

Southport and Ormskirk Hospital NHS Trust

Southport and Formby District General Hospital

Quality Report

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2014

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care

Requires improvement



Surgery

Requires improvement



Regional spinal injuries centre

Inadequate



Critical care

Requires improvement



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The comprehensive inspection at Southport and Formby District General Hospital was conducted between 12 and 14 November 2014 and an unannounced inspection was carried out on 20 November 2014 between 10pm and 1am.

This inspection was conducted under the new model of inspection as part of the inspection of Southport and Ormskirk NHS Trust.

Overall the hospital was rated as requiring improvement as the safe, effective and responsive domains were rated requires improvement and responsive, caring and well led domains were rated as good.

Our key findings were as follows:

Safe

Systems were in place for reporting and managing incidents. There was a risk-aware culture and a willingness to learn from mistakes but feedback was inconsistent. We found that some risks had been on the risk register for over two years without full resolution of the issues. We were told of a major infection control issue in critical care which had not been put on the risk register although it was being addressed. Concerns raised by staff about the safety of the ophthalmology clinic at Southport had been taken to the risk management team and the trust risk manager had been to the clinic, but no action appeared to have been taken, and the staff who raised the issue had been given no feedback about proposed action or why action was not required.

There were insufficient members of nursing staff to provide a safe service for patients being cared for in the North West Regional Spinal Injuries Centre (NWR SIC). Corridors were cluttered with equipment, which had an impact on the control of infection within the centre and there was no planned replacement programme for essential pieces of equipment. Medicines were well managed within the centre and quality of record keeping was good.

Patients received care in safe and clean environments. Staff were aware of policies but adherence in medicine needs improvement. We noted 19 separate occasions in A&E in the previous month where two members of staff had not always checked controlled drugs such as morphine sulphate during dispensing or as part of the daily stock check in the resuscitation area and in critical care medicines storage was not in accordance with current guidance on security. This had been identified by the trust and was on the risk register, but had not been promptly addressed.

Staff assessed and responded to patients' risks. Patient records were completed appropriately although some end of life individualised care plans were found to be incomplete, meaning that some patients and their families may not get preferred care at the end of their life. The system for reviewing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms was unclear to us and to the member of staff we spoke with, which may result in unnecessary confusion and distress if CPR is required.

Staff were aware of the safeguarding policy and got appropriate consent from patients. There were efficient and well managed handovers. There was an appropriate and up to date trust major incident plan.

Patients were supported with the right equipment; however there was no approved schedule for replacing older equipment used in the theatres and records across the hospital of service status were inconsistent.

Processes were in place to ensure resource and capacity risks were managed. However, the staffing levels in A&E, surgery and medicine were not always deemed sufficient to meet patient's needs. The staffing levels were maintained through the use of bank and agency staff and this meant that the skills mix was not always sufficient to meet patients' needs.

We found that the end of life/palliative care services at Southport Hospital were generally good, and were supported by a robust training programme and adherence to national guidelines

Summary of findings

Effective

There was evidence of adherence to national guidance. The A&E department participated in national College of Emergency Medicine audits and there were clear action plans indicating what improvements need to be made as a result. In surgery the lack of an orthopaedic geriatrician meant that compliance with the national hip fracture audit had not been achieved and patients did not always receive the best possible care.

Evidence based guidelines were in place for the treatment of patients with spinal injuries. Care plans for patients with spinal injuries identified goals set by the patients and these were monitored by them in partnership with the staff. The discharge planning process was part of the goal setting undertaken with the patient and began as soon as the patient was admitted to the ward.

Staff on critical care told us that they had not achieved full implementation of the relevant guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the national core standards for intensive care.

The adult critical care beds occupancy had been consistently above national average in the previous twelve months. This activity had reduced since June 2014. National Intensive Care audit data (ICNARC) showed that the service discharge out of hours to ward and delayed discharges over 4 hours was worse than the England average.

The majority of surgical patients had a positive outcome following their care and treatment; however, the number of patients that had elective urology and general surgery and were readmitted to hospital after discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was worse than the England average for elective and non-elective patients having general, trauma and orthopaedic surgery.

Caring

Staff treated patients with dignity, compassion and respect, even while working under pressure.

Although patients spoke positively about the care and treatment they had received and we observed many positive interactions data showed that the A&E department scored worse than the England average for similar departments which might indicate that patients would not recommend the department to their friends and family however the low response rate between April 2013 and July 2014 means the results were not fully reliable.

In the NWRSIC most patients were treated with compassion and respect, but low nurse staffing levels meant that sometimes staff were slow to respond to the needs of patients.

Responsive

Performance was improving trust wide, but on its own, Southport Hospital struggled to meet the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

There were rehabilitation and sports facilities within the NWRSIC but sometimes patients were unable to access them due to shortages of staff.

Improvements were needed in the management of stroke. Timely access to computer passwords for newly appointed medical staff, including locum doctors, was required. The flow of medical patients throughout the hospital was disorganised and medical staff had no formal process by which to locate their patients. At the time of the inspection 15 surgical beds were occupied by medical patients and 4 surgical patients were being care for in medical beds. There was insufficient bed capacity in the wards and theatres, which meant that extra beds were occasionally placed on the surgical wards although we had been assured that this practice was no longer custom and practice. There were plans in place to improve theatre efficiency.

Summary of findings

Despite this being an integrated trust there were few examples of integration between community and acute services. Although there was often good communication and co-operation, the community and acute services were usually managed and operated separately. This did not provide a seamless or holistic service for patients, particularly those with chronic health conditions that required frequent hospital admissions. We noted that 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 mortuary and bereavement service was focused on making its environment and interaction with patients and relatives as minimally distressing as possible, and displayed excellent, innovative care.

National targets for referral to appointment times were exceeded in all areas. Clinics that consistently ran late were reviewed to identify blocks in patient flow.

Well led

The overall ethos centred around the quality of care patients received. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. There was a disconnection between the staff providing hands-on care and the executive team in some areas. The system in place to communicate risks and changes in practice to nursing staff required improvement.

The emergency department faced challenges such as patient flow and local changing needs, such as an increased elderly population, and had initiatives in place to tackle these.

There was no clear strategy for the development of the NWSIC and there were insufficient senior nursing managers allocated to the NWSIC to be able to provide effective leadership for this service.

We saw several areas of outstanding practice including:

- 85% of patients who had a documented preferred place of death died where they chose to, facilitated by an effective end of life rapid transfer programme.
- An access film showing the experience of a child attending an outpatient department is being posted on the trust website. This will allow parents of young children or carers of patients with learning difficulties to view the film with them and explain the process and what to expect before they attend for their own appointment.
- The introduction of dressing clinics to complement fracture and orthopaedic clinics, reducing the need for formal appointments and freeing up consultants' time.
- Improvements to help children and patients with learning disabilities settle into the outpatients department.

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

Importantly, the trust must:

- Ensure adequate nurse staffing levels and an appropriate skill mix in all areas
- Ensure equipment used in the theatres is fit for purpose and older equipment is replaced under a planned replacement schedule.
- Ensure medicines management meets national standards in the critical care unit and in the Accident and Emergency department.
- Improve infection prevention and control processes within the medical directorate.

In addition the trust should:

Medicine

- Take immediate action to prevent the sharing of computer passwords between medical staff.

Summary of findings

- Improve storage on medical wards for essential pieces of equipment and staffs' personal clothing and belongings.
- Improve feedback and learning from incidents.
- Increase 7 day working for all disciplines across the medical directorate.
- Improve the flow of medical patients within the hospital.
- Improve learning from complaints.
- Improve the way risks are communicated to nursing staff within the medical directorate.

Surgery

- Reduce clutter in the theatres.
- Improve compliance with the national hip fracture audit.
- Reduce the number of patients that are readmitted to hospital after having elective urology and general surgery.
- Improve performance relating to the patient length of stay at the hospital.
- Reduce delays to admitted patients awaiting surgery in the theatres.
- Improve bed utilisation on the surgical wards to ensure patients are located in the best available place.

Urgent and emergency services

- Continue to ensure that all staff complete their mandatory training in a timely manner.
- Have a list of appropriate staff that have been trained with the required scene safety and awareness training.
- Ensure the environment in the triage area can allow patient conversations to be private.
- Ensure that all items of equipment have a record of being serviced or calibrated and that the service is in date.
- Ensure that two members of staff check controlled drugs during dispensation and as part of the daily stock check.
- Designate a lead for education in the department.
- Look to improve the location target to treat 95% of patients within 4 hours.
- Tackle the issue of junior medical staff who felt bullied by senior staff

Outpatients

- Ensure concerns raised about outpatient services are addressed appropriately and in a timely manner

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?

The overall rating for the urgent and emergency services at Southport Hospital is requires improvements in the safe and responsive domains. Systems were in place for reporting and managing incidents. There was a risk-aware culture and a willingness to learn from mistakes. Patients received care in safe and clean environments. Staff were aware of the safeguarding policy and got appropriate consent from patients. There were efficient and well managed handovers. There was an appropriate and up to date trust major incident plan.

Although appropriate equipment was available, the records of service status were not always clear. Medicines and records were managed effectively and safely, however, we noted 19 separate occasions in the previous month where two members of staff had not always checked controlled drugs such as morphine sulphate during dispensing or as part of the daily stock check in the resuscitation area. Processes were in place to ensure resource and capacity risks were managed. However, the staffing levels were not always deemed sufficient to meet patient's needs and the training records showed staff were not meeting the targets set by the trust. There was evidence of adherence to national guidance. Patients were assessed for pain relief as they entered the emergency department. The department participated in national College of Emergency Medicine audits and there were clear action plans indicating what improvements need to be made as a result. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run 7 days a week.

Staff treated patients with dignity, compassion and respect, even while working under pressure.

Although patients spoke positively about the care and treatment they had received and we observed many positive interactions data showed that the

Summary of findings

department scored worse than the England average for similar departments indicating that patients would not recommend the department to their friends and family.

A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings.

Performance was improving trust wide, but on its own, Southport Hospital struggled to meet the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

Translation services were available for patients for whom English was not their first language, and the service sought feedback from patients through complaints and patient engagement.

The overall ethos centred around the quality of care patients received. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. The emergency department faced challenges such as patient flow and local changing needs, such as an increased elderly population, and had initiatives in place to tackle these.

Medical care

Requires improvement



Medical care services were delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect. Shortages of nursing staff, combined with insufficient storage for equipment and on-going issues with the prevention and control of infection meant that services within the medical directorate were not being delivered safely.

Improvements were needed in the management of stroke. Timely access to computer passwords for newly appointed medical staff, including locum doctors, was required. The flow of medical patients throughout the hospital was disorganised and medical staff had no formal process by which to locate their patients.

Despite this being an integrated trust there were few examples of integration between community and

Summary of findings

acute services. Although there was often good communication and co-operation, the community and acute services were usually managed and operated separately. This did not provide a seamless or holistic service for patients, particularly those with chronic health conditions that required frequent hospital admissions. We noted that 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.

Generally the individual wards/departments were well-led, although there was a disconnection between the staff providing hands-on care and the executive team. The system in place to communicate risks and changes in practice to nursing staff required improvement.

Surgery

Requires improvement



Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff assessed and responded to patients' risks. Patient records were completed appropriately. Patients received care in safe and clean premises. Patients were supported with the right equipment, but there was no approved schedule for replacing older equipment used in the operating theatres. The staffing levels were maintained through the use of bank and agency staff and this meant that the skills mix was not always sufficient to meet patients' needs.

The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. They participated in national and local clinical audits and performed in line with similar sized hospitals and within the England average for most safety and clinical performance measures. However, the lack of an orthopaedic geriatrician meant that compliance with the national hip fracture audit had not been achieved and patients did not always receive the best possible care.

The majority of patients had a positive outcome following their care and treatment; however, the number of patients that had elective urology and

Summary of findings

general surgery and were readmitted to hospital after discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was worse than the England average for elective and non-elective patients having general, trauma and orthopaedic surgery. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

The services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints were shared with staff to aid learning. The number of cancelled elective operations was better than the England average and there had been recent improvements in performance against 18 week referral to treatment standards.

There was insufficient bed capacity in the wards and theatres, which meant that extra beds were occasionally placed on the surgical wards and patients experienced delays during surgery. There were plans in place to improve theatre efficiency. There was clearly visible leadership within the service. The majority of staff were positive about the culture and support available. 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 service and how to resolve these.



There were insufficient members of nursing staff to provide a safe service for patients being cared for in the NWSIC. Corridors were cluttered with equipment, which had an impact on the control of

Summary of findings

infection within the centre and there was no planned replacement programme for essential pieces of equipment. Medicines were well managed within the centre and quality of record keeping was good.

The service was effective. Evidence based guidelines were in place for the treatment of patients with spinal injuries. Care plans for patients with spinal injuries identified goals set by the patients and these were monitored by them in partnership with the staff. The discharge planning process was part of the goal setting undertaken with the patient and began as soon as the patient was admitted to the ward. Most patients were treated with compassion and respect, but low nurse staffing levels meant that sometimes staff were slow to respond to the needs of patients.

There were rehabilitation and sports facilities within the centre but sometimes patients were unable to access them due to shortages of staff.

There was no clear strategy for the development of the NWSIC. There was insufficient senior nursing managers allocated to the NWSIC to be able to provide effective leadership for this service.

Critical care

Requires improvement



Critical care services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients. Medicines storage was not in accordance with current guidance; this had been identified by the trust and was on the risk register but had not been promptly addressed. We found that some risks had been on the risk register for over two years without full resolution of the issues. We were told of a major infection control issue which had not been put on the risk register.

Staff told us that they had not achieved full implementation of the relevant guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the national core standards for intensive care.

The adult critical care beds occupancy had been consistently above national average in the previous twelve months. This activity had reduced since June

Summary of findings

2014. National Intensive Care audit data (ICNARC) showed that the service discharge out of hours to ward and delayed discharges over 4 hours was worse than the England average.

There was clearly visible leadership within the critical care service. Staff told us they were proud of the unit and the care they provided. The trust vision, values and objectives had been cascaded across the critical care service and some staff had a clear understanding of what these involved.

End of life care

Good



We found that the end of life/palliative care services at Southport Hospital were generally good, and were supported by a robust training programme and adherence to national guidelines.

Staff from both the general wards and the specialist palliative care team and transform team displayed enthusiasm for providing safe, effective and compassionate care to patients reaching the end of their life. The multidisciplinary team worked well together to achieve this.

The mortuary and bereavement service was focused on making its environment and interaction with patients and relatives as minimally distressing as possible, and displayed excellent, innovative care. Some end of life individualised care plans were found to be incomplete, meaning that some patients and their families may not get preferred care at the end of their life. The system for reviewing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms was unclear to us and to staff, which may result in unnecessary confusion and distress if CPR is required.

Outpatients and diagnostic imaging

Good



Overall, the outpatient and diagnostic services was good but improvement was required in the patient safety domain. This was because we could not be sure that all matters of concern were properly recorded or that the trust had clear oversight of the issues.

Concerns had been raised by staff about the safety of the ophthalmology clinic at Southport. These had been taken to the risk management team and the trust risk manager had been to the clinic, but no action appeared to have been taken, and the staff who raised the issue had been given no feedback about proposed action or why action was not required.

Summary of findings

Staff were trained in infection prevention and control and understood their responsibilities. Safeguarding processes were in place to identify and prevent abuse. Other equipment had been properly maintained, serviced and cleaned.

National targets for referral to appointment times were exceeded in all areas. Staff were well trained and encouraged to do additional training or broaden their skills. Outpatient staff of band 5 and below were rotated between departments and sites to increase their skill base and provide greater flexibility for the department.

Multidisciplinary working was evident both at a local level and within the wider health community. Specialist consultants from neighbouring trusts ran clinics which were staffed by Southport and Ormskirk staff, enabling patients to receive a first appointment nearer to home.

We observed staff at all levels interacting with their patients. All the encounters we saw involved friendly and helpful interactions. Patients could not speak highly enough of the nursing staff who cared for them. Patients told us how doctors, nurses and receptionists had all taken time to explain things to them, in ways that they understood.

Audits were completed and services were reviewed. We saw how information was used to identify areas for improvement; changes had been made to the waiting rooms at both sites, improving the environment for patients and staff. Diagnostic services had identified how they could improve privacy and dignity for patients who are brought to the department in beds.

Children's activity boards were being put up to occupy young people while they or their parents waited to be seen. A video was being produced to show young children or patients with learning disabilities what it would be like when they attend the department. This was to be published on the trust website.

Additional services had been created, such as the 'dressings' clinics, which had freed up consultants' time and reduced delays in fracture and orthopaedic clinics.

Clinics that consistently ran late were reviewed to identify blocks in patient flow.

Summary of findings

We found that staff respected their local managers; they were supported in the decisions they made and encouraged to develop. Managers had a good understanding of their teams and recognised where improvements could be made, and led on the issues on behalf of the teams.

Innovation was encouraged, which was demonstrated by the improvements to help children and patients with learning disabilities settle into the department, and proposals submitted by porters to improve waste services.

Requires improvement

Southport and Formby District General Hospital

Detailed findings

Services we looked at

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

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Detailed findings

Background to Southport and Formby District General Hospital

Southport and Formby District General Hospital is one of two hospitals within the Southport and Ormskirk NHS Trust. The trust is not a foundation trust. The hospital provides the accident and emergency, medical, critical care and surgical services and an outpatients facility. The

North West Regional Spinal Injuries Centre is also located at Southport and Formby District General Hospital. The hospital was inspected as part of a new approach comprehensive inspection.

Our inspection team

Our inspection team was led by:

Chair: Christopher Tibbs, Medical Director and Consultant Gastroenterologist at The Royal Surrey County Hospital.

Heads of Hospital Inspections: Tim Cooper and Alan Thorne, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants in acute medicine,

trauma and orthopaedics, gastroenterology and a consultant anaesthetist. There was also a chief nurse, deputy director of nursing, consultant nurse in orthopaedics, McMillan nurse specialist, advanced nurse practitioner in paediatrics, specialist nurses in accident and emergency and medicine. The team also had a risk manager, physiotherapist and speech and language specialist. The team was also supported by four experts by experience who are lay members of the team.

How we carried out this inspection

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

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

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

We held a listening event in Southport on 05 November 2014 when 100 people attended and shared their views and experiences of both Southport and Formby District General Hospital and Ormskirk District General Hospital. Some people who were unable to attend the listening event shared their experiences via our web site, by letter or telephone.

We undertook an announced inspection of the trust between 12 and 14 November 2014, and an unannounced inspection at both hospitals on 20 November 2014 between 10pm and 1am. We looked at the following core services at Ormskirk District General Hospital:

- Accident and emergency (A&E)
- Medical care
- Surgery
- Critical care
- Palliative and end of life care
- Outpatients
- Regional Spinal Injuries Centre

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually, as requested. We also trialled a focus group for BME staff which was well attended

Detailed findings

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, spoke with carers and/or family members, and reviewed patients' records of personal care and treatment.

Facts and data about Southport and Formby District General Hospital

Southport and Ormskirk Hospital NHS Trust provides healthcare in hospital and the community to 258,000 people across Southport, Formby and West Lancashire. Care is provided at Southport District General Hospital and Ormskirk District General Hospital, 8 miles apart.

Deprivation in communities predominantly served by the trust is mixed compared to the England average – better in the Sefton area and worse in West Lancashire. Life expectancy rates are below England average.

A number of population measures are worse (particularly malignant melanoma and some of the child health measures).

There are 375 inpatient and 18 day case beds at Southport and Formby District General Hospital.

Across the trust there are 3026 staff and in 2012/13 there were 61,096 inpatient admissions, 248,102 outpatient attendances and 69,108 Accident & Emergency attendances.

The trust is currently in financial surplus.

Detailed findings

Our ratings for this hospital







Our ratings for this hospital are:

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

Notes

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Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites that formed part of Southport and Ormskirk Hospital NHS Trust. The emergency department at Southport Hospital was open 24 hours a day, seven days a week, providing emergency care and treatment for adults only. The department treated people with serious and life threatening emergencies as well as those with illnesses or injuries which were not life threatening, but still needed prompt treatment, such as minor head injuries or suspected broken bones. Children under 16 years of age were assessed and if the condition was not life threatening they were referred to the paediatric accident and emergency (A&E) department at Ormskirk Hospital.

The urgent & emergency services saw approximately 105,000 patients between April 2013 and March 2014.

There were 15 bays in the major injuries area of the adults A&E department including four bays for resuscitation. There were six bays in the minor injuries area with one bay designated as a plaster area. There were ample waiting rooms including a reception area.

Patients who required diagnosis, observation, treatment and rehabilitation but were not expected to need an overnight stay attended the observation ward, which consisted of five beds, and nine chairs for patients who were mobile. Patients could be discharged home and booked an appointment to return for further assessment.

We carried out an announced inspection during 12–14 November and an unannounced inspection on 20 November between 10pm and 1am. We spoke with 12

patients and relatives, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the clinical director for emergency medicine, matrons, senior sisters, nurse practitioners, consultants, healthcare assistants and the receptionist staff. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

The overall rating for the urgent and emergency services at Southport and Formby District General Hospital is that it requires improvements to be made in the safe and responsive domains.

Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments. Staff were aware of the safeguarding policy and got appropriate consent from patients. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the provision of care and treatment.

However, we found several items of equipment that had no record of being serviced or calibrated and the service date shown on the label was overdue on some equipment such as ventilators and blood pressure measuring devices since 2012. We also noted that the fridges used to store medication had not been serviced or double checked by the pharmacy department since 2012. There was no lead for the service and maintenance of the equipment in the department.

Medicines and records were generally managed effectively and safely across the areas we inspected, however, we noted 19 separate occasions in the previous month where two members of staff had not checked controlled drugs such as morphine sulphate during dispensing or as part of the daily stock check in the resuscitation area.

Processes were in place to ensure resource and capacity risks were managed. However, the staffing levels were not always deemed sufficient to meet patient's needs and the training records showed staff were not meeting the targets set by the trust.

There was evidence of adherence to national guidance to provide evidence-based care and treatment. Patients were assessed for pain relief as they entered the emergency department. The department participated in national College of Emergency Medicine audits and there were clear action plans indicating what

improvements need to be made as a result. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run 7 days a week.

Staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious.

A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings.

Performance was improving trust wide, but on its own, Southport Hospital struggled to meet the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

Translation services were available for patients for whom English was not their first language, and the service sought feedback from patients through complaints and patient engagement.

The organisation's vision and strategy had been cascaded to all staff, who were proud of the work they did. The overall ethos centred around the quality of care patients received, and meeting targets was secondary. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. The emergency department faced challenges such as patient flow and local changing needs, such as an increased elderly population, and had initiatives in place to tackle these.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments. Staff were aware of the safeguarding policy and got appropriate consent from patients. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the provision of care and treatment.

