for example during holiday periods. Feedback was also received from GP's that was considered when service planning.
 - Quality was assured with many regular clinical and internal audits performed. Audits compared against national standards and followed best practice guidance. Safety standards were monitored and policies and procedures in place to ensure continuity.
 - Radiology participated in bi-monthly quality summit meetings. The group addressed a set agenda including quality assurance of equipment, audits and reports. We were given an example of changes made by the group following a patient experience exercise.
 - Some hard copies of procedures that were seen were noted to be out of date. The infection prevention department produced monthly audit data, which highlighted any issues across the hospital
- Managers expressed a concern about the length of time a business case took to process. Some cases had been submitted over two years earlier and decisions had yet to be made, for example, increase in the number of radiologists needed.
 - We examined the nurse staffing structure with regard to roles and responsibilities and found that there was some disparity. The gaps in part time nurse management roles were not being filled with equivalent grades and staff were being regularly managed by peers. We requested staffing structures and job descriptions, but they were not supplied. This issue may have been addressed if the improvement project had been completed.

Culture within the service

- All staff told us they felt supported and valued as team members. Receptionists told us they did not feel isolated in clinics and were supported by their administration manager, who was easy to contact. A health care assistant told us she feels part of her team and able to make practice change suggestions.
- Cross-site culture was good and all staff reported there was good collaborative working, staff were happy to move between hospital teams, though regular cross site workers complained of commuting and parking issues.
- In the 2015 NHS Staff survey the trust performed poorly with nine positive findings and 14 negative findings. However, the planned care management team met and created an action plan to address the issues within their directorate.
- Managers told us they were proud of their staff. Their ability to manage under pressure and staff turnover and sickness was low. Compliments about the team received by the executive team were shared with the individuals and at staff meetings.

Public engagement

- Staff told us that the managers were visible and approachable. They felt supported and able to speak to line managers easily. Senior staff were always available for advice and guidance including the Directorate Manager
- Staff were complimentary about the leadership in radiology. They felt that positive changes had been made to the service in the last 12 months.
- The trust engaged with patients by hosting 'In your shoes' cancer patient and carers experience events. Staff attended an offsite location to listen to the experiences and views of patients to help plan and improve services.
- NHS Friends and Family surveys were completed by patients who visited the hospital. There was a trust

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target of 94% that responders would recommend the trust to their loved ones. The figures were collated on a monthly basis. In the last 12 months there had been a steady increase in the positive responses received, from 81% in January 2015 to 93.7% in December 2015. This meant the trust target had not been met.

- The friends and family comment cards and post box was in evidence in the outpatient waiting area. We were told that comments were regularly collected and the information passed to management; however, we discussed this with the deputy matron who told us the comment cards had only recently been reinstated and no data had been collected.
- The radiology department had the 'You said we did' initiatives in place that were established in the treatment centre and were something the outpatient department were considering.

Staff engagement

- A project called Scope for Change had begun in July 2015. One thousand staff had participated in workshops to understand what staff wanted to change. Five topics were chosen and teams engaged to work on the changes. Regular electronic updates were sent to staff demonstrating the improvements. The first five projects chosen were; value and respect, time to recruit, car parking, career development and mandatory training.
- Trust staff participated in the NHS Staff survey annually. In 2015, the planned care directorate had developed an action plan to address the negative issues that had been highlighted in the survey. Issues such as low appraisal rate, poor communication with management and staff experience violence and aggression were addressed. Actions were planned, responsible persons assigned, progress monitored and completion dates set. Progress was ongoing.
- The trust held staff awards for recognising teams and individuals who had done exceptional work. We were told of several nominations of staff from outpatients and diagnostics since the awards began.

- We spoke with a staff member who was unhappy in her role. The key issues were she felt unsupported and unable to progress. Another staff member told us she loved her job but had been asking to progress her education for three years and had been refused.

Innovation, improvement and sustainability

- Directorate managers were aware of where services could be improved and extended to meet the needs of the population. Analysis of risks and opportunities had been performed and management teams had a good understanding of strategic issues.
- Southport and Ormskirk hospital teams were involved in the Mersey Cancer Network and regularly participated in regional meetings to ensure the local population were receiving the most up to date treatments possible.
- The pain management team recognised the lack of a patient focused outcome measurement tool, so developed their own. This was modified to be used therapeutically and became known as iGro. The team won a national innovation award in 2013 and were in the process of developing an electronic application.
- In radiology, a sepsis box had been introduced to the department, so that early intervention could take place, if sepsis was identified while a patient was undergoing investigation. The box contained medicine, consumables and protocols in a sealed and dated container that could be quickly taken to any imaging room.
- A radiographer described a 'work in progress' that she felt would improve the quality of the care provided. The plan was to introduce a pre-operative appointment for patients attending for interventional examinations, such as angiograms, coronary angioplasty and peripherally inserted central catheter (PICC line). She felt the patient would benefit from being able to ask questions prior to arrival and alleviate fears, and their suitability for the study could be assessed, avoiding wasted appointments.