However, we found several items of equipment that had no record of being serviced or calibrated and the service date shown on the label was overdue on some equipment such as ventilators and blood pressure measuring devices since 2012. We also noted that the fridges used to store medication had not been serviced or double checked by the pharmacy department since 2012. There was no lead for the service and maintenance of the equipment in the department.

Medicines and records were generally managed effectively and safely across the areas we inspected, however, we noted 19 separate occasions in the previous month where two members of staff had not checked controlled drugs such as morphine sulphate during dispensing or as part of the daily stock check in the resuscitation area.

The numbers of nursing staff during the inspection were adequate for the flow of patients we observed. However, issues also arose during the night shift when the nursing staff were called away from the A&E department to assist in other duties. We saw a number of incidents related to inadequate staffing within the A&E department where no additional cover was available when needed. Although this hadn't resulted in any known patient harm. The RCN also identified concerns in relation to the high use of agency staff, high rates of staff vacancies and the skill mix, in particular the high use of band 5 nurses.

Training records showed staff were not meeting the targets set by the trust. According to the records supplied by the trust only 10% of medical and dental staff had

completed basic clinical resuscitation training and compliance with training in the safeguarding of adults was also poor among the medical and dental staff with only 45% of staff attending training.

Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments. Staff were aware of the safeguarding policy and got appropriate consent from patients. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the provision of care and treatment.

Incidents

- Staff were confident about reporting incidents, near misses and poor practice via the electronic incident reporting system for issues such as abuse from patients, patients who had absconded and for medication errors.
- Data showed there were 168 incidents reported in the accident and emergency (A&E) department from 1 May 2014 to 12 October 2014. The majority of these were rated as being low risk.
- We reviewed a number of these incidents and found action had been taken, where appropriate, to prevent reoccurrence. In one instance, a patient had not received an appropriate screening test for MRSA, and all staff were reminded about the MRSA policy and the A&E coordinators were checking patients had been screened appropriately before they were discharged.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of investigations of incidents to prevent reoccurrence. We saw that all members of the multidisciplinary team were involved in these investigations.
- When the risk from an incident was rated as high, it had been added to the divisional risk register that was being routinely reviewed. A number of incidents relating to poor patient flow out of the department had been raised and the risk had been added to the A&E risk register.
- Learning from incidents was shared across the department via noticeboards, newsletters and safety huddles at handovers.

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Cleanliness, infection control and hygiene

- The emergency department and the observation ward were both clean, well maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as:
 - Staff following hand hygiene and 'bare below the elbow' guidance.
 - Staff wearing personal protective equipment, such as gloves and aprons, while delivering care.
 - Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
 - Cleaning schedules in place and displayed throughout the ward areas.
 - Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
 - Hand washing facilities and hand gel were available throughout the department, but we didn't see staff using these facilities after every patient contact.
- Data showed that healthcare-associated infections with MRSA and *Clostridium difficile* (*C. difficile*) rates for the trust were within expected limits. There were no cases of *C. difficile* attributed to the A&E department from October 2013 to September 2014.
- The electronic patient administration system made a note and tracked all patients with any infectious conditions so staff could be alerted.
- The policy was to screen for MRSA all patients admitted to a ward area from A&E. With the observation ward patients being discounted, emergency admission screening for MRSA was 92.5% in September 2014. A total of 46 patients weren't screened before being admitted. The performance report stated that the infection prevention and control team checked all missed patients.
- The A&E dashboard showed the department met the trust compliance criteria for the matrons checklist for the environment and infection control as well as for the hand hygiene and commode cleanliness audits.

Environment and equipment

- The emergency department including the observation ward was well maintained, safe and secure. The adult A&E department was built to treat between 130 and 150 patients daily and was mostly able to accommodate the number of patients who attended.

- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality. However, we noted the environment in the triage area was not always private and patient conversations could be overheard.
- The route for patients was streamlined and well laid out. The emergency department was set up so patients deemed to be at high risk from such events as falls were visible from the nursing stations for continual observation and quick intervention if required.
- The x-ray service was situated close to the department for easy access.
- A secure room was available to assess patients with mental health problems. This room complied with Section 136 requirements (a designated place of safety) under the Mental Health Act (1983).
- Staff were aware of alerts that had been issued by the National Patient Safety Agency (NPSA) and warnings had been shared with staff such as potential equipment sabotage.
- The resuscitation room had four cubicles designated for trauma that were all well equipped for adults, and one was set up with additional equipment for paediatrics.
- Equipment was in place for specific procedures that may only be carried out several times a year. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Equipment was mostly checked and decontaminated regularly with checklists in place for daily, weekly and monthly monitoring of equipment such as the resuscitation trolleys.
- However, we found several items of equipment that had no record of being serviced or calibrated and the service date shown on the label was overdue on some equipment such as ventilators and blood pressure measuring devices since 2012. We also noted that the fridges used to store medication had not been serviced or double checked by the pharmacy department since 2012. There was no lead for the service and maintenance of the equipment in the department.

Medicines

- Policies were available for managing medication, and posters were displayed reminding staff to check protocols if changes were made to regular medication.

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- Medication was safely stored with an audit trail of who had accessed it. When issuing medication, staff adjusted stock levels, and the pharmacy department was responsible for maintaining minimum stock levels.
- Medicines throughout the emergency department were stored correctly and safely in locked cupboards or fridges, and temperatures were recorded where necessary.
- We checked the storage and balance of controlled drugs in the observation ward and in the A&E areas. We found the controlled drugs register in the observation ward had been signed by two staff members when drugs were dispensed and the amount wasted was recorded. However, we noted 19 separate occasions in the previous month where two members of staff had not always checked controlled drugs such as morphine sulphate during dispensing or as part of the daily stock check in the resuscitation area. We also found some medication that was out of date.

Records

- The emergency department had developed its own patient clinical assessment record that included patients' personal details, previous admissions, alerts for allergies, patients' weight, observations charts and national early warning scores and triggers for coma with a flowchart for easy understanding.
- Patient records were kept securely, were easy to locate, and we could easily obtain any notes we required when conducting our patient record reviews.
- We looked at 12 sets of notes across the A&E department including the observation ward. We were able to follow and track patient care and treatment easily. Observations were well recorded; the timing of such was dependent on the intensity of treatment needed by the patient.

Safeguarding

- Policies were in place that outlined the trust's position on safeguarding vulnerable adults and children. Staff received mandatory training in these policies.
- A safeguarding link nurse worked with specific teams to ensure patients were not at increased risk of neglect or abuse.
- Staff confirmed they were aware of the services offered and knew whom to contact.

Mandatory training

- Staff received mandatory training in areas such as infection prevention and control, moving and handling, safeguarding children and vulnerable adults, and investigating incidents.
- Staff in urgent and emergency care also received training in areas applicable to their role such as medicines management, resuscitation training such as advanced paediatric life support (APLS), trauma nursing core course (TNCC), advanced and immediate and paediatric life support (ALS, ILS and PILS).
- The trust target was to have 90% of staff having received mandatory training. Trust data, as of October 2014, showed that compliance with the target was poor in many areas. Only 10% of medical and dental staff had completed basic clinical resuscitation training, whereas around 75% of the nursing staff had completed this training.
- Compliance with training in the safeguarding of adults was also poor among the medical and dental staff with only 45% of staff attending training. Nurses in the A&E department were around 80% compliant, and 100% of staff in the observation ward had attended the training.
- The performance dashboards showed that compliance with achieving the mandatory targets had been poor over the previous 12 months.
- There was no lead for education within the department and staff were responsible for maintaining their own training, which meant that training could be missed.

Assessing and responding to patient risk

- Patients either presented to the emergency department themselves or were brought in by an ambulance. All patients were booked in by staff who asked routine questions to determine the nature of the ailment, and a triage was performed using the Manchester Triage System.
- All minor injuries (self-referral) patients were streamed and assessed immediately to check the severity of their ailment.
- A qualified senior sister or an experienced band 5 nurse performed screening and triage of patients depending on the severity of their ailment. Patients were then streamed to the appropriate route (the minor or major injuries departments, or the observation ward).
- If there were no cubicles in the A&E area or if there was a long wait, the nurses in triage would carry out initial

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observations and request initial blood tests and x-rays so patients were not delayed, and results were available when they were reviewed by a consultant for a more efficient diagnosis.

- Upon admission, patients at high risk were placed on care pathways to ensure they received the right level of care. An early warning tool was included in the patient record with clear directions for escalation printed on the reverse of the observation charts.
- Staff were aware of the appropriate actions to take if patients deteriorated acutely.
- We reviewed completed charts and saw that staff had escalated correctly, and repeated observations within the necessary periods.
- An A&E consultant performed a ward round daily in the observation ward and any patients who were not being treated as part of the A&E pathways were seen by their own specialty consultants.
- Staff knew how to escalate in response to key risks that could affect patient safety, such as staffing and bed capacity issues. There was an escalation and bed management policy in place with daily involvement of matrons and senior staff to address these risks.
- Patients 16 years and younger were triaged by the triage nurse who asks for a medical review if required before being referred to the children's A&E department at Ormskirk District General Hospital. The clinical director told us children were not treated at Southport Hospital because they did not want to set a precedent for all children to be treated here.
- Figures showed that 67 children (age on arrival of 16 years or under) were transferred from Southport Hospital to Ormskirk Hospital between April 2014 and October 2014.

Nursing staffing

- Nursing staff of differing grades were assigned to each of the patient areas in the department.
- The numbers of nursing staff during the inspection were adequate for the flow of patients we observed, but if the department had a surge of patients, particularly in the resuscitation area, then these numbers did not have the flexibility to cope.
- The nursing establishment was based on a recognised staffing assessment tool based on the Royal College of Nursing (RCN) recommendations. The tool had

identified shortfalls in nursing staffing, but the staff felt this should be reviewed again as they felt the allocation of nursing staffing had historically been low in the department.

- The observation ward had been assessed with the RCN tool, which showed 9.8 full time nurses and five healthcare assistants were required in various shift patterns over the week to manage the ward. Eight nurses were currently employed and one had been recently recruited. The RCN tool had been reused and showed that a further 0.51 registered nurses were required for the night duty.
- The shift patterns showed there were always two nurses and one healthcare assistant assigned to the observation ward. However, staff were routinely moved from the observation ward to assist other areas when demand increased, which could leave them short staffed.
- During the night-time shifts the minor injuries area was closed and the department operated from the major injuries area so staff were consolidated.
- Staff felt the morale was low and there was low staff retention due to the pressures in the department at peak times. A large number of staff informed us they were struggling to take time out for refreshments and were routinely missing breaks.
- Before the inspection, we contacted the RCN, who identified concerns in relation to the high use of agency staff, high rates of staff vacancies and the skill mix, in particular the high use of band 5 nurses.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or agency nurses to provide cover at short notice. Where agency staff were used, the organisation carried out checks to ensure they had the right level of training in delivering emergency care. The dashboard showed that on average around £20,000 was spent on bank or agency staff each month for the previous 6 months.
- Issues also arose during the night shift when the nursing staff were called away from the A&E department to assist in other duties. Staff told us that healthcare assistants in the A&E would help with putting dressings on patients and with some minor ailments. However, during busy times they were moved to other wards which meant the nursing staff had to carry out these additional tasks.
- We saw a number of incidents related to inadequate staffing within the A&E department where no additional

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cover was available when needed. Although this hadn't resulted in any known patient harm, staff felt the staffing was unsafe and that it had caused a build-up of patients in the waiting areas.

Medical staffing

- The proportion of consultants was at 17% of the total medical staffing in the A&E and registrars was at 22% which was lower than the England average of the proportion of consultants at 23% and registrars at 39% respectively. The ratio of middle career doctors (for example, senior house officers) at 30% was above the England average of 13%, as was the ratio of junior doctors at 30% compared with the England average of 25% working in the A&E.
- The skills mix of the medical staffing meant there were more junior and middle grade staff and fewer senior staff, which could cause delays in confirming decisions about patient care.
- All staff worked various shifts over a 24-hour period to cover rotas and to be on call during out of hours and weekends. The department had funding for six consultants but only four were in full time posts.
- The staffing comprised one middle grade staff member from 8am to 4pm and another from 2pm to 10pm, three senior house officers with various shifts from 8am to midnight, and consultant cover from 8am to 10pm.
- The night time staffing comprised two senior house officers, and a consultant on call from 10pm to 8am, with an additional doctor and senior house officer from the day shift who finished at midnight.
- It was proving difficult to recruit medical staff, so existing vacancies were covered by locum, bank or agency staff when required. Currently the nights and weekends were covered by locums as these were busy periods.
- Staff told us that there were generally sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care. However, when the department was busy, the staff felt the impact.

Handovers

- We observed handovers of patients from the ambulance to the hospital staff. These were discreet, dignified and efficient.

- Each area in the A&E department such as triage, minor and major injuries had their own handover huddles that took place a number of times throughout the day. A full departmental safety huddle was also held during shift changes.
- Professionals such as nursing and medical staff attended and the mental health and alcohol liaison teams would attend if required. Topics discussed included patient handover related issues such as clinical acuity (the intensity of care needed by patients) and medication needs as well as staffing levels, complaints and incidents.
- We observed a thorough handover of all the patients present on the observation ward, where staff discussed input from the therapy teams, medical updates and social circumstances as well as any mental health issues that may be present.
- Senior and junior staff attended to ensure they could all be aware of any risks and tasks that were allocated such as blood samples to be taken from patients.
- All the information was then logged in a communication file to ensure those staff not present could also be made aware.
- A system was in use for tracking patients before handover to the ward areas based on clinical prioritisation by the national early warning scores.

Major incident awareness and training

- There was a documented business continuity plan within the Southport and Ormskirk NHS Trust that listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in the trust's major incident plan; this contained key action cards for the A&E department with specific roles each person would take.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated or at risk from chemical, biological, radiological, nuclear defence and explosive matter. Equipment to deal with such scenarios was situated within the A&E department.
- The clinical director told us staff did not receive specific major incident safety and scene awareness training.
- There were no onsite security arrangements for the A&E department. Staff told us they had all received conflict resolution training and would dial 999 for police assistance if required. During our unannounced

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inspection, we observed a senior doctor being verbally and physically assaulted by a patient. The team contacted the police who attended and dealt with the patient.

- Staff told us having onsite security, especially during the night shifts, was vital to ensure staff safety as the police did not always respond in a timely manner.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



There was evidence of adherence to national guidance to provide evidence-based care and treatment. Patients were assessed for pain relief as they entered the emergency department. The department participated in national College of Emergency Medicine audits and there were clear action plans indicating what improvements need to be made as a result. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run 7 days a week.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided.
- A range of clinical care pathways had been developed and audited for compliance in accordance with recognised guidance on subjects such as trauma, stroke, pneumonia and fractured neck of femur.
- The patient assessment record reflected evidence-based guidance for effective risk assessment and included tools for assessing patient risks such as sepsis so that if the patient's condition deteriorated, medical staff could be alerted quickly.
- These pathways were put into action as soon the patient entered the department, which meant patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results reviewed promptly.
- Guidance was regularly disseminated at governance meetings, and the impact that it would have on practice

was discussed. Staff were encouraged to audit how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care.

Pain relief

- Patients were assessed as they entered the emergency department. A streaming process identified any patients who may need pain relief, which was given immediately via patient group direction (medication provided on an individual basis where this offers an advantage without compromising safety).
- Patient records and patients we spoke with reported that they had been offered appropriate pain relief.
- The department had participated in the national College of Emergency Medicine audit for renal colic, which assessed the expedience of pain relief. The audits showed room for improvement and actions had been taken in response, including further training.

Nutrition and hydration

- The healthcare assistant was the designated staff member on each shift responsible for offering drinks and small snacks on a 2 hourly basis, such as yoghurts and fruits, to patients waiting in the department.
- We saw patients being offered refreshments during our visit. The healthcare assistant asked nursing staff if patients could have refreshments before offering them due to the nature of their medical conditions.
- The observation ward had an electronic system to order main meals via touch screen monitors placed by each bed. Staff told us they generally assisted patients to order meals especially those people who could not use technology. Staff described one downside as not being able to cancel meals for patients who may have been discharged.
- Snack boxes, Weetabix, tea, toast and sandwiches were available for patients who were admitted out of meal times.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national College of Emergency Medicine audits so it could benchmark its practice and performance against best practice and other A&E departments. Audits included consultant sign off, vital signs and fractured neck of femur.

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- Data from the College of Emergency Medicine audits for consultant sign off (100% of discharged patients need to be at the very least discussed with a consultant) showed that only 37% of patients' diagnoses had been discussed at consultant level in 2013 and only 53% at senior doctor level. However, these figures were actually better than the England average, which was 12% of patients' diagnoses discussed at consultant level and 31% at senior doctor level.
- Data showed the trust was performing poorly in relation to the vital signs in majors (College of Emergency Medicine) audit questions. The trust compliance was 80% for "Were these vital signs measured and recoded after arrival/triage?"; 20% for "If vital signs were abnormal, were observations repeated and recorded in the notes?" and 13% for "Were appropriate investigations carried out and the results recorded in the notes before discharge?". Trust compliance was 0% for the question "Is there evidence in the notes that abnormal vital signs were communicated to the nurse in charge?". There were action plans in place, which included adding information into the patient clinical assessment record and updating observation charts and national early warning scores to improve performance against the standards.
- The National Hip Fracture audit results (October 2014) was been addressed through an action plan regarding a fast track process being in place but not being effectively used due to no rolling bed and better use of the discharge lounge; time to the orthopaedic ward (14) and the A&E pre-operative proforma not always being commenced. Time to surgery in less than 36 hours was hindered by there being no trauma list on Sundays. Bone health assessments were not always completed due to the lack of an orthogeriatrician. There were also concerns regarding length of stay, the figures had improved from August to October 2013 when the average length of stay was 19.8 days, with August to October 2014 the figure was 15.6 days.
- External audits included a trauma audit in relation to the Trauma Audit Research Network, whereby 168 patients were reviewed between 01 April 2013 and 31 March 2014. The hospital performed within expected limits in all areas.
- Unplanned re-admittance rates to A&E within 7 days from January 2013 to May 2014 were above the 5% target set by the Department of Health but were below the England average for the same timeframe.

Competent staff

- Departmental records showed that all staff had received appraisals for the year 2013 to 2014. Staff we spoke with reported they had received an appraisal within the last year. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Information provided by the trust identified that the process for 2014 to 2015 had started and was still on-going.
- Staff underwent peer appraisals using an electronic appraisal system and were overseen by their managers.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities.
- Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- We saw effective collaboration and communication among all members of the multidisciplinary team to support the planning and delivery of patient-centred care. Daily multidisciplinary team meetings, involving the medical staff, nursing staff, therapists as well as social workers and safeguarding leads, where required, ensured patients' needs were fully explored.
- Issues discussed included identification of patients' existing care needs, relevant social and family issues, mental capacity, and any support needed from other providers, such as home care support or alcohol rehabilitation.
- The hospital alcohol liaison team was staffed externally by a team of nurses, and support was available from 8am to 8pm Monday to Friday and during the safety huddles, and linked in with the discharge process. There was a specific pathway for people with alcohol withdrawal symptoms and therapies provided by hospital alcohol liaison team included linking potential patients with other professionals, educating staff and patients about alcohol misuse, and also providing drop-in sessions for patients so they could avoid re-admittance to A&E.
- The mental health liaison team provided support to patients with psychiatric issues and worked with staff in the emergency department 24 hours a day, 7 days a

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week. A consultant liaison psychiatrist and nurse practitioner could be called to see patients, usually within an hour. The team had their own pathways, management plans and confidential systems in place.

- There was evidence of good partnership working with the local ambulance service, with regular meetings between the matron and the liaison staff from the ambulance service to ensure they worked cooperatively and kept delays to a minimum.

Seven-day services

- Staff rotas showed that medical and nursing staff levels were sufficiently maintained out of hours and at weekends.
- The x-ray department was open 24 hours a day, 7 days a week. However, there was limited access to specialist investigations such as MRI and CT scans, and to a radiologist to interpret scans, between midnight and 8am. An on-call radiologist was available if needed and senior staff were able to interpret certain scans out of hours so that treatment/admission was not delayed.
- Pharmacy services were not available on site 7 days a week, but pharmacy support was available on call out of hours. During working hours, patients attending A&E who required medication were directed to the hospital pharmacy which was also open Saturday and Sunday morning. The departments held a stock of frequently used medicines such as antibiotics and painkillers, which staff could access out of hours. Stock levels were appropriate and were regularly checked to ensure the supply was adequate for peak times such as weekends and public holidays.
- Specialist nursing staff treated venous thromboembolisms from 8am to 8pm, 7 days a week (a venous thromboembolism is when a blood clot breaks loose and travels in the blood). Outside of these times the patients are treated in A&E.

Access to information

- Patients confirmed they had received information about their care and treatment in a manner they understood.
- Information on patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents.

- Staff could access information such as audit results, lessons learned from incidents, performance indicators and updates to policies via the staff room and clinical pathways, and policies and procedures were accessible on the intranet site.
- The department used a recently acquired electronic system to track when patients were admitted to the department and found the system to be cumbersome. It did not link easily with the other departments, which meant it did not show real time patient movement. We saw staff were still getting used to the system and felt it would improve over time.
- Another issue with the new system was that printers were not configured properly. This meant receptionist and nursing staff had to leave the department to collect printed items, which was not efficient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives.
- Staff were clear on how they mostly sought verbal and implied informed consent due to the nature of the patients attending the departments. Written consent was mostly sought before providing care or treatment such as anaesthetics.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults and children, the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead.
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient. Patient records showed that verbal or written consent had been obtained from patients or their representatives.

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Are urgent and emergency services caring?

Good



Staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Data showed that the department scored worse than the England average for similar departments indicating that patients would not recommend the department to their friends and family. Staff provided patients and their families with emotional support and comforted patients who were anxious.

Compassionate care

- We observed many occasions of compassionate care, including one in the observation ward whereby an elderly patient with dementia couldn't be discharged as there was no help in their home. Staff interacted with the social services to get them a home care package set up.
- The majority of patients, relatives and representatives we spoke to during the inspection were positive about the care and treatment provided.
- However, a number of patients provided negative feedback in relation to long waiting times, particularly during busy hours. Patients told us they were not always kept informed about the waiting times and felt the department could not cope when there was a large influx of patients. One patient with a minor injury informed us they had left the department without being seen by a member of staff.
- The NHS Friends and Family Test data showed that the department scored worse than the England average for similar departments, which might indicate that patients would not recommend the department to their friends however the low response between April 2013 and July 2014, means the results were not fully reliable.
- Data in the observation ward for May 2014 to September 2014 scored around 80% for patients stating they were extremely likely to recommend this ward to their friends and family.