Outstanding practice and areas for improvement

Outstanding practice

Regional spinal injuries unit

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

Areas for improvement

Action the hospital MUST take to improve Urgent and Emergency Services

- Ensure mortality is discussed monthly and minutes taken to evidence discussion.
- Ensure mandatory training compliance reaches and consistently achieves the trust target.
- Ensure appropriate signage is displayed in areas where close circuit television cameras are used.
- Ensure the actions identified following our concerns about the death of a patient during our inspection, are implemented in accordance with planned timescales
- Ensure all patients receive timely (particularly initial) observations whilst in the department
- Ensure staff use and evidence use of the sepsis care pathway for patients suffering sepsis.
- Increase middle grade staffing to ensure rotas can be planned without the routine use of consultants or junior doctors to back fill vacant middle grade shifts. Where it is not possible to recruit staff, ensure suitable alternative and sustainable solutions are identified and implemented.
- Ensure action plans following CEM audits target areas of poor performance and improve practice.
- Ensure staff make use of the trust capacity assessment documents when required and properly evidence that where a patient lacks capacity best interests have been adequately considered.
- Improve performance, particularly in relation to the department of health four hour target, wait times following a decision to admit, ambulance handovers.
- Ensure robust processes are in place to mitigate risks to staff in relation to violence in the work place.
- Improve the organisation of major incident equipment in the store room.
- Develop and embed a clear escalation process with identified actions for managers and executives.

Surgery

- The service must take action to ensure that there are adequate staffing levels present on all wards to provide safe level of care and treatment for the acuity and dependency of the patients on the wards.
- The service must take action to ensure that Oxygen is prescribed to patients, in line with recommended guidelines, prior to administration.
- The service must take action to ensure that all patients, particularly those who are very confused and able to wander off a ward, are cared for in a secure environment.

Outstanding practice and areas for improvement

- The service must take action to ensure that a system of feedback is in place for staff who have reported incidents.
- The service must take action to ensure that medically deteriorating patients are always identified as they deteriorate and are medically reviewed in line with trust policy.
- The service must take action to ensure that mortality and morbidity events in surgical services are reported to the trust board.
- Surgical services must take action to ensure that the plan for the replacement of old theatre equipment is implemented.
- Surgical services must take action to ensure that all risk assessments are appropriately completed for patients.
- Surgical services must take action to ensure that a system is in place to identify trends and reasons for the high readmissions rates in elective surgery.
- Surgical services must take action to develop an action plan to reduce the high readmission rate in elective surgery.
- Surgical services must take action to improve performance in relation to the indicators in the following national audits,
 - The national emergency laparotomy audit
 - The national bowel audit
 - The national lung cancer audit
 - The national hip fracture audit
- Surgical services must take action to ensure that patients are being fasted for surgery in accordance with national guidelines and trust policy.
- Surgical services must take action to ensure that the surgical admissions process is designed to facilitate a timely flow through the surgical process.
- Surgical services must take action to ensure that patients are cared for in treatment areas with full access to toilet facilities and meals.
- Surgical services must take action to ensure that care is provided to patients with complex needs in a manner that is responsive to the needs that they have.
- Surgical services must take action to ensure that patients with dementia and other cognitive impairments are cared for on wards that take account of these needs in terms of physical environment.
- Surgical services should use service user complaints about to drive service improvements.

Outstanding practice and areas for improvement

End of Life Care

- The service must improve the consistent use and completion of formal pain assessment; assessment of nutritional and hydration status in the community; mental capacity assessments when indicated on the DNACPR.

Medicine

- The service must take action to ensure that all staff have the up to date training they require to be able to safely care and treat patients and performance development reviews are in line with trust policy.
- The service must take action to ensure that all wards and corridors are clean and well maintained, and equipment is stored appropriately.
- The service must ensure that all records relating to patients are kept securely and computers are locked when left unattended to prevent breaches in data protection.
- The service must take action to ensure that all Initial patient risk assessments are consistently completed for all patients.
- The service must ensure that there are sufficient numbers of qualified, competent staff across all medical wards.
- The service must take action to improve the access and flow throughout the medical wards, to reduce bed occupancy and prevent patients being cared for on wards that are outside their specialty.

Action the hospital **SHOULD** take to improve Urgent and Emergency Services

- Review the cleaning procedures of the store room so that the floor in the store room is regularly cleaned and that debris such as cobwebs and dirt is removed immediately.
- Improve the culture described by staff through engagement
- Improve the poor culture that exists relating to staff feelings about a lack of support and a reactive approach to issues, with strategies for engaging with staff and responding to their concerns.

Surgery

- The service should ensure that all risk assessments are completed and kept up to date.
- The service should review the necessity of lengthy suspensions of clinical staff during disciplinary investigations
- The service should ensure that all medication which is prescribed is administered.

Outstanding practice and areas for improvement

- The service should ensure that there is a robust method of assessing the pain of patients who are not able to respond to verbal enquiry.

Critical Care

- Take appropriate actions to improve staff mandatory training and appraisals compliance.
- Take appropriate actions to improve availability of support services (such as speech and language therapy and social worker support) over seven days, including outside of normal working hours.
- Take appropriate actions to reduce the number of delayed discharges and 'mixed sex' breaches.

End of Life Care

- The service should take action to ensure that all GP involvement in the recognition that a person is likely to be dying, whether over the telephone or in person, is documented in the IPOC when the decision is made for this to be commenced. Discussions with GPs were usually taking place, but they were not always being documented by the district nurses.
- The trust should ensure the improved incident monitoring system includes dissemination of feedback and lessons learned to all relevant areas, including the mortuary.
- The service and trust should consider using the unified DNACPR form and process.
- The service should consider the auditing of DNACPR forms or decisions.
- The service should consider the appointment of a lay member on the trust board with a responsibility/ role for EOLC.
- The service should improve the checking of syringe drivers in line with hospital policy.

Outpatients

- Ensure that staffing levels are sufficient and recruit medical consultants, radiologists and ultra-sonographers in line with substantive numbers. Sufficient cover should be arranged for long-term sickness vacancies to maintain a service.
- Ensure the safety of patients with known allergies, by making clear reference to the allergy on the front of their health care record.

- Replace or repair equipment and improve processes that will reduce the possibility of infection/contamination, for example, the phlebotomy chair and use of lenses during glaucoma clinics.
- Procedure documentation should be accurate and reviewed in a timely manner, and ensure all appropriate staff are aware of procedural changes.
- Liaise with pharmacy to develop a robust system for highlighting short dated drugs and replacement when expired. Out of date drugs should be removed and disposed of safely.
- Ensure that outpatient and diagnostic staff numbers reach trust target figures for Basic Life support, Mental Capacity Act, Derivation of Liberty Safeguards and duty of candour training.
- Consider investment in an electronic communication system between GP services and radiology in line with the rest of Merseyside and Cheshire, to improve referrals, appointments and report accuracy and timeliness.
- Ensure continuation of the outpatient improvement project ensuring the review roles and job descriptions so that senior staff are performing appropriate roles and clinical staff are graded to match the role performed. The cancellation of appointments project continues and reaches the targets of improvement defined. Consider improving the IT system to enable the waiting time screens to work effectively.
- Consider introducing visible cleaning checklists so that all staff and visitors have assurance that cleaning has been completed.

Regional Spinal Injuries Unit

- The service ensure that all NWSIC staff have the up to date training they require to be able to safely care and treat patients and staff appraisals are completed in line with trust policy.
- The service had limited facilities to manage infectious patients which remained a challenge. Although staff were aware of plans to increase these facilities, there was no confirmation of the work being carried out.
- The service should ensure wider attendance at mortality and morbidity meetings as only medical staff took part in these currently. Note taking and action plans were poor following these, which meant that opportunities to learn how to improve patient care were possibly being missed.

Outstanding practice and areas for improvement

- The service should continue to develop care pathways and update standard operating procedures. The service should ensure procedures include the date reviewed, the next review date or include the staff group aimed at.
- The service should consider developing its five year strategy for the NWRSIC which had not yet been made available following the sustainability review.
- The service should consider using a dependency/acuity tool relating specifically to the spinal speciality.