- A review of the data from our adult inpatient survey in 2013 showed that 79% of patients felt they were given information about their condition and 89% felt they were given sufficient privacy and dignity.

Understanding and involvement of patients and those close to them

- We saw ambulance staff work with the hospital staff to ensure continuity of care by making sure all the information about patients was handed over to the staff at triage.
- Upon admission, patients were allocated a named nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed their consent had been sought before care and treatment was delivered.
- We found that relatives and patients' representatives were consulted in discussions about the planning process for discharge from the observation ward.

Emotional support

- We observed staff providing patients with emotional support, with many positive interactions such as staff providing reassurance and comfort to people who were anxious or worried.
- A relatives' room was available for people who had witnessed trauma such as road traffic accidents. There was a viewing room for deceased patients, which allowed family to spend extra time with their loved ones. Plans were in place to refurbish the rooms to make the environment more appropriate.
- A link nurse was assigned to A&E from the end of life team. This nurse had provided training to A&E staff in dealing with patients who were deteriorating and families of those who had passed away. Bereavement packs were also available in the department.
- A noticeboard and information leaflets outlined the chaplaincy services available with timings for specific prayers and services.
- Staff confirmed that debriefs were held after all traumatic events. They could access counselling services after they had assisted with a patient who had been involved in traumatic or distressing events, such as fatal road traffic accidents, or if they had had a negative experience.
- Staff told us a senior manager was available for emotional support if required, and they could take some downtime following very traumatic experiences.

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

Requires improvement



Performance to meet the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E was improving trust wide, but on its own, Southport Hospital struggled to meet the target between April 2014 and September 2014. We looked at the data that showed the highest number of breaches was in April 2014, when there were 370 breaches of which 83 were delayed 4–12 hours, and 14 were delayed 8–12 hours.

The target of 85% of ambulance handovers within 15 minutes was mostly achieved by the department. Data showed the number of handovers delayed by over 30 minutes from November 2013 to March 2014 was 298, which was low compared with all trusts for the same period.

Patient flow was a challenge in the department. During routine operating hours, the department could cope. However, when patients could not be discharged from the emergency department, this negatively affected the flow.

A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings.

Translation services were available for patients for whom English was not their first language, and the service sought feedback from patients through complaints and patient engagement.

Service planning and delivery to meet the needs of local people

- The departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, where there was significant demand for services.

- There was a responsive coordination of senior staff who arranged beds, investigations and scans for patients to ensure the service could better manage patients at busy times.
- Capacity was being constantly monitored via daily bed management and safe staffing meetings.

Meeting people's individual needs

- A variety of information leaflets were available in all areas of the emergency department and via the trust internet site. Some leaflets had been translated to Polish due to the large local Polish community. The leaflets had references to recognised guidance such as the National Institute for Health and Care Excellence (NICE).
- Staff told us they would use interpretation services via telephone or face-to-face, if English was not a patient's first language. Staff would only use relatives or family members to assist patients when it did not involve consenting to procedures.
- The department had implemented a system of applying a discreet sticker to the patients record to denote a patient who may be vulnerable and may need assistance with some tasks.
- If a patient was identified as having dementia or learning disabilities, staff could contact specific link nurses for advice and support.
- Staff had access to a passport document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's medical history and likes and dislikes, and made it easier for staff to meet patients' individual needs.
- Care plans were in place for adults with learning disabilities who regularly accessed the emergency department for reoccurring and on-going conditions. The file was conveniently located and all staff were aware of the actions to take if someone known to them attended.
- We observed the process to manage bariatric patients (patients with obesity). When a patient with obesity was being brought to the department, the ambulance staff would usually make this known in advance. Additional staff and appropriate equipment, such as a bariatric trolley, bed or chair would be provided to support the moving and handling of these patients as required.

Urgent and emergency services

Access and flow

- Patient flow was a challenge in the department. During routine operating hours, the department could cope. However, when patients could not be discharged from the emergency department, this negatively affected the flow.
- Staff felt there was a constant pressure to move patients through the department to meet targets.
- The trust had done extensive work to investigate why the 4-hour waiting target was sometimes exceeded.
- Factors contributing to poor performance included bed capacity within the hospital, which had been above the England average of 85% between April 2013 and July 2014.
- Despite access to social workers on the observation ward, having no designated social worker meant patients waiting further input such as a care home assessment.
- The hospital had a clear escalation policy that described the steps staff would take when demand caused pressure on capacity. Staff were familiar with this policy and were clear about the importance of the whole hospital, and other agencies, working together.
- Overall, the trust met the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E by achieving 97% from April 2014 to September 2014.
- The Department of Health data are a combination of Southport Hospital and Ormskirk Hospital. Data for the Southport Hospital adults A&E showed that the department struggled to meet the target between April 2014 and September 2014, where the range was from 90.5% compliance in April 2014 to 94.6% in July 2014.
- All individual breaches were investigated and categorised by why they occurred. We looked at the data that showed the highest number of breaches was in April 2014, when there were 370 breaches of which 83 were delayed 4–12 hours, and 14 were delayed 8–12 hours.
- Data showed that from 15 September 2014 to 13 November 2014 the adults A&E department saw 135 patients daily on average.
- Total time in A&E (average per patient) from January 2013 to May 2014 was below the England average.
- The number of attendances to the emergency department also varied with the department: there were 3905 patients in April, 3935 patients in May, 3910 patients in June, 4266 patients in July, 4140 patients in August and 3951 patients in September.
- Data were also collated on patients leaving the department without being seen, and showed that the rate of this was below the England average from January 2013 to May 2014 and always below the upper target of 5% set by the DH.
- The target of 85% of ambulance handovers within 15 minutes was mostly achieved by the department. Data showed the number of handovers delayed by over 30 minutes from November 2013 to March 2014 was 298, which was low compared with all trusts for the same period.
- The clinical director for the emergency department told us any ambulance that waited for over 60 minutes was automatically raised as an incident and a root-cause analysis investigation was undertaken.
- The percentage of emergency admissions via A&E for which the time between the decision to admit and being admitted was between 4 and 12 hours was below the England average.
- Referral to treatment times were below the England average for similar trusts.

Learning from complaints and concerns

- Information was displayed in the department about how patients and their representatives could complain.
- Complaints were recorded on a centralised trust-wide system. The centralised customer services team managed formal complaints. A complaints review panel was held to discuss more serious complaints.
- Staff understood the process for receiving and handling complaints. They told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.
- Noticeboards included information such as the number of complaints and compliments received. For September 2014 three complaints had been received in the A&E department and one in the observation ward.
- The emergency department had received 35 complaints over the previous year. We looked at three of these, and found staff had followed the correct process and timescales.

Urgent and emergency services

Are urgent and emergency services well-led?

Good



The organisation's vision and strategy had been cascaded to all staff, who were proud of the work they did. The overall ethos centred around the quality of care patients received, and meeting targets was secondary. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties. The emergency department faced challenges such as patient flow and local changing needs, such as an increased elderly population, and had initiatives in place to tackle these.

Vision and strategy for this service

- The trust values, **'to be supportive, caring, open and honest, professional and efficient (SCOPE)'**, were visible across the emergency department. The trust's core objectives were patient safety, care and clinical effectiveness.
- Staff had a corporate induction that included the trust's core values and objectives and had a clear understanding of what these involved.

Governance, risk management and quality measurement

- Senior staff were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators.
- The divisional risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and executive levels.
- Risks were rated from low to high, with the lower risks being managed at ward level and the higher risks being escalated corporately.
- The clinical director told us the departments' biggest risk was not being able to recruit medical staff, which impacted on the skill mix. The second risk was patient flow during busy times. We looked at the divisional risk register and saw these and other key risks had been identified and assessed.

- Day-to-day issues, information about complaints, incidents and audit results were shared on notice boards around the department and via meetings and safety huddles.
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles in department. The departments were well led locally by the senior staff on the wards, the clinical leads and the matrons.
- Senior staff in the department provided visible leadership, particularly at times when the department was stretched.
- The teams were motivated and worked well together, with good communication between all grades of staff.
- Staff felt their efforts were acknowledged and felt managers listened and reacted to their needs.
- Staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in supporting the effective running of the service.

Culture within the service

- The clinical director, and staff in the emergency department, told us the overall ethos was centred around the quality of care patients received, and meeting targets was secondary.
- We observed that staff from all specialties worked well together and had mutual respect for each other's specialties.
- Staff told us they were encouraged to report any issues in relation to patient care or any adverse incidents that occurred.
- Overall, staff spoke of an open culture where they could raise concerns that would be acted upon. They were dedicated and compassionate and felt proud to work at the hospital. However, we spoke with some junior medical staff who felt bullied by senior staff.
- Staff told us the morale within the department was mostly good and the teams worked well together. However, at times, when the department reached high patient capacity, staff felt that the morale dropped.

Urgent and emergency services

Public and staff engagement







- Information on how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also available on the internet site.
- Staff told us they routinely asked patients and relatives for their feedback.
- Information on the number of compliments and complaints received in the department was displayed on notice boards in the observation ward and in the A&E area.
- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and departmental meetings. Staff told us they were made aware when new policies were issued.
- The autumn/winter 2014 newsletter included feedback from the public and staff, and relayed information about events and strategies taking place. Positive feedback about the latest A&E target for spring being met was also included.
- Staff had completed the NHS survey. The trust's results for overall staff engagement were in the lowest (worst) 20%. Out of the 28 key factors the trust was below average/worst 20% for 10 factors, average for 8 and 10 were above average. The trust was above (better than) average for support from immediate managers(KF9), average for feeling satisfied with the quality of work and patient care they able to deliver (KF1), below (better than) average for experiencing harassment bullying or abuse from staff in the last 12 months(KF19).

- The adults inpatient survey 2013 scored the trust as being average for the questions:
 - While you were in the A&E department, how much information about your condition or treatment was given to you?
 - Were you given enough privacy when being examined or treated in the A&E department?
- The department included 'What are you saying' information on notice boards, which listed improvements made by the trust in response to queries raised by patients.

Innovation, improvement and sustainability

- The clinical director told us the main challenge was the flow of patients out of the emergency department and the recruitment of medical and nursing staff.
- A number of initiatives were in place to reduce patient flow and admission. These included patients being triaged and streamed from A&E using ambulatory emergency care such as the observation ward to directly discharge patients on the same day without hospital admission.
- The department was looking to work with other wards in a more proactive manner and to rotate staff from other wards into the A&E department to allow them to appreciate the pressures and gain an understanding of emergency medicine.

Medical care (including older people's care)

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

Information about the service

The acute medical care services at Southport and Formby District General Hospital provided care and treatment for a wide range of medical conditions. We visited wards 7a, 7b, 9a, 9b, 10a, 10b, 11b, 14b and the medical oncology unit over the course of our inspection. The acute stroke unit was located within ward 9a. The discharge lounge was closed during our visit.

We observed care, looked at records for 15 people and spoke with 17 patients, eight relatives and 33 staff across all disciplines.

We also visited the coronary care unit, where we observed care and treatment and reviewed a sample of care records. We talked with two patients and six members of the nursing and medical staff.

Summary of findings

Medical care services were delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect. Shortages of nursing staff, combined with insufficient storage for equipment and on-going issues with the prevention and control of infection meant that services within the medical directorate were not being delivered safely.

Improvements were needed in the management of stroke. Timely access to computer passwords for newly appointed medical staff, including locum doctors, was required. The flow of medical patients throughout the hospital was disorganised and medical staff had no formal process by which to locate their patients.

Despite this being an integrated trust there were few examples of integration between community and acute services. Although there was often good communication and co-operation, the community and acute services were usually managed and operated separately. This did not provide a seamless or holistic service for patients, particularly those with chronic health conditions that required frequent hospital admissions. We noted that 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.

Medical care (including older people's care)

Generally the individual wards/departments were well-led, although there was a disconnection between the staff providing hands-on care and the executive team. The system in place to communicate risks and changes in practice to nursing staff required improvement.

Are medical care services safe?

Requires improvement



Levels of medical staffing were satisfactory but doctors told us there was a significant safety issue with the doctor to doctor handover of patients. Written handover information was produced after admission which was not always completed before the patient was moved and there was no process in place for a verbal doctor to doctor handover. Nurse staffing levels on some wards were below established numbers, meaning that high levels of bank and agency staff were necessary to provide safe and effective care for patients.

Performance in infection prevention and control was monitored monthly across the medical directorate, but patients with diarrhoea were not always isolated before confirmation of a diagnosis and there were not enough clinical waste bins on some wards.

Storage for equipment was limited. This meant that corridors and bays in the wards were cluttered with equipment, making it difficult for staff and patients to move freely around the wards. Storage was particularly poor on ward 9a, where we observed one hoist blocking an emergency exit door when it was not in use.

Staff were confident in reporting incidents but did not always receive feedback, and although lessons learned were shared via various routes, the staff did not recognise the feedback.

Incidents

- There were robust systems for reporting incidents and 'near misses' across the medical directorate. Staff were confident in reporting incidents and 'near misses', and were supported by managers to do so.
- Several staff told us that incidents were under reported, particularly when wards were understaffed, as they didn't feel that any action would be taken.
- Unless staff were involved in an incident, they did not routinely receive feedback and lessons learned from incidents were not widely shared.

Medical care (including older people's care)

- Mortality and morbidity meetings were held regularly and were usually attended by ward managers. These meetings discussed any deaths that had occurred within the medical directorate and any learning from the deaths.

Safety thermometer

- The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure harm such as falls, blood clots, pressure ulcers, and urinary and catheter infections. Staff within the medical directorate were managing these risks and displayed information on the ward notice boards.

Cleanliness, infection control and hygiene

- Performance in infection prevention and control was monitored monthly across the medical directorate.
- Specific infection control issues were discussed during the ward safety huddles and at handover meetings. Staff could describe some of the actions taken to improve infection control performance.
- Clostridium difficile (C.difficile) rates had been above the England average since August 2013 and consistently high within the medical directorate. There had been an outbreak of C. difficile on ward 7a during August 2014. Despite this, the infection control audit for September 2014 identified that staff on 7a continued to fail to isolate patients with diarrhoea until laboratory investigations confirmed a diagnosis.
- There was an ample supply of hand washing facilities and liquid soap and hand towel dispensers were adequately stocked. Alcohol hand gel was available throughout the medical directorate and good hand hygiene was observed throughout our visits.
- Staff observed 'bare below the elbow' guidance and wore personal protective equipment, such as gloves and aprons, while delivering care.
- The trust housekeeping cleaning schedule required ward floors to be mopped daily. Domestic staff we spoke with informed us that this was not always possible as the mop heads were frequently unavailable.

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

equipment, making it difficult for staff and patients to move freely around the wards. Storage was particularly poor on ward 9a, where we observed one hoist blocking an emergency exit door when it was not in use.

- Lockers and changing facilities for staff were very limited. On three wards we observed that staff used a set of very small lockers situated within the main ward corridor. Staff had to cram outdoor clothing and footwear into the lockers and were unable to change out of their uniforms at the end of a shift as there was nowhere to store any additional clothing. This was an infection risk to patients and the families of staff who travelled home in their uniforms.
- Doctors told us they often experienced delays in accessing equipment to undertake procedures. An example was given of an hour to locate equipment for a lumbar puncture. One doctor commented, "Often getting the equipment takes longer than the procedure itself".
- 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.
- Multi-disciplinary board rounds on the frail elderly short stay unit were held on the emergency department as there was no private space to hold them within the unit.
- Emergency equipment was checked daily and was ready for use if required.

Medicines

- Medicines were stored correctly, including the safe storage of controlled drugs.
- During our inspection we reviewed nine medicine charts and found them to be well completed.
- Patients with medication allergies should have been given red wrist bands to indicate this. Four medicine charts we reviewed contained details of allergies but these patients had not been given red wristbands.
- There was a reluctance by the ward pharmacists to record minor medicines errors on the incident reporting system and pharmacists told us they tended to "sort it out" themselves. This meant that there was no record of minor medicines errors and therefore no way to improve by learning from these minor incidents.

Medical care (including older people's care)

Records

- During our inspection we reviewed 15 sets of patient records. In all 15, documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patients' care and treatment.

Safeguarding

- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities for the safeguarding of both children and vulnerable adults.
- Staff were aware of how to make a referral if they had any safeguarding concerns.

Mandatory training

- Levels of compliance with mandatory training varied throughout the medical directorate and between clinicians.
- Compliance with mandatory training for allied health professionals across the medical directorate was very good, showing compliance rates well above the trust target of 90%.
- Compliance with mandatory training was poor for medical staff. With the exception of safeguarding, all the compliance rates were below the trust target of 90%, with some, such as fire safety, as low as 24%.
- Compliance with mandatory training for nurses was variable, depending on the ward, but many had achieved the trust mandatory training compliance rates of 90% in most areas. Ward managers informed us that there had been a reduction in compliance rates since nursing staff had been given responsibility for managing their own training. Some managers had taken back the management of mandatory training on behalf of the staff and compliance rates had improved considerably on these wards.

Assessing and responding to patient risk

- Staff within the medical directorate used the national early warning score, which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and steps had been taken to ensure staff understood how to use it.

- Staff we spoke with told us how they accessed specialist medical help both within and outside of normal working hours.
- Staff on one medical ward were piloting the use of an electronic early warning tool which automatically notified an appropriate healthcare professional if a patient's condition deteriorated beyond set parameters. This tool was easy to use, popular with nursing staff and worked well. Subject to a favourable evaluation and the necessary funding, it is anticipated that the tool would be rolled out across the medical directorate.

Nursing staffing

- Nursing staffing levels had been reviewed throughout the trust earlier in 2014 and were assessed using a validated acuity tool. There were minimum staffing levels set for wards throughout the medical directorate. Staffing levels required and actual staffing numbers were displayed on every ward we visited.
- There were high nurse vacancy rates on some wards, with further vacancies anticipated in the near future. Ward 7b had eight whole time equivalent vacancies for trained nurses and ward 11b had six whole time equivalent vacancies. Shifts were filled with regular bank and agency staff, where possible, but copies of duty rotas we reviewed indicated that the skill mix was poor if a trained nurse was not available and was substituted by a healthcare assistant. We also noted that on 7b there had been several nights during the last month where only one permanent member of staff had been on duty with three bank and agency staff.
- The skills and experience of temporary staff differed and it was not always possible to provide care from the same staff. This had an impact on the continuity of care provided.
- We spoke with three agency nursing staff during our unannounced inspection. All had received an induction and orientation onto the ward in which they were working and had signed a pro forma as a record of their induction to the ward.
- Nursing handovers took place at the start of each shift on all the medical wards. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were detailed and staff on duty were familiar with the needs of patients under their care.

Medical care (including older people's care)

Medical staffing

- There were several long-standing consultant vacancies within the medical directorate that the trust had had difficulties recruiting into.
- There was a consultant presence on site between 8am and 7pm on weekdays. However, there was no routine consultant presence on the general medical wards at weekends.
- During weekends there was a consultant on site who worked predominantly with patients on the assessment and short stay units, but there was no routine consultant presence on the medical wards at weekends.
- Three cardiologists covered the coronary care unit during the week but provided on call cover only at weekends.
- Junior medical staff we spoke with all told us they felt well supported in their roles by senior medical staff, and that they did not feel their workload was excessive.
- Comprehensive medical handovers for the hospital took place twice daily and were consultant led. We observed two handovers and found them to be very organised and well co-ordinated.
- Doctors we spoke with told us there was a significant safety issue with the doctor to doctor handover of patients. Written handover information was produced after admission which was not always completed before the patient was moved and there was no process in place for a verbal doctor to doctor handover.

Major incident awareness and training

- Plans were in place to deal with the additional pressures on beds and staffing during the winter. The effectiveness of these plans was reviewed regularly in line with changing demands on the service.

Are medical care services effective?

Requires improvement



National guidelines were used to treat patients, however outcomes for patients experiencing a stroke were in the next to worst category nationally. We observed care during a lunchtime meal on the stroke unit in a formal way using the Short Observational Framework for Inspection. We observed that there were insufficient staff to help everyone who needed assistance with eating and drinking. Staff

rushed patients to finish their meals and one person waited 50 minutes to be given their meal, which was not re-heated. A red lid system was used for water jugs to indicate those patients who needed assistance with drinking. We observed domestic staff changing water jugs without noting which patient needed a red lid. One member of the domestic staff told us they re-allocated the red lids to patients with catheters as they were not given any information about which patients needed assistance with drinking.

Patient care and treatment was delivered by a multi-disciplinary care team but seven day working was not in place throughout the medical directorate. Medical staff were sharing passwords in breach of data protection regulations.

Delays in re-siting of cannulas outside of normal working hours to administer intravenous fluids, was highlighted as a problem by pharmacists and also by patients at the listening event. Nursing staff informed us that training to enable them to undertake this procedure was difficult to access.

Evidence-based care and treatment

- The medical directorate used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with these and were updated periodically.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with dementia and stroke.
- The medical directorate undertook individual local audits and directorate wide audits. The infection prevention and control audit was particularly comprehensive and well managed. This audit looked at many aspects of the prevention and control of infection including hand hygiene and the cleanliness of commodes. A monthly report was produced and actions taken to address any issues identified within the audits.

Pain relief

- Patients we spoke with told us they received timely and effective pain relief.

Medical care (including older people's care)

Nutrition and hydration

- Appropriate nutritional assessments were done and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.
- Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assistance was given to those patients who needed help.
- We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking.
- We observed care during a lunchtime meal on the stroke unit in a formal way using the Short Observational Framework for Inspection. We observed that there were insufficient staff to help everyone who needed assistance with eating and drinking. Staff rushed patients to finish their meals and one person waited 50 minutes to be given their meal, which was not re-heated.
- A red lid system was used for water jugs to indicate those patients who needed assistance with drinking. We observed domestic staff changing water jugs without noting which patient needed a red lid. One member of the domestic staff told us they re-allocated the red lids to patients with catheters as they were not given any information about which patients needed assistance with drinking.

Patient outcomes

- An analysis of data submitted by the trust for April to June 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) placed the hospital in the next to worst category of trusts nationally for the effective management of stroke. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. However, it should be recognised that the data relating to the management of stroke by allied health professionals was in the next to best category.
- An action plan had been produced to improve the management of stroke.

- The trust has consistently been a mortality outlier for acute cerebrovascular disease since April 2012.
- The Summary Hospital-Level Mortality Indicator (SHMI) data from October 2014 shows that standardised rates of death were higher than expected, compared with other trusts.
- An analysis of the National Diabetes Inpatient Audit 2013 showed 11 of 20 measures were better than the England average, however four of these measures were based on a very small sample size of patients and therefore should not be regarded as reliable.
- The Heart Failure Audit 2012/3 showed that the trust performed as well as or better than most trusts in England and Wales for almost every category.
- The trust could only submit limited data to the Myocardial Ischaemia National Audit Project as many of the high risk patients were treated at a local specialists trust. The data submitted by the trust demonstrated that two of the indicators were better than the England average and one was worse.
- The re-admission rates for the medical directorate were better than the England average at this hospital.

Competent staff

- Seventy four per cent of staff across the trust had received an appraisal within the last year. The 2013 NHS staff survey showed that the trust was in the worst 20% nationally for staff reporting that their appraisal was well structured.
- The General Medical Council's decisions on revalidation of doctors at this trust was in line with other trusts throughout England.

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, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- We saw that teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. Multidisciplinary team decisions were recorded and care and treatment plans were amended to include changes.
- There were good links with the community diabetes service. This meant there was effective support diabetics discharged into the community.

Medical care (including older people's care)

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 doctor at weekends.
- There was no routine service provided by allied health professionals out of normal working hours.
- There was a dispensing pharmacy service provided on Saturday and Sunday mornings and adequate out of hours and on-call pharmacy support.
- Delays in re-siting of cannulas outside of normal working hours to administer intravenous fluids, was highlighted as a problem by pharmacists and also by patients at the listening event. Nursing staff informed us that training to enable them to undertake this procedure was difficult to access.
- Diagnostic services, such as x-rays and ultrasound were available outside of normal working hours.

Access to information

- Staff from the information technology department were slow to issue access to the trust information system. We spoke with two locum doctors and one consultant who had all been employed within the medical directorate during the last month. Despite numerous contacts with the information technology team, they had all waited between 3 and 5 days for access to the hospital information system. This would affect access to patient information and may have caused delays in treatment although none were evidenced.
- In order to be able to work effectively, these doctors had all used other doctors' passwords in order to access the electronic system. This breached data protection regulations.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of patients who did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately and the deprivation of liberty safeguards were applied, when necessary.

Are medical care services caring?

Good



Medical services were delivered by hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

However, the named nurse system which was in place throughout the medical directorate identified the ward manager as the named nurse for every patient on each of the wards we visited rather than the nurse directly responsible for providing their care. Patients and their families told us they did not find this useful.

Compassionate care

- We found that care and treatment throughout the medical directorate was delivered by a hardworking, caring and compassionate staff.
- We spoke with 15 patients and 5 relatives who all spoke very positively about the care that they, or their family member, had received. Some comments made were, "I have been very impressed with the quality of care" and "The staff are very caring and supportive".
- We also saw examples of ways in which people were encouraged to share their impression of the hospital and ways in which improvements could be made
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Of the patients who responded to the Friends and Family Test within the medical directorate in the six months before the inspection, the majority of patients would recommend the trust for care, with between 80% and 92% reporting they would be likely or extremely likely to recommend the trust. Between April 2014 and September 2014 an average of 70% of patients said they would be extremely likely to recommend the service.

Understanding and involvement of patients and those close to them

- Staff planned and delivered care in a way that took into account the wishes of patients. Patients we spoke with told us they felt involved in their care and treatment and staff explained the benefits and risks of any care and treatment they provided.

Medical care (including older people's care)

- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.
- We saw staff obtaining verbal consent when helping patients with personal care.
- A named nurse system was in place throughout the medical directorate. The ward manager was the named nurse for every patient on each of the wards we visited rather than the nurse directly responsible for providing their care. Patients and their families told us they did not find this useful.

Emotional support

- Although patients told us that they felt staff were caring, pressures caused by reduced staffing on some wards affected the ability of staff to consistently offer emotional support to patients.
- The use of specialist teams, such as the alcohol misuse liaison team, enabled patients to access appropriate emotional support relevant to their medical conditions.

Are medical care services responsive?

Requires improvement



There were frequently more medical patients than available beds on medical wards within the hospital. This was managed by using beds on surgical wards and the planned investigations unit for medical patients and re-designating the discharge lounge as a temporary ward area. The flow of medical patients throughout the hospital was disorganised and medical staff had no formal process by which to locate their patients.

Despite this being an integrated trust there were few examples of integration between community and acute services. Although there was often good communication and co-operation, the community and acute services were usually managed and operated separately. This did not provide a seamless or holistic service for patients, particularly those with chronic health conditions that required frequent hospital admissions.

Telemedicine (the remote diagnosis and treatment of patients by means of telecommunications technology) was used very effectively for stroke patients outside of normal working hours.

There was limited evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- Telemedicine was used very effectively 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.
- Although this was an integrated trust there were few examples of integration between community and acute services. Although there was often good communication and co-operation, the community and acute services were usually managed and operated separately. This did not provide a seamless or holistic service for patients, particularly those with chronic health conditions that required frequent hospital admissions.

Access and flow

- There were frequently more medical patients than available beds on medical wards within the hospital. This was managed by using beds on surgical wards and the planned investigations unit for medical patients and re-designating the discharge lounge as a temporary ward area.
- One discharge coordinator we spoke with told us they were not always told when the discharge lounge was re-opened and therefore did not routinely use it when it was available.
- The flow of medical patients throughout the hospital was disorganised and we saw examples of patients who had been moved three times during their hospital stay. We saw an example of two surgical patients being cared for on the stroke unit while there were available beds on the surgical wards which had been filled with medical patients. This increased the risk of infection to the surgical patients.
- The bed managers kept a record of patients who were particularly vulnerable, such as those with dementia, and told us they would not move these patients unless there was a clinical reason to do so.
- There was no formal process in place to inform junior doctors treating medical patients outlying on other wards where these patients could be found if they had been moved following admission. This meant that doctors had to ring around to locate the patients or they would be unaware of the patient until nursing staff contacted them when the patient had not been seen by a doctor.

Medical care (including older people's care)

- The proportion of patients who had a recorded expected date of discharge was 60% for planned care and 66% for urgent care in August 2014, which is the lowest since February 2014. The trust target was 90%. Setting an estimated date of discharge and working towards this is an important part of the discharge planning process.

Meeting people's individual needs

- There was a system in place throughout the medical directorate to ensure that all staff were aware if a patient has dementia. This was achieved using a series of 'helping hand' stickers on patient identification bands, care plans and on the boards at the back of patients' beds. All staff we spoke with were aware of the meaning of the helping hands stickers.
- We saw the dementia passport used on several of the wards in the medical directorate, and witnessed a specialist nurse completing appropriate documentation for a patient with dementia during our visit.
- For patients whose first language was not English, staff could access a language interpreter if needed. British Sign Language interpreters were available for deaf people.
- The trust had audited how the needs of people with a learning disability were addressed during their hospital stay. An action plan had been produced to address the issues highlighted in the audit and progress had been made to improve the in-patient experience for this patient group.
- 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.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would explain to patients how to contact the customer services team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- There was information displayed throughout the medical wards on how to complain. We spoke with patients and relatives who knew how to raise concerns, make complaints and provide comments, should they wish to do so.

- There was very limited evidence of learning from complaints. Most of the examples of changes made in response to complaints described in the complaints report we reviewed from July 2014 were simply reminders to clinical staff about basic care. Examples of this were. "Staff to ensure that free flowing IV fluids are checked regularly to ensure they are running" and "Doctors to communicate treatment and diagnosis clearly".

Are medical care services well-led?

Requires improvement



The trust had a vision and strategy for the organisation, with clear aims and objectives which had been cascaded to the medical wards. Risks within the medical directorate were discussed regularly but 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.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives which had been cascaded to the medical wards. Most staff we spoke with had some awareness of these, particularly the trust values, although awareness by the medical staff was lower than that of other clinicians.
- The trust chief executive assured us prior to the visit that all staff were aware of the professional standards introduced throughout the trust. None of the staff we asked within medical directorate could tell us what the professional standards were and many confused them with trust values.

Governance, risk management and quality measurement

- Risks within the medical directorate were discussed regularly at both ward and divisional level and escalated where necessary.
- The medical directorate had a quality dashboard for each service and ward area. This showed performance against targets and these were presented monthly at clinical governance meetings.

Medical care (including older people's care)

- The system in place to communicate risks and changes in practice to nursing staff was not robust. All the ward managers we spoke with told us they relied on verbal dissemination of information during staff handovers and a 'read and sign' system. This system required staff to read information and sign to say they had done so. It was difficult to keep track of which staff had read the information, particularly when they were off on holiday or sick leave and several weeks could pass without all staff accessing important risk related information. On one of the wards we visited we saw a read and sign sheet containing important safety information that was dated a month before our visit, but had only been signed by four members of the staff team. This method does not give staff an opportunity to comment, ask questions or suggest alternative ways of working.

Leadership of the service

- We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical directorate that were positive role models for staff.
- Staff told us that their immediate line managers were accessible and approachable. They told us they felt disconnected from the executive team and did not feel that the executive team appreciated the day to day operational challenges involved in delivering direct care and treatment.

Culture within the service

- Most staff spoke enthusiastically about their work. They described how they enjoyed their work, and how proud they were to work at the trust.

- 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.






Public and staff engagement

- Data from the NHS staff survey 2013 showed that the percentage of staff reporting good communication between senior management and staff was in the worst 20% nationally.
- The trust was also in the worst 20% for staff recommending the trust as a good place to work or receive treatment, staff motivation and the percentage of staff being able to contribute towards improvements at work. This puts the trust in the worst 20% nationally for overall staff engagement.
- The 2013 CQC in-patient survey, which asked patients about their experience of care and treatment, showed that the trust performance was similar to other trusts throughout England.

Innovation, improvement and sustainability

- The frail elderly short stay unit had been successful in reducing the length of stay for this patient group.
- Staff on 9a were piloting the use of an electronic early warning tool. This tool was easy to use, popular with nursing staff and worked well. Subject to a favourable evaluation and the necessary funding, it is anticipated that the electronic early warning tool will be rolled out across the trust in due course.

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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

We visited Southport and Formby District General Hospital as part of our announced inspection on 12 November 2014. We also carried out an out-of-hours unannounced visit on 20 November 2014.

The hospital carried out a range of surgical services, including ophthalmology, orthopaedics and general surgery (such as colorectal surgery). There were four surgical wards and five theatres that carried out emergency surgery procedures as well as some day case and elective surgical procedures.

As part of the inspection, we inspected the main theatres, ward 10a (the emergency assessment unit), ward 11a (the planned investigation unit), ward 14a (the orthopaedic and trauma ward), ward 15a (the urology and general surgical ward) and ward 15b (the colorectal and general surgical ward).

We spoke with 20 patients and the relative of another patient. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, the theatre manager, matrons, a clinical director, the directorate manager and members of the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff assessed and responded to patients' risks. Patient records were completed appropriately. Patients received care in safe, clean and suitably maintained premises.

The nursing and medical staff we spoke with told us they experienced connectivity issues with the pager (bleep) system and doctors could not be contacted in certain parts of the hospital. The staff had identified alternative methods to manage this, but there was a potential patient safety risk if medical staff could not be contacted in a timely manner.

Patients were supported with the right equipment, but there was no approved schedule for replacing older equipment used in the operating theatres. The staffing levels were maintained through the use of bank and agency staff and this meant that the skills mix was not always sufficient to meet patients' needs.

The surgical services provided care and treatment that followed national clinical guidelines except in the preparation for patients undergoing colorectal surgery. However, we did not find any evidence of difference in outcomes for patients.

The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and within the England average for most safety and clinical performance measures.

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However, the lack of an orthopaedic geriatrician had not promoted compliance with the national hip fracture audit and patients did not always receive the best possible care.

The majority of patients had a positive outcome following their care and treatment; however, the number of patients that had elective urology and general surgery and were readmitted to hospital after discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was worse than the England average for elective and non-elective patients having general, trauma and orthopaedic surgery.

We also found that adherence to the WHO safer surgery checklist was being audited but there remained room for improvement in some aspects of the checklist which lacked consistency.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. The number of cancelled elective operations was better than the England average and there had been recent improvements in performance against 18 week referral to treatment standards.

There was insufficient capacity in the wards and theatres, which meant that extra beds were occasionally placed on the surgical wards and patients experienced

delays during surgery. There were plans in place to improve theatre efficiency so that patients admitted to the surgical services received timely and appropriate care.

There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available. 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 service and how to resolve these.

However, we received some negative comments that the use of agency staff increased staff workload and that this affected their morale. We also received negative comments through our medical staff focus groups, in which some members of staff highlighted a culture of bullying and discrimination of medical staff by individuals in the senior management team.

Also trust data showed that staff sickness levels between April 2014 and September 2014 across the planned care division were worse than the England average. The average sickness levels across the four surgical wards ranged from 5.86% to 8.49% during this period.

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Are surgery services safe?

Requires improvement



The wards and theatres we inspected did not have sufficient numbers of trained nursing and support staff. We found that there were five whole time equivalent nursing vacancies in the theatres, three vacancies in ward 14a (the trauma and orthopaedics ward) and three vacancies in ward 15b (the colorectal and general surgery ward). The staffing levels were maintained through the use of bank and agency staff and this meant that the skills mix was not always sufficient to meet patients' needs.

The associate medical director told us they recognised they needed additional medical staff but had experienced difficulties in recruiting suitable candidates. Locum doctors were being used in the interim.

We found that adherence to the WHO safer surgery checklist was being audited but there remained room for improvement in some aspects of the checklist which lacked consistency.

The nursing and medical staff we spoke with told us they experienced connectivity issues with the pager (bleep) system and doctors could not be contacted in certain parts of the hospital. The staff had identified alternative methods to manage this, but there was a potential patient safety risk if medical staff could not be contacted in a timely manner.

Patients were supported with the right equipment, but there was no approved schedule for replacing older equipment used in the operating theatres. The surgical risk register stated that anaesthetic machines were greater than 8 years old and therefore at risk of breakdown. Staff carried out routine checks on the equipment so faulty equipment could be identified and replaced if needed.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff assessed and responded to patients' risks. Patient records were completed appropriately. Patients received care in safe, clean and suitably maintained premises.

Incidents

- The strategic executive information system data showed that there had been one 'never event' (serious, largely

preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) reported by the hospital since March 2013 relating to surgery.

- The incident occurred when a swab was left inside a patient after hemicolectomy (resection of descending colon) surgery in July 2013. This incident was investigated and remedial actions were put in place to prevent recurrence, such as the standardisation of information on theatre white boards and increased monitoring of staff compliance with the World Health Organization (WHO) surgical safety checklist.
- The trust reported that there were five serious incidents relating to surgical services at this hospital during 2013/14. Two of these were surgical errors, two were confidential information leaks and one was the delayed diagnosis of a patient. During the inspection, we saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care.
- The staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system. Complaints, compliments and allegations of abuse were also logged on the electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Information relating to lessons learned from incidents such as medication errors were displayed on notice boards in all the areas we inspected. Staff told us incidents and complaints were also discussed during routine staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.
- The number of patient deaths in surgical services was in line with national averages. Patient deaths were reviewed by individual consultants within their surgical specialty area and reviewed at monthly or bi-monthly audit meetings within each specialty. This information also fed in to trust-wide hospital mortality and morbidity review meetings.

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Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections). Safety Thermometer information between July 2013 and July 2014 showed that the surgical services performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.
- Information relating to this was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- Information supplied by the trust showed there were no cases of MRSA bacteraemia infections relating to surgery.
- Trust data showed that in the surgical specialty areas there were 14 *Clostridium difficile* (C. diff) infections in the 12 months to the end of September 2014. There were a total of 45 C. diff infections reported across the trust within this period and this was above the trust's target trajectory.
- Each C. diff incident was investigated to identify the root cause. We looked at the investigation report and actions plans for two C. diff incidents in ward 14a (the orthopaedics and trauma ward) and saw that these had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- Trust data for surgical site infections showed that between April 2013 and March 2014 the infection rate following total hip replacement surgery was 2.30% and the infection rate following total knee replacement surgery was 1.18%.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. 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. Gowning procedures were adhered to in the theatre areas. Patients identified with an infection were isolated in side rooms and we saw that appropriate signage was used to protect staff and visitors.

- Staff carried out weekly commode audits and monthly hand hygiene audits. Trust data showed that there was a high level of staff compliance across the areas we inspected.

Environment and equipment

- The nursing and medical staff we spoke with told us they experienced connectivity issues with the pager (bleep) system and doctors could not be contacted in certain parts of the hospital. The staff had identified alternative methods to manage this, but there was a potential patient safety risk if medical staff could not be contacted in a timely manner.
- The wards we inspected were clean, safe and well maintained.
- The hospital had five operating theatres. Theatre 5 (used for ear, nose and throat surgery) was closed for refurbishment at the time of our inspection.
- The theatre areas we inspected were observed as clean and well maintained in the patient care areas, such as the operating theatre rooms and the patient recovery area. However, we found that non-patient areas such as staff changing rooms were not well maintained. The change area appeared to be aged and worn out with rust stains on the floor.
- The matron for theatres confirmed that the patient areas in the theatres had been well maintained but other parts, such as the staff changing areas, were not given the same priority and had not been maintained to the same standard.
- We found there was limited storage space in the theatre areas and corridors and the storage rooms were very cluttered. Items of equipment such as procedure packs were stored in the corridors. Equipment such as catheter infusion pumps and diathermy kits were kept on a table in a scrub room. Consumable items, such as gloves, were also stored in the scrub rooms.
- The theatre manager confirmed that storage was an issue in the theatres department and they had started to replenish stock less frequently to save space.
- The lack of storage space had been identified as a moderate risk and placed on the surgical risk register in

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July 2012. The theatre improvement project action plan included a feasibility study to determine the storage issues during October 2013, but there were no clear actions listed as to how the issues would be addressed.

- The equipment we observed in the wards and theatre areas was clean, safe and well maintained. However, we found that equipment such as the anaesthetic machines and monitors were old. The surgical risk register included key risks relating to equipment. For example, the manufacturer of the existing epidural pump and giving sets had stopped making the equipment and consumables. The trust had identified an alternative supplier and quotes had been obtained.
- The surgical risk register also stated that anaesthetic machines were greater than 8 years old and therefore at risk of breakdown. Staff carried out routine checks on the equipment so faulty equipment could be identified and replaced if needed.
- The associate medical director told us there was minimal impact to patient safety, because the theatre equipment was fully functional and well maintained. There was no formal planned and approved equipment replacement schedule for replacing the older equipment. The associate medical director told us this was mainly due to financial constraints.
- The staff we spoke with told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs. However, they told us that some surgical instruments, such as those in orthopaedic kits, were old and needed replacement.
- Staff told us they used single-use, sterile instruments where possible. The majority of single use instruments were within their expiry dates, but we found that anaesthetic tubing in the theatres was still available for use although the expiry date was 26 October 2014.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly. There was also a monthly medication audit carried out by a pharmacist.
- We found that medicines were ordered, stored and discarded safely and appropriately.
- Instructions for prescribing antimicrobial medicines were clearly displayed in the areas we inspected. Trust data showed that the prescribing and use of antimicrobial drugs was reviewed on a monthly basis and that there was a high level of compliance across the surgical wards.
- We saw that medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for four patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- The trust used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for seven patients. These were structured, legible, complete and up to date. However, we found some minor errors and omissions. For example, a patient needed a venous thromboembolism risk assessment 24 hours after the initial assessment but there was no record to show this was done.
- We found that staff had not completed the section to confirm if written information leaflets were given to patients in four consent records. We also found that the consent form for a patient having colorectal surgery listed key risks but did not include the risk to the patient's life.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition. These were completed correctly.

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- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded; the timing of such was dependent on the level of care needed.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. The staff we spoke were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was clearly displayed in the areas we inspected. Each area we inspected also had safeguarding link nurses in place.
- Safeguarding incidents were reviewed by the departmental managers and also by the trust safeguarding committee, which held meetings every two months.

Mandatory training

- Staff received annual mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire 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.
- Trust data showed that the majority of staff across the surgical wards and theatres had completed their mandatory training. However, the trust's internal target of 90% compliance had not been achieved.

Assessing and responding to patient risk

- The staff we spoke with were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and matrons to address these risks.
- Upon admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure

ulcers, nutritional needs, risk of falls and infection control risks. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.

- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff also carried out an audit to monitor adherence to the WHO checklist by observing at least one surgical procedure within each in each theatre on a monthly basis. The results for September 2014 audit demonstrated that a briefing took place prior to the commencement of the operation list in 100% of cases although names were only recorded on a visible wipe clean board in 80% of cases and changes to the published Galaxy list were only discussed in 80% of cases. All checks during and post procedure were carried out in 100% of cases which was an improvement on the August audit where only 80% of documentation was completed at each stage of the process and not retrospectively.

Nursing staffing

- Staffing levels were monitored against minimum compliance standards, based on national NHS safe staffing guidelines. Information on staffing levels, including actual versus expected numbers of staff on duty was clearly displayed near the entrance to the ward and theatre areas and these were updated daily.
- The matron for planned care carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The matron for planned care told us staffing levels were based on the dependency of patients and that this was reviewed daily.
- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.

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- The wards and theatres we inspected did not have sufficient substantive numbers of trained nursing and support staff. We found that there were five whole time equivalent nursing vacancies in the theatres (9%), overall nurse staffing vacancies were at 5.9% and we noted there to be three vacancies in ward 14a (the trauma and orthopaedics ward) and three vacancies in ward 15b (the colorectal and general surgery ward).
- The matron for planned care had identified where the ward staffing shortfalls were and was in the process of recruiting additional staff to fill these vacancies. The matron had also introduced a twilight shift from 4.30pm to 12am, where an additional healthcare assistant worked on wards 15a and 15b, and an additional nurse worked on ward 14a. The ward staff we spoke with told us this had been beneficial and the additional resources allowed them to carry out duties such as medication rounds and evening meals more efficiently.
- The matron for theatres told us they were currently interviewing for a band 5 nurse position, and an additional nurse had been recruited and was due to start work in April 2015. The matron for theatres was also scheduled to travel to Eastern Europe in December 2014 to source band 5 theatre nurses and operating department practitioners.
- Staffing levels were maintained with the use of bank and agency staff. Trust data showed that there was a high usage of temporary staff in wards 14a, 15a and 15b. The use of temporary staff exceeded 20% for at least nine of the 12 months before the inspection on wards 14a and 15a.
- The ward managers we spoke with told us they tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so that patients received an appropriate level of care. Agency staff had inductions, and checks were carried out to ensure they had completed mandatory training before starting work.
- The ward staff we spoke with told us the level of training of agency staff varied, because some temporary staff regularly worked on the wards and some were new. They told us this affected their workload as they had to support the temporary staff as well as carry out their own duties.
- The ward staff we spoke with also told us they were routinely transferred to work on other wards during busy periods. This meant that the skills mix was not always maintained and patients were not always cared for by staff trained in their particular specialty area.
- The ward managers were included as part of the staffing establishment and had one administrative day allocated for carrying out their management duties. The ward managers we spoke with told us it was not always possible to carry out their management duties effectively as patient needs took priority over their administrative duties.
- The majority of patients spoke positively about the staff and did not identify any concerns relating to staffing. However, two patients on ward 14a told us they had experienced delays in the time taken by staff on nights to respond to call bells.