Medicine

- The service should consider the use of a security team within the trust to be able to provide security to staff and patients if a patient or visitor is violent or aggressive.
- The service should consider that there is a regular formal process of monitoring the performance of each ward by senior staff to ensure ward quality standards and that staff are compliant with all necessary policies and procedures.
- The service should take action to ensure that all patient care needs are addressed prior to lunch being served and all patient tables are clear of any waste materials.
- The service should consider the storage spaces for staff on wards to be able to safely store their belongings.
- The service should consider the use of GPAU and Discharge lounge as escalation areas as they do not currently provide all the necessary amenities to the patients.
- The service should consider improvements in seven day services to provide an equitable service throughout the week.
- The service should take action to provide staff with a clear vision and strategy of the direction of the trust and senior managers should be visible and approachable to all staff.
- The trust should take action to ensure that ligature points in patient bathrooms are risk assessed to protect those individuals at risk of harming themselves.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>12(2)(a): Assessments, planning and delivery of care and treatment should be based on risk assessments... carried out in accordance with the Mental Capacity Act 2005. This includes best interest decision making, lawful restraint.</p> <p>Following a review of care for a mental health patient in the ED who had been restrained with medicine administered, we found no evidence of a risk assessment, or capacity assessment.</p> <p>12(2)(a): Assessments, planning and delivery of care and treatment should include arrangements to respond appropriately and in good time to people's changing needs.</p> <p>The ED was routinely missing Department of Health targets in relation to timely care, treatment, admission or discharge.</p> <p>12(2)(b): Staff must follow plans and pathways</p> <p>We found several ED records where, although sepsis care was provided there was no evidence of adherence to the sepsis care pathway in place.</p> <p>12(2)(b): Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as possible.</p> <p>Security staff were not employed to support staff in the ED. A number of incidents had been reported by staff which cited examples of physical and verbal abuse of staff.</p> <p>Escalation tools specific to the ED were not in use at the time of inspection.</p>

Requirement notices

We found multiple examples in ED records where triage tools used to manage risks to patients, were not used in a timely way. These included clinical observations, early warning scores and risk assessments.

12(2)(d): Medical care and treatment was being provided on wards outside the staff speciality as outlying patients were being cared for on wards that were not suited to their needs or condition.

12(2)(a): Risk assessments within medical services were not completed consistently for all patients when admitted to Hospital or reviewed regularly.

Response to deteriorating patient in a timely way was inconsistent through poor use of the electronic system and delayed escalation of the deteriorating patient and suboptimal medical response in some cases.

12(2)(h): Staff in medical services did not always wear suitable protection to minimise the spread of infection.

12 (1)(2)(a)(b)(c)(d)(g)

We found that there were frequently inadequate numbers of staff to provide safe care and treatment on surgical wards.

We found that on some wards staff were did not receive feedback regarding incidents that had occurred and that some types of incidents related to the safety of patients were being repeated.

We found that patients on surgical wards did not always receive the required risk assessments to identify any medical deterioration and when they did receive them they were not always escalated in line with trust policy.

We found that there was that the surgical readmission rate for elective surgery was higher than the national average.

We found that surgical patients were being fasted for surgery for longer than necessary according to national guidelines and in contravention of the trust's own policy.

We found that performance in national surgical audits was worse than the national average.

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

13(2): Systems and processes must be established and operated effectively to prevent abuse of service users
(13(6): 'abuse' means (d) neglect of a service user)

We saw the record of a patient in the ED who had passed away and from this concluded that care was not provided in a timely way, risks were not identified and action was not taken to provide treatment which may have improved the outcome for this patient.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

15(1)(b): Any surveillance should be operated in line with current guidance

The ED was not displaying appropriate signage to indicate that close circuit television was in use.

Regulation 15(1) All premises and equipment used by the service provider must be-

(c) suitable for the purpose for which they are being used.

(e) properly maintained

In surgical services we found that the plan for replacement theatre equipment had not been implemented.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

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

Requirement notices

Meetings focusing on mortality were not held routinely by ED staff.

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

Action by the ED following poor results from CEM audits was insufficient.

17 (1) (2c): Records in medical services were not always secure. This was because record trolleys were left unlocked on the ward and nursing assessments were not kept secure. Computer terminals screens must be locked when not in use to avoid data being viewed by unauthorised personnel.

17 (1)(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

We found that surgical services did not use service user complaints received to drive continuous service improvements.

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

18(1): Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

Middle grade staffing levels in the ED did not sufficiently cover the needs of the department.

18 (1): In medical services there was not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients.

18(2)(a): Not all staff in medical services were up to date with the training they required to be able to safely care and treat patients, and staff performance development reviews were not in line with trust policy.

This section is primarily information for the provider

Requirement notices

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

(1)(a)(b)(c)(2)(e)(h)(i)

We found that on surgical wards patients with complex needs were not always cared for in a manner that is responsive to the needs that they had.

We found that on surgical wards the physical environment did not take into account the needs of patients with complex needs such as cognitive impairment.