Surgical staffing

- The wards and theatres we inspected had a sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. However, staff told us on-call consultants were not always free from other clinical duties and could be involved in ward-based duties or have limited elective surgery lists.
- The junior doctors and middle career doctors (e.g. senior house officers) we spoke with told us they received good support and could easily access the on-call consultant if needed.
- The proportion of middle career doctors and junior doctors was greater than the England average. The proportion of consultants was below the England average (30% compared with the England average of 40%). The proportion of registrars was also below the England average (25% compared with the England average of 37%).
- The associate medical director for planned care told us the middle career doctors and registrars at the hospital were experienced so they were able to meet patient needs effectively. The associate medical director had

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highlighted where additional surgical staff were needed and had recently appointed two colorectal consultants and two additional orthopaedic consultants that had not yet started employment.

- The associate medical director told us they recognised they needed additional medical staff but had experienced difficulties in recruiting suitable candidates. Locum doctors were being used in the interim.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- Staff received mandatory training in resuscitation, fire safety and health and safety.
- There was a documented major incident plan and business continuity plan in the surgical services, and this listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected.

Are surgery services effective?

Requires improvement



The majority of patients had a positive outcome following their care and treatment; however, the number of patients that had elective urology and general surgery and were readmitted to hospital after discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was worse than the England average for elective and non-elective patients having general, trauma and orthopaedic surgery.

Surgical services provided care and treatment that followed national clinical guidelines except in colorectal surgery preparation which varied between consultants although we found no evidence of negative impact on patients. Staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and within the England average for most safety and clinical performance measures.

However, the lung cancer audit 2014, reporting on all of 2013, showed the trust performed worse than the England

and Wales average for the number of cases discussed at multidisciplinary meetings (88.8% nationally compared with only 74.8% at this trust with a target of 95%). Also the national hip fracture audit report 2013 highlighted that only 0.4% of patients had had a pre-operative assessment by an orthopaedic geriatrician compared with the England average of 53.8%. The data also showed that no bone health medication assessments were carried out compared with the England average of 85%. This meant that best practice guidelines were not being followed effectively. The lack of an orthopaedic geriatrician meant that compliance with the national hip fracture audit had not been achieved and patients did not always receive the best possible care.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Trust data showed that between April 2014 and September 2014 the planned care division had 121 clinical audits planned, of which 74% were in progress. Findings from clinical audits were reviewed at the monthly clinical governance and performance meetings.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- We found that there were differences in the practice of colorectal surgery, where some consultants conducted bowel preparation for colorectal surgery and others did not. However, we did not find any evidence of difference in outcomes for patients. Evidence-based NICE guidelines showed that mechanical bowel preparation is not effective for improving outcomes in patients having elective colorectal surgery and should not be used routinely.
- Staff in the surgical wards used enhanced care and recovery pathways, in line with national guidance, but these were only used for selected patients. During the inspection, we identified one patient in the surgical

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wards that was on enhanced recovery. The majority of patients admitted to the wards post-operatively still had cannulas and catheters in place. Enhanced recovery guidelines state that routine catheters should be avoided or removed early. The limited use of enhanced care pathways meant that patients would take longer to recover fully.

- The staff we spoke with told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. However, one specialty registrar grade doctor we spoke with told us they could not always access external literature as access to certain websites was restricted.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.
- The majority of patients we spoke told us staff gave them pain relief medication when needed.

Nutrition and hydration

- The patient records we looked at included assessments of patients' nutritional requirements.
- Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used a red tray system so patients with dementia could be identified and supported by staff during mealtimes.
- The majority of patients we spoke with told us they were offered a choice of food and drink and spoke positively about the quality and portion sizes.

Patient outcomes

- There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit.

- The national emergency laparotomy audit (NELA) report from May 2014 showed that 18 out of the 28 standards were met by the trust. There was an action plan to address gaps from the NELA audit, such as staff and theatre availability to provide 24 hour, seven day emergency surgery.
- The latest national bowel cancer audit of 2013 showed that the trust was performing better than the England average for case ascertainment, the number of patients that had a CT scan, the number of cases discussed at multidisciplinary team meetings and the number of patients for whom laparoscopic surgery was attempted.
- The national bowel cancer audit also showed that the trust was only marginally worse than the England average for the number of patients seen by a clinical nurse specialist (86.9% compared with England average of 87.7%), the number of patients that had major surgery (51.5% compared with 58.6%) and for patient length of stay above 5 days (75.7% compared to 68.9%).
- The trust performed worse than the national average for data completeness (54% compared with the national average of 79%).
- The associate medical director for planned care told us clinical audits were routinely reviewed and could not attribute the bowel cancer audit performance to any specific factors.
- The lung cancer audit 2014, reporting on all of 2013, showed the trust performed worse than the England and Wales average for the number of cases discussed at multidisciplinary meetings (88.8% nationally compared with only 74.8% at this trust with a target of 95%).
- It also showed that the trust performed slightly worse than the England and Wales average for the percentage of patients having a CT scan before bronchoscopy (95.2% nationally compared with 93.9% at this trust with a target of 95%) and for the percentage of patients having a histological diagnosis (69.4% nationally compared with 60.5% at this trust with a target of 95%) and for the percentage of patients having active treatment (57.7% nationally compared with 48.3% at this trust with a target of 60%).
- The trust scored well for the percentage of patients being seen by a specialist lung cancer nurse at 84.4% compared with a national score of 81.8% (target of 80%) and in the lung cancer specialist nurse being present at diagnosis scoring 61.2% compared with 54.4% nationally (target of 80%).

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- The national hip fracture audit 2013 showed that trust performance was better than the England average for seven out of the 11 indicators, including ascertainment rate, percentage of patients admitted to orthopaedic care within hours, patients developing pressure ulcers, falls assessments and length of stay.
- The trust performance was slightly worse than the average for the percentage of patients having hip surgery within 36 hours and within 48 hours.
- The hip fracture report also highlighted that only 0.4% of patients had had a pre-operative assessment by an orthopaedic geriatrician compared with the England average of 53.8%. The data also showed that no bone health medication assessments were carried out compared with the England average of 85%. This meant that best practice guidelines were not being followed effectively.
- The associate medical director for planned care told us they were actively seeking an additional orthopaedic geriatrician but had had difficulties in recruiting a suitably qualified candidate. The trust also did not have an orthopaedic clinical nurse specialist. Interim cover was provided by part-time locum orthopaedic geriatricians on Wednesday and Friday mornings. Orthopaedic ward staff told us the prescribing of bone health medicines such as calcium and vitamin D varied depending on the prescribing doctor.
- Performance reported outcomes measures (PROMs) data between April 2013 - March 2014 showed that the percentage of patients reporting improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was similar to the England average. However, the percentage of patients reporting worse outcomes following groin hernia was 50.8% compared with an England average of 44.4%.
- The hospital participated in the advanced quality standards for hip and knee surgery. Trust data showed that performance against the key standards was monitored on a monthly basis and there was a high level of compliance.
- Hospital episode statistics 2013/14 data showed that the number of patients that had elective urology and general surgery and were readmitted to hospital following discharge was higher (worse) than the England average. The readmission rate for non-elective surgery patients was comparable to the England average for all specialties except trauma and orthopaedics.
- Trust data for this hospital between April 2014 and September 2014 showed there had been 306 elective and non-elective readmissions within 30 days across the planned care division.
- The associate medical director for planned care told us readmission rates were routinely monitored to look for improvements to the service.
- Hospital episode statistics 2013/14 data showed that day surgery rates across all specialties at the hospital were within acceptable standards.
- Hospital episode statistics 2013/14 data showed that the average length of stay for elective and non-elective urology patients was in line with the England average. The average length of stay was above the England average for elective and non-elective patients having general, trauma and orthopaedic surgery. The average length of stay for non-elective trauma and orthopaedics was 11 days compared with the England average of eight days.
- The associate medical director for planned care attributed patient length of stay to a historical caring and patient-focused staff culture and confirmed this was an area that could be further improved.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- There was an education manager for theatres who supported the theatre manager to manage staff training.
- Trust data showed the majority of staff across the planned care division (74.63%) had completed their annual appraisals during the year (April 2014 to March 2015). Appraisals were on-going and the staff we spoke with told us they routinely received supervision and annual appraisals.
- Consultants had peer appraisals and were overseen by the medical director.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities, and told us they were supported well by their line management.

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Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff we spoke with told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed that there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff we spoke with told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for x-rays and scans.
- The surgical service had arrangements in place with a neighbouring trust to provide on-call support for ear, nose and throat surgical specialties.
- There were also routine multidisciplinary meetings that took place with urology and vascular surgery consultants, who ran outpatient clinics at the hospital and carried out surgical procedures at other external hospitals.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays and Sundays.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

- Within the theatres, emergency operating lists ran from 1.30pm to 5pm from Monday to Thursday and all day Friday. There was a 24 hour service on weekends so any patients admitted over the weekend that required emergency surgery could be operated on.
- There was a dedicated emergency trauma list on Saturdays but there was no trauma list on Sunday. The associate medical director for planned care told us that if trauma surgery was needed on a Sunday, this would be included into the emergency list without any impact on services.

Access to information

- The trust used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- The surgical services were in the process of implementing an electronic records system for the medical staff to store and access patient information such as referral letters. However, this had only started recently and staff were still being trained in its use.
- Staff told us the information about patients they cared for was easily accessible.
- 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 trust's intranet.
- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives. The staff we spoke with were clear about how they sought informed verbal and written consent before providing care or treatment.
- The patient records we looked at showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- The staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

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- If patients lacked the capacity to make their own decisions, staff told us they sought consent from their carers or representatives. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the trust's 'safeguarding adults' and 'safeguarding and child protection' policies.
- The patient records we looked showed that staff carried out mental capacity assessments for patients that lacked capacity and where deprivation of liberties safeguards applications had been made, the records for these were in place and completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Are surgery services caring?

Good



Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
 - The areas we inspected were compliant with same-sex accommodation guidelines. However, staff told us it was not always possible to segregate patients in the post-operative recovery room. Where this was the case, staff told us curtains were drawn to ensure patients' privacy and dignity was maintained.
 - We spoke with 20 patients and the relative of another patient. The majority of patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "the staff are brilliant, can't do enough" and "the staff are positive and caring".
- We received negative feedback from one patient on ward 14a (the trauma and orthopaedic ward) relating to the delay in staff responding to call bells at night. This patient also witnessed another patient that needed nursing assistance at night but staff did not respond until over 10 minutes later. The patient had raised their concerns as a complaint with the trust.
 - The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between April 2013 and July 2014 showed that the four surgical wards consistently scored below the England average, indicating a mixed response from patients about whether they would recommend the hospital's wards to friends and family.
 - The average response rates were also below the England average across three of the four surgical wards with only ward 14a (the trauma and orthopaedic ward) achieving a better response rate of 35% compared with the England average of 33%.
 - The ward managers told us staff struggled to get patients to complete the survey because the wards were generally busy. The matron for planned care told us the Friends and Family Test was routinely discussed at monthly performance meetings and ward staff were prompted to encourage more patients to complete the test.
 - A review of the data from the CQC's adult inpatient survey 2013 showed that the trust was about the same compared with other trusts for all 10 sections, based on 380 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- The patient records we looked at included pre-admission and pre-operative assessments that took into account individual patient preferences.

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- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- The patients we spoke with told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. They also told us they could easily arrange to meet a registrar or consultant if they needed to discuss their care or treatment. We saw that medical ward rounds occurred on a daily basis and included input from the nursing staff and other health professionals such as physiotherapists and social workers if needed.

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients. For example, we observed staff holding the hand of a patient before they went into the operating theatre to calm their nerves. The patients we spoke with told us they were supported with their emotional needs.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services. Patients and their relatives were also provided with a bereavement booklet if needed.
- Staff told us they were supported by the trust's palliative (end of life care) team and the trust-wide bereavement team for support and advice during bereavement.

Are surgery services responsive?

Requires improvement



There was insufficient capacity in the wards and theatres, which meant that extra beds were occasionally placed on the surgical wards and patients experienced delays during surgery.

There was an action plan in place to address the key reasons for cancelled operations and there were specific actions listed to address issues such as unavailability of

ward beds, list overruns, unavailability of the surgeon, anaesthetist or theatre staff, and equipment issues. Remedial actions taken had included a review of start times and delays in lists, reduced theatre activity during anticipated periods of high pressure on beds, the appointment of a business support manager in October 2014 to manage anaesthetic staff availability, and the implementation of scheduling meetings to identify theatre staff issues in advance.

However, a number of the identified actions had not yet been completed, including the recruitment of additional theatre staff and the replacement of equipment overdue for renewal.

The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. The number of cancelled elective operations was better than the England average and there had been recent improvements in performance against the 18 week referral to treatment standards.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, ophthalmology, urology and general surgery (such as colorectal surgery and upper gastrointestinal surgery).
- Hospital episode statistics 2013/14 data showed that 24% of patients had day case procedures, 18% had elective surgery and 59% were emergency surgical patients.
- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery.
- There was routine engagement and collaboration with staff from these trusts, such as on-site outpatient clinics and routine multidisciplinary team meetings.
- The trust made a decision to close its breast care service to new patients at Southport and Formby District General Hospital from 1 September 2014. The trust stated that the service could not be managed safely due to difficulties in recruiting a breast specialist radiologist.

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- Breast service meeting minutes from November 2014 showed that existing patients were still supported with care at the hospital. The majority of these patients were in the process of being transferred to outpatient care or transferred to the care of a neighbouring trust.
- The associate medical director for planned care told us that ophthalmology day case services were provided from Ormskirk District General Hospital and the trust was reviewing whether these services should be offered from Southport. This was so that the trust could provide ophthalmology services under the 'choose and book' system for patients living in the Southport area. Patients in the Southport area were currently receiving these services from an independent healthcare provider.
- During the inspection, we found that across the four surgical wards, 15 surgical beds were occupied by patients receiving medical care (medical outliers). These patients were routinely seen by doctors from the medicine specialties.
- We also found that four surgical patients were placed in medical wards (surgical outliers). A doctor on the surgical wards told us the surgical consultants and doctors were issued with a daily list of surgical patients across the hospital's wards and they made sure surgical outlier patients were seen daily.
- Ward 11a (the planned investigation unit) was designated to operate during weekdays only. However, ward staff told us that the ward was frequently used to accommodate patients at weekends (Friday evening until Sunday morning) during busy periods. Where this was the case, the staff we spoke with confirmed that additional staff were supplied so that patients could be cared for appropriately.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed that patients were assessed upon admission to the wards or before having surgery.
- The majority of patients we spoke with did not have any concerns about their admission, waiting times or discharge arrangements. However, one patient told us their discharge was delayed because there were no beds available at the rehabilitation ward at Ormskirk District General Hospital.
- We looked at three patient records that showed that discharge planning took place at an early stage and that there was multidisciplinary input (for example, from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. There was a discharge lounge but the majority of surgical patients were discharged directly from the wards, so staff could continue to monitor them during their wait.
- We found that all available beds were occupied in the surgical wards we visited. Trust data between September 2013 and September 2014 showed that bed capacity across the four surgical wards was consistently over 90% during that period. The bed capacity in ward 11a (the planned investigation unit) was 100% for six months including between April 2014 and September 2014.
- Staff on the surgical wards told us that additional beds were occasionally brought on to the wards during busy periods. Trust data showed that over the 12 months before the inspection, there were a total of 16 recorded instances where additional beds were used on wards 14a, 15a and 15b.
- Where extra beds were used on the wards, each patient was assessed by the bed manager, the surgical matrons spoke with the patients and offered an apology, and the patients were prioritised to move within 24 hours.
- The ward staff we spoke with told us the patient beds were placed in the bay areas and screens were provided for privacy. However, the beds did not connect to auxiliary supplies (e.g. oxygen) or call bells.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for before and after surgery. However, theatre staff told us that the theatre recovery area was routinely used as a holding area for patients waiting for beds on the wards.
- The recovery area was also used to hold patients waiting for intensive care beds. We spoke with an operating department practitioner who told us that critically ill patients admitted via accident and emergency were occasionally transferred to the recovery area to be stabilised and kept in the area for a short period of time before being transferred to the intensive care unit.
- NHS England data showed that the number of elective operations cancelled was lower (better) than the

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England average from April 2014 to September 2014.

Trust data showed that between May 2014 and October 2014, there were 115 cancelled operations, including 74 planned (elective) operations and 41 unplanned cancellations.

- Trust data showed that during August and September 2014, the most frequent reasons for cancellations on the day of operation were that patients had pre-existing medical conditions, patients did not attend, ward beds were unavailable, lists overran and the surgeon was unavailable.
- There was an action plan in place to address the key reasons for cancelled operations and there were specific actions listed to address issues such as unavailability of ward beds, list overruns, unavailability of the surgeon, anaesthetist or theatre staff, and equipment issues.
- Remedial actions taken had included a review of start times and delays in lists, reduced theatre activity during anticipated periods of high pressure on beds, the appointment of a business support manager in October 2014 to manage anaesthetic staff availability, and the implementation of scheduling meetings to identify theatre staff issues in advance.
- A number of the identified actions had not yet been completed, including the recruitment of additional theatre staff and the replacement of equipment overdue for renewal.
- NHS England data showed that between July 2013 and June 2014, all patients whose operations were cancelled were treated within 28 days. The directorate manager for theatres told us staff arranged new dates on the day of the cancellation and this had significantly reduced the number of patients not treated within 28 days.
- The theatre staff we spoke with told us theatre lists frequently started late and overran. The trust carried out an audit across theatres one to four over a four week period during April 2014 and May 2014. The purpose of the audit was to measure patient delays in the four theatres. The audit looked at 136 patients and identified that 71 patients (52%) experienced delays. The three main causes for delays were no beds being available on admission, patients not ready on the ward, and the late arrival of the anaesthetist and surgeon (mainly due to seeing patients on the ward preoperatively).
- There was a theatres improvement action plan in place, with specific actions to address cancelled operations and to review the way theatres are used to improve this.

- NHS England data showed national targets for 18 week referral to treatment standards for admitted patients at the end of September 2014 were being met for most specialties. The data showed that this hospital was just below the waiting time target of 90% for general surgery (89%). Performance against waiting time standards had improved significantly since April 2013 to June 2014, where this hospital was not meeting the standards for trauma and orthopaedics, general surgery or ear, nose and throat surgery.
- The national hip fracture audit 2013 showed that trust performance was slightly worse than the average for the percentage of patients having hip surgery within 36 hours of admission (68.5% compared with the national average of 73.4%) and within 48 hours of admission (85.4% compared with the national average of 87.3%).
- The associate medical director for planned care told us they were confident that the appointment of two additional orthopaedic and two colorectal consultant surgeons would improve compliance with the hip fracture audit and referral to treatment standards.

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.
- Ward 14a (trauma and orthopaedics) had a bay designated for patients with dementia. This area had a 'reminiscence' theme and used colour coding and easy-to-read signs to help patients living with dementia. A 'reminiscence' themed environment is where objects, music and practical activities are organised in a manner that can help patients living with dementia to recall memories.
- Staff could contact a trust-wide specialist safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff also used a document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.

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Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the trust's customer services team. The patients we spoke with were aware of the process for raising their concerns with the trust.
- We saw that notice boards included information such as the number of complaints and compliments received during the month. The staff we spoke with understood the process for receiving and handling complaints.
- Complaints and compliments were recorded on the trust-wide incident reporting system. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the complaints and governance lead for planned care, who notified individual managers when complaints were overdue.
- The majority of complaints raised in the surgical services were reported, investigated and responded to within the trust timescales. Trust data showed that between April 2014 and September 2014, there had been 27 complaints raised across the four surgical wards. During this period, there had been a total of 83 complaints raised across the planned care division and 21 complaint responses were overdue by less than one month.
- We looked at two complaints records and saw that these were appropriately documented and responded to promptly.
- Staff told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We saw evidence of this in the meeting minutes we looked at.

Are surgery services well-led?

Requires improvement



There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available. 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 service and how to resolve these.

However, we received some negative comments from some ward staff, who told us the use of agency staff increased their workload and that this affected their morale. We also received negative comments through our medical staff focus groups, in which some members of staff highlighted a culture of bullying and discrimination of medical staff by individuals in the senior management team.

Also trust data showed that between April 2014 and September 2014 staff sickness levels across the planned care division were 4.80%, which was worse than the England average during that period. The average sickness levels across the four surgical wards ranged from 5.86% to 8.49% during this period.

Vision and strategy for this service

- The trust vision of 'excellent, lifelong, integrated care' was clearly visible and displayed across the wards and theatre area. The planned care division business plan 2014/15 outlined the strategy for surgical services and included plans to meet financial and performance targets.
- The trust quality strategy 2012–2015 incorporated this vision and included specific performance targets relating to patient experience, effective services and patient safety.
- The trust's nursing and care staff strategy 2013–2016 was based on the NHS England compassionate care standards (also known as 6 C's) and information relating to this was displayed on notice boards in the areas we inspected.
- The majority of staff we spoke with understood the trust vision and values. The trust chief executive assured us before the visit that all staff were aware of the professional standards introduced throughout the trust. However, we received a mixed response from staff about their understanding of these.

Governance, risk management and quality measurement

- There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.

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- During the inspection, we looked at the risk register for surgery and saw that key risks had been identified and assessed. The risk register was maintained by the Head of Nursing and reviewed at routine clinical governance, performance and quality and safety meetings.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through monthly performance dashboards and these were visibly displayed in the areas we inspected.

Leadership of service

- There were clearly defined and visible leadership roles across the surgical services. The services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical director and directorate manager.
- The surgical wards were led by ward managers, who reported to the matron for planned care.
- The theatres and ward based staff we spoke with told us they understood the reporting structures clearly and that they received good support from their line managers.

Culture within the service

- The staff we spoke with were proud and spoke positively about the care they delivered. The majority of staff we spoke with told us there was a friendly and open culture. However, we received some negative comments from some ward staff, who told us the use of agency staff increased their workload and that this affected their morale.
- We also received negative comments through our medical staff focus groups, in which some members of staff highlighted a culture of bullying and discrimination of medical staff by individuals in the senior management team.
- Staff told us they were supported with their training needs by the management team within their specific area. Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- Trust data showed that staff turnover was consistently low over the past 12 months.

- Trust data showed that between April 2014 and September 2014 staff sickness levels across the planned care division were 4.80%, which was worse than the England average during that period. The average sickness levels across the four surgical wards ranged from 5.86% to 8.49% during this period.
- Staff sickness levels were reviewed daily and staffing levels were maintained through the use of bank and agency staff.

Public and staff engagement

- The theatres and ward-based staff we spoke with told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of compliments and complaints was displayed on notice boards in each of the wards we inspected.
- Patient feedback was also obtained through monthly matron's checklist surveys, which were conducted in the surgical wards by the matron for planned care and sampled at least 10 patients per ward. The survey asked for patient feedback in areas such as patient safety, cleanliness and the quality of food and drink. The findings from the surveys were reported in monthly performance dashboards and we saw that they were mostly positive. The matron for planned care told us any concerns raised by patients were reviewed and addressed by the ward managers.
- There was also ad hoc engagement with the public via patient support groups and patient and public involvement groups.
- The staff we spoke with told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via email blogs, newsletters and through other general information and correspondence that was displayed on notice boards in staff rooms.
- As part of the trust's SCOPE values (supportive, caring, open and honest, professional and efficient), the matron for planned care had carried out feedback surveys on ward 14a. Information was collated from 12 patients and 22 members of staff.
- The majority of the feedback from patients and staff was positive. However, there were some negative staff comments received in relation to the level of recognition for work carried out, opportunities to use their skills and

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the amount of responsibility given to staff. The matron for planned care told us the information was currently being reviewed to look for possible improvements to the service.

- The findings from the 2013 survey of NHS staff were reviewed as part of divisional operation meetings. Meeting minutes showed that the concerns relating to communication between managers and staff, staff appraisals and the ability of staff to contribute towards improvements at work were identified as key concerns and actions on how to improve these were documented.
- We received negative comments from patients and staff in relation to staff and public engagement before the closure of the breast services to new patients from September 2014. The trust carried out staff and public engagement after the decision of closure had been made but the patients and staff we spoke with told us they were not involved in earlier discussions.

Innovation, improvement and sustainability

- The planned care division business plan 2014/15 outlined the strategy for surgical services and included plans to meet financial and performance targets.
- The matron for planned care, matron for theatres and associate medical director for planned care told us the key risks to the surgical services were staffing and ensuring vacancies were filled. They told us they were confident the services were sustainable.
- The matron for planned care told us that the introduction of the twilight shift on the surgical wards and two dedicated trauma nurses on the orthopaedic wards had improved patient care.
- The associate medical director for planned care told us they carried out approximately 58% of orthopaedic procedures in the local area. The trust wanted to increase the number of patients having orthopaedic procedures at the hospital by improving theatre efficiency and with the introduction of two additional orthopaedic surgeons who had been recently been appointed.

Regional spinal injuries centre

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

Information about the service

The North West Regional Spinal Injuries Centre (NWR SIC) is located at Southport and Formby District General Hospital. The NWR SIC treats patients with spinal cord injuries or related neurological disorders both as inpatients and through an outreach programme. The centre has 33 rehabilitation beds, six high dependency beds and four intensive care beds.

We inspected this service as part of our comprehensive inspection of Southport and Ormskirk NHS Trust. The team included CQC inspectors and a variety of specialists including a specialist nurse, a consultant anaesthetist, a junior doctor and an expert by experience.

Before visiting, we reviewed a range of information about the service and asked other organisations to share what they knew. During the visit we held focus groups and talked individually with a range of staff who worked within the service, 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 six people. We met with people who used the service and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 20 November 2014.

Summary of findings

There were insufficient members of nursing staff to provide a safe service for patients being cared for in the NWR SIC. Corridors were cluttered with equipment, which had an impact on the control of infection within the centre and there was no planned replacement programme for essential pieces of equipment. Medicines were well managed within the centre and quality of record keeping was good.

The service was effective. Evidence based guidelines were in place for the treatment of patients with spinal injuries. Care plans for patients with spinal injuries identified goals set by the patients and these were monitored by them in partnership with the staff. The discharge planning process was part of the goal setting undertaken with the patient and began as soon as the patient was admitted to the ward.

Most patients were treated with compassion and respect, but low nurse staffing levels meant that sometimes staff were slow to respond to the needs of patients.

There were rehabilitation and sports facilities within the centre but sometimes patients were unable to access them due to shortages of staff.

There was no clear strategy for the development of the NWR SIC. There was insufficient senior nursing managers allocated to the NWR SIC to be able to provide effective leadership for this service.

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Are regional spinal injuries centre services safe?

Inadequate



Summary

There were insufficient members of nursing staff to provide a safe service for patients being cared for in the North West Regional Spinal Injuries Centre (NWRNIC). A recent trust review of the units nurse staffing had identified poor staff to patient ratios which did not meet national guidelines and staff shortages had been noted as a long standing risk on the trust risk register. The trust were informed of our concerns directly after the unannounced inspection.

Healthcare assistants were providing care that would usually have been delivered by trained nurses. Corridors were cluttered with equipment, which had an impact on the control of infection within the centre. There was no planned replacement programme for essential pieces of equipment. Medicines were well managed in the NWRNIC and quality of record keeping was good.

Incident reporting, learning and improvement

- All staff we spoke with were aware of how to report incidents, but unless staff were involved in an incident, they did not routinely receive feedback.
- There was some evidence of learning from incidents, such as input from the psychology team in order to enable staff to deal more effectively with incidents of verbal aggression.
- Nursing staff told us they rarely reported low staffing levels via the incident reporting system.

Safeguarding

- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities for the safeguarding of both children and vulnerable adults.
- Staff were aware of how to make a referral if they had any safeguarding concerns.

Medicines management

- Medicines were stored correctly, including the safe storage of controlled drugs.

- During our inspection we reviewed three medicine charts and found them to be well completed, with the exception of the inclusion of dates when some medication should be either stopped or reviewed.
- There was no provision for patients to administer their own medicines, except when they were near to discharge despite some of these people, who are in the unit for months, being well capable of self medicating earlier in the rehabilitation process.

Safety of equipment

- There was insufficient storage for essential equipment. This meant that corridors in the NWRNIC were cluttered, which made it difficult for staff to manoeuvre patients around the Centre although a business case for additional storage was being progressed.
- The trust infection control action plan for the NWRNIC identified the lack of equipment storage as an infection control risk.
- Emergency equipment was checked daily and was ready for use if required.
- There was no planned replacement programme for essential equipment, which included electrically controlled wheelchairs. Several of these wheelchairs, although still working, were nearing the end of their useful life.

Records and management

- During our inspection we reviewed six sets of patient records. In all the records we looked at documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment.

Cleanliness, infection control and hygiene

- There was an ample supply of hand washing facilities and liquid soap, and hand towel dispensers were adequately stocked. Alcohol hand gel was available throughout the NWRNIC and good hand hygiene was observed throughout our visits to the centre.
- Staff observed 'bare below the elbow' guidance and wore personal protective equipment, such as gloves and aprons while delivering care.
- Bins for the disposal of clinical waste were not available in each room. We discussed this with a member of the infection control team, who informed us that this was to discourage staff from using them for non-clinical waste, as the disposal of clinical waste is more expensive. Reduced availability of the clinical waste bins increases

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the risk that staff will dispose of clinical waste inappropriately. The impact of the reduction in clinical waste bins, including the levels of clinical waste disposed of in domestic waste bins, had not been assessed.

Mandatory training

- Compliance rates for mandatory staff training in the NWRISIC were high, with most being recorded above the trust target of 90%.

Assessing and responding to patient risk

- Staff in the NWRISIC used the national early warning score, which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and steps had been taken to ensure staff understood how to use it.
- Staff we spoke with told us how they accessed specialist medical help both within and outside of normal working hours.

Staffing levels and caseload

- Boards displaying the staffing levels that should be assigned to NWRISIC and the actual staffing levels were prominently displayed at the entrance to the centre.
- A review of nurse staffing on NWRISIC was undertaken in July 2014, which compared the existing levels of nurse staffing with two other spinal injuries units at Glasgow and Sheffield. The review also considered the NHS service specification for specialist rehabilitation, the Core Standards for Intensive Care Units (2013) and the Cheshire and Mersey Critical Care Network staffing specifications for intensive care units. Findings from this review were 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. Further findings from the review described an “increased risk to patient safety due to lack of qualified staff to undertake all required tasks resulting on occasions where HCAs are delivering care that would be deemed as trained nurse duties”. The review was submitted for consideration to the deputy director of performance and the deputy director of finance approximately 5 weeks before our inspection, with the recommendation that the executive team

support the proposal. During our inspection we were informed that verbal feedback had been received that no action would be taken on the proposal during the 2014-2015 financial year. Since the inspection a further review has taken place because at the time of submission to the business planning process, the Spinal Staffing Review that commenced in July 2014 and completed end of September 2014 had not been reviewed for factual accuracy and endorsed by the Executive Nurse. The decision to defer action was made at non clinical deputy Director level and once the interim Executive Nurse had sight of the review, due to a number of factual inaccuracies and statements requiring further clarification, and that the basis for the review was based primarily on professional judgement, a second review was commissioned using a validated, evidence based acuity tool. This was applied to consider safe staffing for the 43 inpatient beds in preparation for review by the incoming Director of Nursing prior to sanctioning. This has been completed and has resulted in Executive agreement for an immediate investment of £370k for an additional 9.38 WTE staff.

- In July 2014 the National Institute for Health and Care Excellence (NICE) issued guidance on safe nurse staffing for hospitals, in which a breach of nurse to patient ratio of 1:8 was cited as a high-risk level that should trigger urgent review. Staffing levels in the rehabilitation area of NWRISIC were assessed regularly as 1:16 on the early shift, 1:22 on the late shift and 1:33 on the night shift. It should also be noted that the patients cared for on the NWRISIC are highly dependent and require greater than average levels of nursing care and expertise.
- There were four patients receiving mechanical ventilation (machines to help people breathe) in the intensive care area of the centre. We were informed by the ward manager that 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. During our inspection one of the two nurses allocated to the intensive care area was helping staff in other areas. This was discussed with the nurse left in charge of the intensive care area who felt that this was not unsafe as the patients were very stable.
- There was a high use of agency staff in the NWRISIC, with £180,000 spent on agency staff between 1 April and 31 July 2014.

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- Staffing shortages within NWR SIC had been added to the corporate risk register 10 years ago, in April 2004. One of the controls is documented as considering the admission criteria in order to reduce potential staffing pressures. In practice, there is a growing trend to admit patients to the NWR SIC earlier in their rehabilitation, when their levels of dependency are greater.

Managing anticipated risks

- The NHS Safety Thermometer is a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, pressure ulcers, and urinary and catheter infections. Staff in the NWR SIC were managing and monitoring these risks and displayed information on the ward performance board.
- Risk assessments were well documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage individual risks to patient safety.

Are regional spinal injuries centre services effective?
(for example, treatment is effective)

Requires improvement



Summary

Evidence based guidelines were in place for the treatment of patients with spinal injuries. Care plans for patients with spinal injuries identified goals set by the patients, and these were monitored by them in partnership with the staff. Former patients of the centre provided support for current patients. There were times when patients had to wait for assistance for pain relief or meals. Assistive technology was used to enhance the patient experience.

Evidence based care and treatment

- There were many evidence based guidelines in place for the treatment of patients with spinal injuries.

Pain relief

- Most of the patients we spoke with told us they received timely and effective pain relief, although this was occasionally delayed due to the availability of trained staff to administer the medication. During our

inspection we observed one patient who asked to be re-positioned in the bed as they were in pain. There were no members of staff available for 15 minutes to re-position this patient and relieve their pain.

Nutrition and hydration

- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day. Most of the patients we spoke with were satisfied with the meals served at the trust but commented that they were repetitive once they had been in the North West Regional Spinal Injuries Centre (NWR SIC) for a long time.
- There were insufficient staff members to assist patients with meals. This resulted in cold meals which had to be re-heated and delays in patients receiving meals.

Use of technology and telemedicine

- We observed several ways in which technology had been used to enhance the patient experience, including mouth controlled computer equipment in the intensive care unit.
- There was no budget for assistive technology and any equipment was purchased using charitable funds.

Outcomes of care and treatment

- 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.
- Care plans for patients with spinal injuries identified goals set by the patients, and these were monitored by them in partnership with the multidisciplinary staff team.
- The NWR SIC provided telephone advice to patients, their families and other healthcare professionals on a daily basis. This enabled patients to be better supported and treated more effectively after discharge.
- All of the 11 regional spinal units nationally have been submitting data to the National Spinal Injuries database since October 2013 however it remains in pilot phase and no comparable data is available.
- The trust is supported by a CQUIN programme (Clinical Quality Incentive Scheme) and the data from that has shown 100% compliance since introduction in April 2014 with exception of one month for outreach visits within 5 days of Referral.

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Competent staff

- The Core Standards for Intensive Care Units (2013) recommend that a minimum of 50% of registered nursing staff should have a post registration award in critical care nursing. Twenty five per cent of nursing staff in NWRSIC were trained to this level. However, following the inspection discussions with the trust regarding the nature of care in the named intensive care and high dependency units of the NWRSIC revealed that intensive care was not delivered at the centre. The trust will review the naming of these areas of the centre.

Multi-disciplinary working and coordination of care pathways

- There was multidisciplinary team working in the NWRSIC that included regular input from healthcare professionals such as physiotherapists, psychologists and occupational therapists.
- There was a highly skilled and effective respiratory team working at the centre who provided safe and effective care for the ventilated patients and others who required respiratory support.
- Daily multidisciplinary ward rounds were undertaken on weekdays. Nursing and medical staff both confirmed that access to emergency medical support out of normal working hours was satisfactory.

Referral, transfer, discharge and transition

- The discharge planning process was part of the goal setting undertaken with the patient which began as soon as the patient was admitted to the centre.
- Comprehensive discharge information from all relevant healthcare professionals, such as the psychologist, physiotherapist and consultant was sent to the patient's GP or referring organisation.
- Patient passports were in use in the NWRSIC and were an effective way of communicating basic essential patient information.

Availability of information

- There was a comprehensive range of paper based and electronic information for patients of the NWRSIC and their families.
- There was also a series of education sessions and evening drop-in sessions available.

Consent

- Records we reviewed showed that patients had given valid consent for procedures. Patients we spoke with

confirmed this and gave examples of how procedures had been explained to them so that they fully understood and could ask questions before giving their consent.

Are regional spinal injuries centre services caring?

Requires improvement



Summary

Most patients were treated with dignity, compassion and respect. Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable emotional support. However, 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 no effective strategies in place to deal with the challenging behaviour of some patients.

Dignity, respect and compassionate care

- Throughout our inspection, we witnessed most patients being treated with compassion, dignity and respect. Past and current patients we spoke with confirmed this. Most patients and relatives we spoke with told us that staff were caring and supportive. We received many comments such as, "The staff here feel like members of my own family" and "We could not do without them, they are brilliant".
- During our inspection three members of the inspection team witnessed two staff members assisting a patient from a bathroom, covered only by three hand towels, with much of their body exposed. This person was wheeled passed several other members of staff who did not react or appear to find this unusual or inappropriate.
- The behaviour of a small number of patients was described to us as "difficult" by both nursing and allied health professionals. Strategies in place to deal with the challenges presented in the care of these patients were not always effective and staff struggled, at times, to deal with their behaviour. Other patients described to us the adverse effects of witnessing these behaviours on their emotional well-being.
- When staff were delivering care it was sometimes difficult for them to hear other patients who were

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unable to use the call bells calling for assistance. We observed one patient who was calling for assistance as we entered the centre. We highlighted this to staff who appeared unaware that they were calling. We were informed by two other patients that this patient had been calling for 20 minutes.

- One patient had informed us during the spinal injuries focus group that they regularly waited an hour to be assisted into bed at night. We observed this patient asking nursing staff to assist them for an hour before they received the help they needed. We discussed this with staff who informed us that this patient had been offered assistance earlier in the evening but had not wanted to go to bed at that time. As staff were then providing care for other patients this person had to wait until two staff members were available to assist them.

Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. They had opportunities to speak with the consultant looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.

Emotional support

- Staff built up trusting relationships with patients and their relatives through their interactions. Patients and relatives told us that they received considerable emotional support.

Promotion of self care

- Promotion of independence and self care is an important part of the goal setting process and patients were supported from admission towards as much independence as it was possible for them to achieve.

Are regional spinal injuries centre services responsive to people's needs?

(for example, to feedback?)

Requires improvement



the ward. The storage facilities did not meet the needs of the patients and the day room was in need of refurbishment. Sometimes patients could not attend workshops or planned sessions with allied health professionals, such as occupational therapists, because there were insufficient nursing staff to assist them with washing and dressing prior to the sessions. Patients were also unable to access the gym facilities in the evenings as there were no staff members available to supervise them.

Staff felt unsupported to manage the recent escalation of verbal and aggressive behaviour by the patients especially at night.

The Centre had a waiting list of patients who fulfilled the admission criteria and were awaiting admission once a bed became available.

Verbal complaints referred to timely service of hot food; delays in preparation for therapy in a morning; excessive waits for call bells to be answered and the untidiness of the ward.

Planning and delivering services which meet people's needs

- Access to the North West Regional Spinal Injuries Centre (NWRISIC) was by referral from other hospitals and healthcare professionals. The community outreach team carried out an initial assessment before patients were admitted. All admission decisions were made on a case-by-case basis in accordance with the National Clinical reference Group Classification for clinical priority and rehabilitation programmes were individually designed for each patient.
- The community outreach team also gave verbal advice and / or visited patients who were not suitable for admission to the NWRISIC to enable them to access the most appropriate services to meet their individual needs.
- Insufficient storage facilities for patients' belongings meant that clothing, cosmetics and other personal items were piled on chairs around patients' beds.
- The centre's day room was shabby and in need of refurbishment. We were informed that a refurbishment of the day room was scheduled to take place in the near future.

Summary

The community outreach team carried out an initial assessment before patients were admitted. The discharge planning process was part of the goal setting undertaken with patients and began as soon as they were admitted to

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Equality and diversity

- Ninety three per cent of staff working on the NWR SIC had received mandatory training in equality and diversity. Staff we spoke with had a good understanding of the needs of minority groups.

Meeting the needs of people in vulnerable services

- The NWR SIC had rehabilitation workshops for both light and heavy work, a gym and a pool. However, patients informed us that sometimes they could not attend the workshops or planned sessions with allied health professionals, such as occupational therapists, because there were insufficient nursing staff to assist them with washing and dressing. Patients also told us that they were unable to access the gym facilities in the evenings as there were no staff members available to supervise them.
- An internal review of the unit presented in September 2014 described an escalation of verbal and aggressive behaviour by the patients especially at night over recent weeks. The staff feeling very vulnerable and concern had been raised by both the staff and patients that there was not enough staff available during the evening or overnight to help subdue these escalations of behaviour.

Access to the right care at the right time

- The Centre had a waiting list of patients who fulfilled the admission criteria and were awaiting admission once a bed became available.

Complaints handling (for this service) and learning from feedback

- Complaints were handled in line with trust policy. Staff would advise patients how to contact the customer services team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- The NWR SIC did not receive many formal complaints, but did receive many on going verbal complaints from patients on the ward of a similar nature The complaints relate to;
 - Food not served timely resulting in cold food which ends up being reheated in the ward kitchen
 - Delays in patients being assisted out of bed and ready in the morning for their rehabilitation
 - Patient waiting excessive lengths of time when a nurse has been called with some delays being reported as up to 40 minutes

- Ward phone not being answered when the ward clerk is not on duty or busy elsewhere
- Untidiness of the ward due to cages being left with stores and linen to be put away - this has been picked up as non-compliance with fire safety.
- There was information displayed throughout the centre on how to complain. We spoke with patients and relatives and they knew how to raise concerns, make complaints and provide comments, should they wish to do so.

Are regional spinal injuries centre services well-led?

Inadequate



Summary

There were not enough senior nurse managers allocated to the North West Regional Spinal Injuries Centre (NWR SIC) to be able to provide effective leadership for this service. Nursing roles and responsibilities lacked clarity. We saw poor local decision making regarding the staff allocation which resulted in some patients being exposed to unnecessary risk.

The initial staffing report shared with the inspection team contained factual inaccuracy. Since the inspection the trust has repeated the review using an evidence based acuity tool and an investment of £370k has been agreed for an additional 9.38 WTE nursing staff.

There was no clear strategy for the future development of the centre and no effective methods of staff engagement. Concerns had been raised regarding the low staffing over an extended period without appropriate action being taken to mitigate the risks associated with staff shortages.

Service vision and strategy

- There was no clear strategy for the development of the NWR SIC post “Vision for 2010-14 Strategy” following which the Centre awaits the National Strategy from the National Clinical Reference Group before proceeding with local review. The Centre has been instrumental in the development of the National Strategy which is in its final consultation stages

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- We discussed this with the recently appointed operations manager. They informed us that engagement meetings with specialist commissioners of the service were due to take place in the near future, prior to creating a strategy for developing the service.

Governance, risk management and quality measurement

- Staff in the NWRsIC held regular meetings where quality issues such as complaints, incidents and audits were discussed and actions agreed. Staff we spoke with across all disciplines and at all levels were unaware of the risks contained within the departmental risk register, with the exception of the low staffing levels.
- Staff meetings did not routinely take place. Information to staff was disseminated via a 'read and sign' sheet which required staff to read information and sign to say they had done so. This method does not engage staff in a way that gives them an opportunity to comment, ask questions or suggest alternative ways of working.
- Management of identified risk was not conducted in a timely fashion leaving patients and staff open to risk, including concerns regarding staffing levels and management workloads for senior nurses.

Leadership of this service

- The nurse staffing review described in the safety section describes "Overload of management responsibility for the band 7 ward manager resulting in lack of clear leadership". The ward manager currently had management responsibility for the out patients department, the intensive care unit, the high dependency unit and the general ward, which consisted of acute and rehabilitation patients. A second band 7 was being recruited.
- Levels of accountability for the band 6 nurses who support the ward manager were unclear.
- The NWRsIC did not have a matron and responsibility for the centre rested with the matron for planned care services and their deputy. This was in addition to their considerable workload with regard to planned care services. There were not enough senior nurse managers allocated to the NWRsIC to be able to provide effective leadership for this service.

- Junior medical staff and nursing staff all spoke positively about the leadership provided by the senior medical team.

Culture within this service

- Staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the NWRsIC.
- There was a culture of 'good will' within the centre, where many members of staff, from all disciplines, worked beyond their contracted hours to support colleagues and to provide good patient care.
- We saw poor local decision making regarding the staff allocation which resulted in some patients being exposed to unnecessary risk.







Public and staff engagement

- The NWRsIC regularly brought in previous patients with spinal injuries. These volunteers gave both patients and relatives encouragement.
- The patient forum is made up of inpatients which are both active and hold regular meetings with Centre managers.
- The Centre also has its own Charitable group, made up of former staff members, current staff members and general public, who regularly host events internal and external to the Centre, actively working with both inpatients, outpatients and their families as well as having full engagement with the Centre staff

Innovation, improvement and sustainability

- The NWRsIC had formed an alliance with Aintree University Hospitals NHS Trust, which meant that long-term ventilated patients benefitted from the additional expertise of consultants from this trust.
- Throughout the public areas in the NWRsIC we saw feedback forms were available for patients and their families to provide comments, concerns and compliments. We did not see evidence of actions taken on the comments of patients and families. We saw that current and previous patients and their families were encouraged to attend events held at the centre throughout the year.

Critical care

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

Information about the service

The critical care services were based at Southport and Formby hospital. The Unit has eleven Intensive care and high dependency inpatient beds, consisting of five intensive care beds, six high dependency beds and four coronary care beds (with the space to go up to seven Intensive care beds). There are facilities to isolate patients with an infectious disease. The unit provided intensive and high dependency care, and there was also a four bedded coronary care unit within the critical care area. The critical care services provided care and treatment to adult patients with a range of serious, life-threatening illnesses from Southport and Ormskirk and the surrounding areas. As part of the inspection, we visited the critical care services and spoke with patients and the relatives of other patients. We observed care and treatment and looked at patient records. We also spoke with a range of staff at different grades, including nurses, doctors, consultants, support staff, allied health professionals and the senior management team. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust. The critical care service was provided through the urgent care division of Southport and Ormskirk Hospital NHS Trust. There was also an outreach service providing follow-up for patients on discharge from critical care. We also looked at the nursing support the coronary care unit received from the critical care service.

Summary of findings

Medicines safe storage was not in accordance with current guidance; this had been identified by the trust and was on the risk register but had not been promptly addressed. We found that some risks had been on the risk register for over two years without full resolution of the issues. We were told of a major infection control issue which was being addressed by the facilities team but their risk reporting system was not linked to the main system and therefore this did not appear on the trust risk register.

Staff told us that they had not achieved full implementation of all the relevant guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the national core standards for intensive care. For example, 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 intensive care standards. We did not see evidence of the daily use of a critical care delirium scoring tool in line with expected guidance. The lack of compliance with national guidance may impact on the service's ability to provide high quality effective care.

The adult critical care beds occupancy had been consistently above national average in the previous twelve months. This activity had reduced since June 2014. National Intensive Care audit data (ICNARC) showed that the service discharge out of hours to ward and delayed discharges over 4 hours were worse than

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the England average. We also found that the critical care service was not able to provide single sex accommodation for high dependency patients who were fit for discharge to the ward.

The trust had a vision and strategy for the organisation with clear aims and objectives. There was clearly visible leaders within the critical care service. Staff told us they were proud of the unit and the care they provided. The trust vision, values and objectives had been cascaded across the critical care service and some staff had a clear understanding of what these involved.

Critical care services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients. Concerns were raised about the efficacy of medical handovers.

Are critical care services safe?

Requires improvement



During our inspection we found that the critical care unit was staffed safely and appropriately by nurses. The service had sufficient trained and support staff with an appropriate skill mix to ensure that patients were safe and received the right level of care.

However, during our inspection we found evidence of pressures on medical staffing in that, contrary to the intensive care standards, the consultants had other clinical commitments when covering critical care and the consultant covering the critical care outside of normal working hours was also the consultant responsible for covering anaesthesia. The consultant covering critical care out of hours did not always have training in intensive care and may not have had access to daytime intensive care sessions. There were also concerns about the safety of the handovers process.

Staff were observed not adhering to infection control hand washing procedures despite regular audits showing 100% compliance with hand hygiene procedures.

Medicines storage was not in accordance with current guidance. This had been identified by the trust and was on the risk register, but had not been promptly addressed.

Individual cubicles were big enough to provide all the equipment required to care for critically ill patients. However, we observed that when a patient required transfer from the critical care unit the staff had to move key equipment to allow the bed to be moved through the unit. We also observed that space within the units was cluttered, and access was limited around the main nurse station.

The service had a clear system for reporting incidents. Staff told us that themes from incidents were discussed and feedback was given.

We reviewed the risks identified by the service. We found that some risks had been on the risk register for over 2 years without full resolution of the issues.

Figures provided by the trust showed that the mandatory training rates for anaesthetic staff were 62%, which was below the trust target.

Critical care

Incidents

- The service had a clear system for reporting incidents. Staff we spoke with were aware of how to report incidents and 'near misses'. Records confirmed that they had been trained to use the trust electronic reporting system (DATIX).
- The service monitored all its risks and had a local risk register. We reviewed the risks identified by the service. Some risks had been on the risk register for over 2 years without full resolution of the issues. We were told of a major infection control issue which was being addressed by the facilities team but their risk reporting system was not linked to the main system and therefore this did not appear on the trust risk register. It is important that all risks are captured and have clear action plans in place to mitigate the risks, and to inform staff of the management actions to improve patient care.
- Staff told us that themes from incidents were discussed and feedback was given at team meetings. For example, we saw evidence of feedback to concerns raised about staff communication with a relative and how to improve communication.
- We were told that staff were aware of the mortality data for the service and had identified that improvements were required to ensure that this information was reviewed on a more formal basis by the service itself. A new consultant had been identified as the mortality lead and plans were in place to refocus the mortality and morbidity meetings (which discuss rates of death and disease) on a formal basis with monthly reviews. The new format mortality review meeting was planned to start in December 2014.

Safety thermometer

- NHS Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, pressure ulcers, blood clots, and catheter and urinary infections) was displayed on the wall at the entrance to the critical care unit.
- Information showed that the critical care service was performing within the expected range for falls with harm, new venous thromboembolisms (blood clots) and pressure ulcers.

Cleanliness, infection control and hygiene

- Information supplied by the trust recorded two cases of Clostridium difficile (C.difficile) infections between April 2014 and October 2014 across the critical care service. We were informed by staff that the C. difficile cases had been reviewed and were not attributable to the unit.
- All patients admitted to the service were screened for MRSA so that any patients with MRSA could be identified and treated promptly.
- There had been no recorded cases of MRSA since October 2013. On the day of our unannounced visit, we found that one high dependency patient was being nursed in a critical care room because they had MRSA. This was being investigated by the unit manager. Intensive Care National Audit and Research Centre data from 2013 demonstrated that the unit's acquired MRSA rates were within statistically acceptable levels.
- We found that there had been an improvement in the number of central venous catheter related infections in the service. We saw evidence that the infection rate had fallen by 55% when compared with the previous 12 month period.
- We saw evidence that the service took part in hand hygiene audits for which it had scored 100% consistently. However, during our visit we observed that medical staff entered the critical care unit and were moving from one area to another without observing hand hygiene procedures. This was not an isolated observation as we also observed members of the nursing staff not following hand hygiene procedures in line with trust policy. This issue was raised directly with the unit manager during our visit for action.
- We were told that the service was investigating the presence of pseudomonas in the tap water involving several areas of the unit. We were told that this was an intermittent problem and records of action plans showed that the issue had been on going since September 2014. Filters had been installed on the water supply which had provided temporary resolution. We saw minutes of regular meetings had been held and the trust was seeking external support to resolve the issue. Pseudomonas is an opportunist infection and has a potentially severe impact on patients in critical and high dependency care because they are more at risk than

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healthy people. The bacteria may cause pneumonia in patients with respiratory complications particularly people on ventilators or similar, urinary tract infections and wound infections.

Environment and equipment

- The majority of equipment was appropriately checked, cleaned and regularly maintained. This included the resuscitation equipment. Safety checklists were completed daily.
- We asked staff to show us the process for checking equipment on the unit. We found that the 'difficult intubation' trolley was not checked at regular intervals but after each time the trolley was used. This did not assure us that the equipment would be ready for use in an emergency. Following discussion with the unit manager during our visit plans were put in place to ensure that this trolley was checked daily.
- The service had easy access to bronchoscopes from theatre if required.
- Individual cubicles were big enough to provide all the equipment required to care for critically ill patients. We observed a patient being transferred from the critical care unit to theatre; this required staff to move key equipment trolleys to allow space for the bed to be moved through the unit. We also observed that in the other areas the bed space was of an adequate size, but space within the units was cluttered, and access was limited around the main nurse station.

Medicines

- The audit of the safe storage of medicines reported in September 2014 highlighted continued non-compliance with current guidance for the safe storage of medicines on the ITU (Intensive Therapy Unit), CCU (Critical Care Unit) and Spinal ITU. These issues had been highlighted two years ago, with little progress made towards resolution.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We found that medicines that required storage at temperatures below 8 degrees were appropriately stored in a medicines fridge. Fridge temperatures were checked daily to ensure that the medicines were stored at the correct temperature.

Records

- We observed that all patient records were well structured, legible, complete and up to date. We looked at four sets of patients' notes, all of which contained daily entries from the multidisciplinary team.
- Nursing documentation included appropriate risk assessments and the implementation of specific care bundles, which provided a systematic approach to manage the treatment of hospital patients, such as those for ventilator acquired pneumonia, skin care, haemodynamic assessments and nutrition.
- Standardised nursing documentation was kept at the end of the patients' beds. Observations were well recorded, and were carried out depending on the acuity of the patient (the intensity of care needed).

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children.
- The staff we spoke were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding was clearly displayed in the staff room.
- Trust data showed that there were no safeguarding incidents reported in the critical service in the 12 months before the inspection.

Mandatory training

- The data supplied by the trust showed that 86% of critical care nursing staff had completed their mandatory training. The manager told us that they had experienced problems with recording the mandatory training onto the trust-wide data base and had now put in a system to record each individual staff member's training. The large number of new nursing staff had meant that some staff had not yet completed all their mandatory training but plans were in place to achieve the trust target by the end of March 2015.
- Figures provided by the trust showed that the mandatory training rates for anaesthetic staff were 62%, which was below the trust target. It is important that staff have access to mandatory training to ensure that they have the right skills to ensure the delivery of high quality safe care.

Critical care

Assessing and responding to patient risk

- There were tools in place for the early detection and escalation of changes in a patient's condition. Ward staff across the trust used an early warning system. This system scores patients' vital signs and is used for identifying patients who are deteriorating clinically.
- Critical care staff carried out routine monitoring based on patients' needs to ensure that any changes in their medical condition could be promptly identified.
- The trust provided a critical care outreach team, which worked collaboratively with nursing and medical teams to offer expert advice about acutely ill or deteriorating patients who were being cared for in the ward environment. The outreach team was working with ward staff to pilot electronic hand held devices used to complete patient observations and create alerts at any signs of deterioration.
- Safety huddles took place on the unit each day to highlight any patients with specific risks such as falls or infections.

Nursing staffing

- During our inspection we found that the critical care unit was staffed safely and appropriately. The service had sufficient trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The nursing establishment was based on a recognised staffing assessment tool and met the Royal College of Nursing's recommendation of one nurse to each patient assessed at level three dependency (those with complex needs including respiratory support) and one nurse between two patients assessed at level two dependency (those who have less urgent needs). The criteria used for determining the needs of patients was in line with The Intensive Care Society's 'Levels of intensive care' document.
- We noted the sickness absence rates on the unit had been above 5% from April 2014 to September 2014 according to the unit dashboard. This also showed high expenditure on agency staffing.
- We found that there was a (nurse) shift coordinator supervising the unit throughout the day and night. This nurse was not allocated patients. Nursing staff handovers occurred twice a day and included discussions such as staffing or capacity issues.

- Information on staffing levels, including actual versus establishment, was clearly displayed near the entrance to the critical care unit and this was updated daily.
- The manager told us that they had used agency staffing whilst recruiting new staff. We were told that they used regular staff that were used to working on the unit and had had an induction.

Medical staffing

- The critical care unit had the cover of one whole time equivalent intensive care consultant during each weekday, plus another consultant covering each morning. Middle grade cover was also based in the critical care unit during the day. We found the staffing levels to be better than the national average.
- During our inspection we found evidence of pressures on medical staffing in that, contrary to the intensive care standards, the consultants had other clinical commitments when covering critical care. Consultants covering critical care should spend the majority of time in the critical care unit and always be immediately available.
- During our inspection we observed a handover on the unit. We found that the handover was not run efficiently. The different grades of staff carried out individual handovers and not collectively. Handover was written (using a pre-printed form) and verbal, although no copy of this was given to the incoming doctors. The form was then filed for audit purposes. After this, the middle grade doctors and consultants met to discuss. The whole process took one and a half hours. The information required was handed over and patients who were at risk on the ward were then discussed. The lack of a clear effective handover may have an impact on the provider's ability to ensure that care and treatment is provided in the most effective and timely manner.
- The consultant covering the critical care outside of normal working hours was also the consultant responsible for covering anaesthesia. The trust confirmed that all consultants in the Department of Anaesthesia had completed training in critical care medicine as part of their core anaesthetic training. All consultants also received regular educational updates in critical care medicine as part of the departmental educational programme. All anaesthetic consultants had access to day time critical care sessions upon request.

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- Junior staff we spoke with felt well supported by the consultants. The consultants were available out of hours and lived within 30 minutes of the unit.
- The clinical lead told us that usually locum usage was low, but had increased over the summer because of staff absences. We were told that locum cover is usually provided internally, although there is an induction process for new external locums, which was done by the middle grade doctor or consultant.
- The clinical lead for critical care was not allocated one programmed activity specifically identified for management functions in critical care.

Major incident awareness and training

- We spoke with staff from different professional groups and grades who all confirmed that they understood the procedure for major incidents and felt confident of what actions they would take and where to find the relevant action plans. Staff confirmed that they had been involved in a test practice for a major incident.
- There was a documented major incident and business continuity plan within the critical care service. Guidance for staff in the event of a major incident was available within the critical care area.

Are critical care services effective?

Requires improvement



Intensive Care National Audit and Research Centre (ICNARC) data showed that discharges out of hours and delayed discharges (of over 4 hours) were worse than the England averages. The majority of patients and relatives we spoke with were very positive about the care and treatment they had received.

We found that although there was input from allied health professionals such as pharmacy, dietician and physiotherapy staff, there were shortfalls in the staffing requirements outlined in the intensive care core standards.

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 intensive care standards. We did not see evidence of the daily use of a critical care delirium scoring tool in line with expected guidance. The lack of compliance with national guidance may impact on the service's ability to provide high quality effective care.

Staff told us that they had not achieved full implementation of the relevant guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the national 'Core standards for intensive care units' (2013). This was confirmed on the service risk register. Trust data showed that the majority of staff in the critical care series had completed their annual appraisals.

We did not find evidence of an equipment replacement programme to ensure that equipment required for the care of patients was fit for purpose at all times.

Evidence-based care and treatment

- The critical care service carried out some routine clinical audits to review compliance against internal standards as well as national guidance such as NICE and other professional guidelines. There was a clinical governance system in place and findings from clinical audits were reviewed within the service.
- We were told that the service had carried out an audit in February 2012 on the ventilator care bundle (for the prevention of ventilator-associated pneumonia) and had achieved 100%.
- We were told that the intensive therapy chart was in the process of being reviewed, which will include daily checks to ensure that care bundles such as the ventilator care bundle are being reviewed. The clinical lead told us the new form was due to be used early in the New Year.
- Staff told us that they had not achieved full implementation of all the relevant guidance issued by professional and expert bodies such as NICE and the national core standards for intensive care. This was confirmed on the service risk register. One staff member told us that a business case had been submitted five years ago for more therapy staff which had not been addressed by the trust. We were told that the service had limited access to rehabilitation and sometimes the rehabilitation passports were not completed. This was not in line with 'Rehabilitation after critical illness' NICE clinical guideline 83.
- 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 intensive care standards. We did not see evidence of the daily use of a

Critical care

critical care delirium scoring tool in line with expected guidance. The lack of compliance with national guidance may impact on the service's ability to provide high quality effective care.

- The consultant rota had individual consultants working daily sessions on the unit rather than working for longer periods to ensure continuity of care.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- The patient records we looked at showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- As part of their individual care plans all critical care patients were assessed for pain management. Staff utilised a pain scoring tool and had clear access to the trust's pain team as required.
- We saw that epidurals and patient-controlled analgesia systems were used in accordance with trust guidelines.

Equipment

- We did not find evidence of an equipment replacement programme to ensure that equipment required for the care of patients was fit for purpose.

Nutrition and hydration

- We were told that staff carried out assessments of patients' nutrition requirements, and the patient records we looked at confirmed this. We found that nutritional risk scores were updated and recorded appropriately.
- Nutrition and screening scores were completed before referral to a dietician. The unit had access to a dedicated dietetic service.
- Where patients were identified as at risk, there were fluid and food charts in place which were reviewed and updated by staff in line with the trust nutritional support policy.

Patient outcomes

- The critical care team was part of the Cheshire and Mersey Critical Care network. The overall aim of the network is to improve patients' experience and outcomes, improve access to critical care services and ensure critical care units practice high quality care.
- Critical care units within the network have an annual service specification assessment. We reviewed the 2013

reports and subsequent action plans. The review highlighted the need to ensure compliance with NICE guidance and to review the access and flow within the unit.

- Nursing and medical staff were involved in a number of national and trust led audits including the National Intensive Care audit (run by ICNARC). The ICNARC data for 01 October 2013 to 31 December 2013 demonstrated that the unit had mean lengths of stay in line with similar units, unit mortality was within expected limits; there had been no unit acquired infections and early discharges were very rare.
- The majority of patients and relatives we spoke with were very positive about the care and treatment they had received.

Competent staff

- Trust data showed that the majority of staff in the critical care series had completed their annual appraisal.
- The service had two clinical practice educators that oversaw the training processes and carried out staff competency assessments. All the staff we spoke with were very positive about this role and felt that they had benefitted from the support to develop their skills and knowledge to carry out their job role. We observed the clinical educator discussing the use of a piece of equipment with staff to highlight a safety alert that had been raised for the service. We were told that the service was piloting the use of a dependency tool in order to improve the allocation of the right skill mix of staff to the acuity of an individual patient.
- We were told that 72% of staff had completed the post registration award in critical care nursing and that this number would increase as the new staff completed their own induction and accessed the post registration training.
- Newly appointed staff underwent an induction process they lasted up to six weeks as supernumerary and their competency was assessed prior to working unsupervised.
- The clinical educator for the service showed us a comprehensive training and information package for nursing staff covering key knowledge areas in intensive care such as pain relief, nutrition and end of life care.

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Personal logs had been introduced to ensure that senior staff had a clear record of all professional training and to encourage professional responsibility to maintain professional standards.

- The service had also introduced an on call competency for physiotherapy staff working out of hours on the unit. Training for tracheostomy care had also taken place across the trust to ensure that patients were treated to an agreed competency.

Multidisciplinary working

- There was effective daily communication between multi-disciplinary teams within the critical care service. Staff did not attend the whole ward round but accessed the round for individual patients. We observed that the nursing team did not attend the whole ward round but individual nurse were available for their own patients.
- We found that although there was input from allied health professionals such as pharmacy, dietician and physiotherapy staff there were shortfalls in the staffing requirements outlined in the intensive care core standards. We found that there was no dedicated psychologist or occupational therapy.
- Physiotherapy did provide a service on critical care and assessed the patient's requirements although they did not have any dedicated critical care time. This was not in line with national guidance.
- The critical care outreach team was highly regarded within the critical care service and across the trust.

Seven-day services

- Out of hours pharmacy, physiotherapy and imaging services were available during the daytime at weekends and were then on call.
- A consultant anaesthetist/intensivist was available 7 days a week including outside normal working hours. This was confirmed during our unannounced visit.

Access to information

- Staff told us that they had access to all the relevant information they required to care for their patients. This included information such as relevant blood test and diagnostic results, which were available to all members of the multidisciplinary team.
- Staff were able to describe discharge process, and we were shown the results of an audit on the internal

transfer of patients, which showed a 90% compliance with the trust transfer policy. We were shown an action plan that had been developed to further improve the transfer forms for handover of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received mandatory training in obtaining patients' consent. All the staff we spoke with were knowledgeable about how to seek consent both verbally and in writing. All the staff we spoke with understood the care of the unconscious patient and worked on the principle of acting in the persons 'best interest'.
- Staff understood the need to protect the rights of the patient. One member of staff was able to describe the process that took place before doctors could agree to use 'mitts', so that patients would not be restrained unnecessarily. Mitts are equipment used to prevent a patient pulling out intravenous lines while unconscious.
- When conscious patients lacked capacity to consent, staff adopted the same 'best interest' principles and had access to advice from appropriate professionals to support decisions made in the best interest of the patient.

Are critical care services caring?

Good



We found that critical care services were delivered by committed and caring staff. We observed that all staff treated patients with dignity and respect. Patients or their representatives spoke positively about their care and treatment. Staff kept patients or their relatives involved in their care. We found that clear systems were in place to offer emotional support to people if required and was carried out with sensitivity and compassion.

Compassionate care

- We observed and were able to talk with patients on the high dependency unit who did not mind the lack of single sex accommodation and felt that they had been well cared for and their dignity had been respected throughout their stay.

Critical care

- The critical care area offered single room accommodation with automatic doors providing privacy. Staff told us and we observed that screens were used in front of the automatic doors to protect individuals' privacy when the doors opened.
- All the relatives we spoke with told us that their loved ones had been looked after in a caring and compassionate manner by all the staff across the critical care service. They gave us positive feedback about the ways the staff had cared for their loved ones and how they had ensured that their dignity was maintained. We observed this ourselves in all areas of the service.
- We observed unconscious patients being spoken to by all the multidisciplinary team with compassion, care and dignity.
- The staff we spoke with were passionate about the care they offered to patients.
- Conversations about patients' conditions, prognosis and end of life care were sensitively managed.

Understanding and involvement of patients and those close to them

- Patients were allocated named nurses either at a ratio of one to one, or one nurse to two patients, depending upon their levels of need. This helped to ensure continuity of care.
- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible the views and preference of patients were taken into account. We saw evidence in clinical notes that patients and relatives had been involved in making decisions about their care and treatment.
- The patients we spoke with told us that they had been seen daily by a doctor, and the medical staff had clearly explained their care and treatment to them.

Emotional support

- When necessary, relatives could ask for a face to face meeting with a doctor. All the relatives we spoke with stated that they had been fully updated on their relatives' care on the unit and felt supported by the clinical team.
- There were defined visiting times for relatives, but relatives could visit patients at any time of day. Relatives were also provided with a direct phone line they could

use if they wanted updated information about a patient's care. The critical care service was able to offer limited facilities for relatives including a private room and facilities for making drinks.

- Staff told us they could seek advice and support from the trust's palliative care team if a patient required end of life care. We observed this working very positively on the high dependency unit during our visit.
- Staff told us how they had been supported after two very difficult cases on the unit. They had been offered debrief sessions and staff counselling, and individual support was available.
- During our inspection we observed that a patient at the end of life and their family were supported with compassion and sensitivity.
- The service actively encouraged the use of diaries for those patients in critical care longer than 4 days. This practice was managed by the critical care outreach team and helped patients to reflect on their illness and alleviate any signs of post-traumatic stress.

Are critical care services responsive?

Requires improvement

The adult critical care bed occupancy had been consistently above the national average in the 12 months before the inspection although there had been a downward trend since June 2014. There were sufficient staff and equipment to meet the needs of the patients.

The service was able to be flexible with bed allocations depending of the needs of patients across high dependency and intensive care. These allocations could be changed depending on patient needs because the service operated as a combined unit.

However, 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 who were fit for discharge to the ward. This did not comply with the Department of Health guidance on ensuring single sex accommodation for these patients.

We saw that information leaflets were given to relatives to explain what to expect in an intensive care unit with useful information to help them during their relatives' stay.

Critical care

Service planning and delivery to meet the needs of local people

- The critical care service was able to be flexible with bed allocations depending of the needs of patients across high dependency and intensive care. These allocations could be changed depending on patient needs because the service operated as a combined unit. On the day of our visit we observed that an individual was being nursed in the isolation unit due to a possible contagious disease.
- We found that there was sufficient staffing and equipment to meet the needs of patients.
- The trust provided critical care services largely for adults, but had admitted 16 year olds in the 12 months before the inspection.

Meeting people's individual needs

- We saw that information leaflets were given to relatives to explain what to expect in an intensive care unit, with useful information to help them during their relatives' stay. We did not see written information readily available in different languages or other formats, such as braille.
- The critical care services were provided by specialist trained staff who involved carers and family in the patients' care when specific care plans were put into place. We observed that personal pictures and information were available in patients' cubicles to ensure that the care was personalised and supported the individual patient.
- Staff told us they could access an interpreter if needed.
- We found that the critical care service was not able to provide single sex accommodation for high dependency patients who were fit for discharge to the ward. This did not comply with the Department of Health directive on ensuring single sex accommodation.

Access and flow

- The adult critical care bed occupancy had been consistently above the national average in the 12 months before the inspection.
- The ICNARC data for 01 October 2013 to 31 December 2013 demonstrated that there were delays in discharge to the wards, delays of 4 or more hours ranged between 70% and 85% over the four quarters. 32% of delays were less than one day, 22% were of one to two days but 2% were delayed by seven or more days. It also demonstrated that discharges out of hours were worse than similar units.

- Staff confirmed that delayed discharges were common. On the day of our visit we met one patient who had been identified as fit to move to a ward four days before our visit. This had not yet been recorded as an incident on the trust electronic recording system. We were not assured that the impact on patients in need of high dependency care could be maintained alongside those patients who have different needs in respect of dignity, privacy and noise levels. We were also not assured that the location was the most appropriate one for continuing rehabilitation.
- As part of our inspection we reviewed the trust escalation policy and discussed the process with staff. The bed manager collected a list from the intensive therapy unit, high dependency unit and critical care unit on a daily basis (between 8am and 9am) of all patients who were ready for transfer to a ward, but delayed discharges continued to be an issue and this was on the risk register. The Intensive Care Bed Information Service (ICBIS) monitors critical care beds on a regional basis throughout the day. All available critical care beds were reported to this service in line with the trust escalation policy.

Learning from complaints and concerns

- We found low levels of complaints about critical care and found evidence that the service responded well to people's concerns and comments.
- We saw that notice boards included information such as the number of complaints and compliments received during the month. The staff we spoke with understood the process for receiving and handling complaints.
- The critical care service had information leaflets displayed for relatives on how to complaint. This included information about the customer services department. The customer service team managed complaints centrally for the trust. Complaints were recorded on a centralised trust-wide system.
- Staff told us information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.

Critical care

Are critical care services well-led?

Requires improvement



We found that there was a clinical governance system in place that allowed risks to be reviewed and escalated to divisional and trust board level but that some risks had been on the risk register for up to 2 years without formal resolution.

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.

There was clearly visible leadership within the critical care service. Staff told us they were proud of the unit and the care they provided. Staff were highly motivated and positive about the future direction of the service.

Vision and strategy for this service

- Staff we spoke with from all disciplines in the service could tell us about the trust's vision and values. The majority of staff told us that the chief executive was visible but did not know the non-executive team.
- The clinical lead for the service clearly outlined his vision for a high performing critical care service. Staff told us they were proud of the unit and the care they provided.

Governance, risk management and quality measurement

- There was a major infection control issue which was being addressed by the facilities team but their risk reporting system was not linked to the main system and therefore this did not appear on the trust risk register. It is important that all risks are captured and have clear action plans in place to mitigate the risks, and to inform staff of the management actions to improve patient care. We were not assured that the service had clear robust action plans in place to carry out remedial action to address the root cause of the issue nor that it was being addressed in a decisive and timely fashion.
- We reviewed the service quality performance dashboard. The service measured itself against the Cheshire and Mersey Critical Care Network service

specifications. We did not see specific evidence of assessment of the service against the Intensive Care Society core standards as they were incorporated in the service specification.

- We found that there was a clinical governance system in place that allowed risks to be reviewed and escalated to divisional and trust board level. Local risks were described by the trust as operational risks, which sat within the local area (that is, the ward or department), but did not have an impact outside of that area. They were low level risks that may affect the operational day to day function of the area. These risks were managed at a local level through the service risk register and monitored through the divisional governance framework.
- We found records of staff meetings to discuss day to day issues and to share information on complaints and incidents.
- We looked at the departmental and divisional risk registers to review key risks. We found that some risks had been on the register for up to 2 years without formal resolution. We also found that a serious infection control problem was not on either the local service or the corporate risk register, despite the existence of an incident team managed through facilities management and regular operational meetings. We were told that this was an administrative oversight, but we noted that the corporate risk register stated in February 2014 that the facilities management risks should not be recorded in a separate stand-alone database and not the main risk register. This means that the concerns raised were not managed as per the trust risk management strategy. We were therefore not assured that the critical care service had robust effective systems in place to ensure that key service risks were escalated and addressed in a timely manner to ensure the safe delivery of high quality care.

Leadership of service

- The senior medical and nurse leaders were passionate and committed to providing a safe, high quality service for their patients.
- The critical care service was incorporated into the urgent care division of the trust. We found clearly defined and visible leadership roles within the service.
- The clinical lead was new to the role. The lead had begun to develop the direction of the service and was further strengthening links with the critical care network to support improvements. We also noted that the

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matron for critical care also had responsibility for two other services. This was identified as an issue in the action plan compiled in response to the service specification review from 2013.

- The ward staff were managed by supernumerary clinical coordinators, who reported to the matron for critical care services.

Culture within the service

- The critical care unit had a very positive feel and staff were highly motivated and committed to their jobs.
- All the staff we spoke with felt supported by their peers and managers and were proud to work in critical care.
- We saw from the service dashboard that the nursing service had a large turnover of staff in July and August 2014 (1.25% and 2.47% respectively); some staff had left as a result of a change in shift patterns. New staff had recently arrived in post and were positive about the team culture.

Public and staff engagement

- Due to the nature of critical care services it can be difficult to engage with patients. Staff sought feedback from patients and their relatives by asking them to complete patient experience questionnaires.
- The critical care service did not formally participate in the NHS Friends and Family Test, which asks patients how likely they are to recommend a hospital for treatment. However these forms were available at the entrance to the unit if families wanted to complete

them. Staff told us that in response to feedback they had upgraded the relatives' room and revised the information leaflets to improve communication with families and patients.

- The overwhelming responses from the patients and relatives we spoke with were positive towards the staff.
- Staff told us that they did feel engaged with the unit manager but would welcome more face to face meetings, although this had not been possible over the months leading up to the inspection because of staffing issues.

Innovation, improvement and sustainability

- The staff told us that they were developing links with the Cheshire and Merseyside Critical Care Network. One staff member worked 1 day a week for the network and was involved in developing audit tools across the network.
- Membership of the network allowed the service to work collaboratively with other centres to focus on improvements where they were required, for example, the introduction of care bundles. The clinical staff told us that further work was required to encourage staff to engage with the network more, to drive service improvement.
- We found that the trust had started to be proactive in responding to performance and quality data and were in the process of finalising a programme of meetings to understand and address shortfalls.

End of life care

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

Information about the service

Southport and Ormskirk NHS Trust provides palliative and end of life care to patients across the two sites and in the community. At Southport Hospital patients with end of life and palliative care needs were cared for in general wards, supported by a dedicated, consultant-led palliative care team which maintained close links with the local hospice. The trust had recently created 'transform team' as part of a national programme aiming to improve the quality of end of life care provided by acute hospitals.

At Southport Hospital we visited 7 wards, the accident and emergency department, the intensive care unit and the spinal injuries unit where palliative and end of life care was being provided. We observed care, looked at records and spoke with healthcare assistants, nurses, junior doctors, consultants and ward sisters. We received feedback about the service from patients and relatives at the local listening event, and followed up with one relative who wanted to discuss her father's care further. We also met with the specialist palliative care consultants who lead the service, the palliative care team and the transform team, and visited the mortuary.

Summary of findings

We found that the end of life/palliative care services at Southport Hospital were generally good, and were supported by a robust training programme and adherence to national guidelines.

Staff from both the general wards and the specialist palliative care team and transform team displayed enthusiasm for providing safe, effective and compassionate care to patients reaching the end of their life. The multidisciplinary team worked well together to achieve this.

The mortuary and bereavement service was focused on making its environment and interaction with patients and relatives as minimally distressing as possible, and displayed excellent, innovative care.

Some end of life individualised care plans were found to be incomplete, meaning that some patients and their families may not get preferred care at the end of their life. The system for regular reviewing of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms was not robust, which may result in unnecessary confusion and distress if CPR is required.

End of life care

Are end of life care services safe?

Good



End of life care was provided in the general wards in the trust, by ward staff supported by the palliative care team and the transform team. The care provided was good. Training of nursing and medical staff reached national accreditation standards and was supported by excellent documentation found on every ward. Staff of all levels talked enthusiastically about this knowledge making them feel empowered to care for patients at the end of their life sensitively and confidently.

Anticipatory medicines were appropriately prescribed and administered to patients at the end of their life, and innovative support materials had been devised by the trust to ensure that symptoms of deterioration were recognised and acted upon. However, Individual 'My vigil' care plans were not always completed in their entirety, and the review process for 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms was unclear.

Incidents

- Incidents were logged on the trust-wide electronic reporting system. Staff were aware of the procedure for reporting incidents and received feedback. Learning was shared in multidisciplinary meetings.
- An example of a clinical incident was observed in the mortuary, and we saw how this was reported and the appropriate action was taken to prevent reoccurrence.

Medicines

- All adult inpatient prescription sheets had a dedicated page where standard and individualised anticipatory drugs could be prescribed, along with clear symptom control guidelines for pain, nausea and vomiting, restlessness, respiratory tract secretions and breathlessness.
- We observed prescription charts with anticipatory drugs prescribed and administered as documented, and these drugs were available on all wards.
- Specialist palliative care doctors were available 24 hours a day for review of medication for patients in hospital approaching end of life.
- Staff told us that syringe drivers were readily available, if needed, for patients at the end of their life to facilitate rapid discharge home.

Records

- Intentional rounding logs were in place for all patients on an end of life pathway, to ensure their basic nutritional, hygiene, environment and toileting needs were assessed every 2 hours. These were generally well completed.
- Six detailed individual plans for care for those thought likely to be dying were examined. Of these, three were fully completed, one was partially completed and two had details missing including family details, holistic assessment and plan, and patient identifiers were not present on every page. Although the majority documented that family members were present at the time of planning the patients' care, one record did not state who this member was or their relationship to the patient, and in one there was no record of this conversation at all.
- All records were stored securely to ensure they could not be accessed by people who did not have the authority to do so.
- 16 DNACPR forms were examined and found to be complete and in the front of patients' notes, although there was uncertainty about when patients' status should be reviewed. The trust 'Cross-setting do not attempt cardiopulmonary resuscitation' policy states that the DNACPR decision, if made in hospital, should be reviewed every 72 hours, unless an enduring decision was felt to be appropriate. When a senior member of the staff was questioned about this she was not aware of the review interval, or how an unlimited DNACPR decision should be documented. She directed us to patients' main notes where 'care to continue' was taken to mean that the DNACPR status had been reviewed and remained in place. This system did not feel robust, meaning that if a patient did need CPR the validity of the DNACPR form could be questioned, causing trauma to them and their family.

Safeguarding

- There were adult safeguarding procedures in place supported by mandatory staff training, which staff confirmed they had had the opportunity to attend. Staff told us they were aware how to raise and escalate a concern in relation to abuse or neglect of both vulnerable adults and children.
- We found that there were safeguarding policies in place with clear procedures for staff to follow should they have a concern.

End of life care

Mandatory training

- The trust was part of the 'Gold standards framework' training programme, with 1074 staff having completed some or the entire training package.
- All members of the transform team had undertaken educator development training, and teach basic palliative care including key enablers, to staff and relatives caring for patients thought to be at the end of life.
- Since the withdrawal of the Liverpool care pathway, the transform team has trained 832 hospital staff in 'New priorities for the care of the dying', and many of the staff we spoke to told us how this training had empowered them to speak confidently to patients and their families at the end of life.

Assessing and responding to patient risk

- The transform team visited every ward daily to identify any patients indicated by staff or relatives to be approaching the end of life, and a plan of care was put in place. The Palliative Care Team visit wards as requested and required.
- Out-of-hours specialist advice could be sought from the on-call consultants and medical/nursing staff at the hospice.

Nursing staffing

- Patients with palliative/end of life care needs were nursed on general wards in the hospital, meaning nursing care relied on the staffing arrangements on the particular wards.
- Handover was completed at the bedside on most wards, ensuring patient/relative involvement, and a 'safety huddle' was held every shift to ensure all staff knew about any changes or deterioration of patients on the ward outside of their allocated responsibility.
- We observed that there were sufficient nursing staff, many with specialist training, along with other clinical and support staff to ensure that patients at the end of life were safe and well cared for.

Medical staffing

- For patients with palliative/end of life care needs, medical cover was provided on the general wards of the hospital. We spoke to three junior doctors who had all received 'New priorities for care of the dying' training from the transform team and felt this empowered them to have difficult conversations with patients reaching the end of life.

- The hospital provided specialist consultant support along with access to the local hospice for advice.

Major incident awareness and training

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

Are end of life care services effective?

Good



All the trust's policies and procedures relating to end of life care were evidence based from national guidelines and were easily accessible to staff. Pain relief was available on all wards, and could be reviewed by a palliative care specialist 24 hours a day.

The trust proactively implemented the 'New priorities for care of those thought to be dying', before the compulsory withdrawal of all references to the Liverpool care pathway. This had been supported by a robust training programme.

Patients' nutrition and hydration needs and preferences were, in general, adequately met and documented, and staff were highly motivated to meet patients' preferences for where they wanted to end their life.

The trust had a proactive attitude to national and local audit, and achieved good multidisciplinary working with GPs, care homes and other allied health professionals.

Evidence-based care and treatment

- The trust implemented the 'New priorities for care of those thought to be dying' 2 weeks before the compulsory withdrawal of all references to the Liverpool care pathway.
- All policies and procedures relating to end of life care were easily accessible to staff using the trust's intranet system and had been updated in line with National Institute for Health and Care Excellence (NICE) guidelines, with updates communicated to staff by email.
- All patients considered to be within a year of the end of life were registered on the 'Gold standards framework' once confirmation had been received from their GP. This ensured that the GP was fully informed of their care needs and they had better coordinated services with

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easier access to emergency care. Once patients were thought to be likely to be dying, a 'My vigil' individualised plan of care was completed with the patient and their family.

- The trust had a proactive attitude to local audit. All staff undergoing the 'End of Life Skillset Challenge' training had to complete a local audit as part of their qualification. Evidence of audits completed and resulting action plans were provided, along with a list of potential audits the trust would like to complete
- Every ward visited had a set of drawers containing all the main cross boundary documentation required for palliative and end of life care. The numbered documents in care coordination, specialists palliative care, future care planning, respecting patient choices, care of the dying and symptom control could be tracked for future audits. Resource folders to support the use of this documentation were also found to be available. All information was based on the Department of Health's national 'End of life' strategy information.
- All staff had been given pocket-sized cards defining appropriate end of life terminology and summarising the role and contact numbers of the transform team.

Pain relief

- Appropriate pain relief was available when required and anticipatory medicines were prescribed to ensure pain medication could be administered in a timely manner.
- All wards were observed to have magnets on drug cabinets showing symptom control algorithms and how to contact the palliative care team.
- The acute pain team was available to advise staff on appropriate pain relief, and most of the palliative care nurses were advanced prescribers.
- An audit into the prescription of opioids had been undertaken, resulting in a leaflet being developed providing patients more information about understanding opioids in palliative care.

Nutrition and hydration

- Patients were supported to eat and drink for as long as possible. Most patients thought likely to be dying had their wishes about food and drink documented on the 'My vigil' individualised care plan.
- We observed that food and fluid logs were completed accurately, with an additional check that these were up to date by the 2 hourly intentional rounding log.
- We observed one patient whose care plan said he should be using red trays for assisted eating but where

the appropriate box was not checked on his intentional rounding form. This could mean that he would not receive the assistance with his nutritional needs that he required.

- One patient described the food as "lovely, what you would have at home".
- Staff were able to tell us how they addressed people's religious and cultural needs in the meals provided for them.
- In the 'National care of the dying' audit (May 2014) the trust achieved better than the England average in reviewing patients' nutritional and hydration requirements.

Patient outcomes

- All staff were highly motivated and committed to meeting patients' preferences of where they wanted to end their life.
- The trust took part in the 'National care of the dying' audit in May 2014, which covered indicators of organisational and clinical performance. The trust achieved all of the organisational key performance indicators, including access to specialist care in the last hours of life, access to information relating to death and dying and promoting privacy, dignity and respect up to and after death. Three of the 10 clinical indicators were worse than the national average, and the trust had action plans in place to address this.

Competent staff

- All new staff undertook an induction programme, which included mandatory training in care of the dying.
- Staff told us that they received annual appraisals and had regular supervision within their ward area.
- All nurses received an initial three days, and healthcare assistants received four half days of palliative care education, with regular update days. Junior doctors attended seminars with the specialist palliative care senior medical team.
- Along with their initial training, the specialist palliative care team received 1 hour's training/updating every week.

Multidisciplinary working

- We observed the weekly multidisciplinary team meeting, which was attended by the palliative care team, two specialist palliative care consultants, student nurses, medical students, a social worker and representatives from the transform team, chaplaincy,

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occupational health, physiotherapy and pharmacy. Each new patient referred to the palliative care team and their plan of care was discussed along with information about who had died and whether they had done so in their preferred place of death.

- The transform team also provided training to staff at care homes, under the "Six Steps to Success principles" with 85 staff trained this year.
- The palliative care consultant told us that patients at the end of their life wishing to die outside of hospital could usually be discharged within 2 hours of the decision being made. This was achieved by effective communication between the ward staff, palliative care and transform teams, pharmacy and the ambulance service.
- The wards could access speech, language and dietetic services, and we saw evidence of patients at the end of life benefiting from these services.
- We saw an electronic palliative care system being updated during the multidisciplinary team meeting.

Seven-day services

- The specialist palliative care team and the transform team worked from 9am to 5pm, 7 days a week.
- Outside of these hours support could be gained from the specialist palliative care consultant, who provided a 24 hours a day, 5 days a week on-call service, or from the medical staff at the adjoining hospice.
- A problem was identified with the community night service, as many staff reported that patients dying at home did not always receive a visit from the district nurse overnight, which could affect their comfort, dignity or pain management.

Access to information

- Information for patients was available in multiple formats.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. Where patients did not have capacity to consent the Mental Capacity Act 2005 was adhered to appropriately and the deprivation of liberty safeguards were applied, when necessary.

Good



Most patients reported receiving compassionate care from the ward staff, supported by the palliative care team and the transform team.

The mortuary team especially was observed to provide excellent compassionate care to patients and their relatives at the end of life.

The trust had invested in providing a comfortable environment for relatives of very sick patients, and designed the mortuary so relatives experienced the minimum amount of distress.

Compassionate care

- We observed patients being treated with compassion, dignity and respect by all staff.
- All staff we spoke to were aware of the importance of treating patients and their families in a sensitive manner.
- One patient told us that nurses were always coming in and out to her, that the palliative care team was supportive, and that she saw the same nurses in the hospital and at home. Another patient told us that the healthcare assistants were "lovely" and that the doctors were easy to talk to.
- We spoke to one patient who felt she had to wait a long time for her pain medication, which was found to be one and a half hours overdue.
- Two patients complained about the lack of doctors at a weekend and the ward rounds often didn't occur until late afternoon, leaving them unsure of their plan of care for that day.
- One relative of a patient being cared for in the community expressed her dissatisfaction about the uncaring attitude of staff on the ward, resulting in her father refusing to be admitted to Southport Hospital. This is being followed up as a formal complaint with the trust.
- The mortuary was found to provide compassionate care to the deceased and to their relatives. A detailed procedure for care after death was documented in order to ensure that all spiritual and physical care was carried out in accordance with cultural and religious beliefs of

Are end of life care services caring?

End of life care

the deceased and their family. The mortuary staff demonstrated that they cared passionately about their work, and their approach to caring for the deceased and their families was observed to be outstanding.

- All porters who transported bodies to the mortuary were required to be assessed against a competency monitoring system, in order to ensure all trust and legal requirements were met.

Understanding and involvement of patients and those close to them

- In the 'National care of the dying' audit (May 2014), health professionals' discussions with both patients and their friends and relatives about their recognition that the patient is dying was better than the England average. Conversations about dying were the subject of a recent audit and an action plan was in place.

Emotional support

- The 'National care of the dying' audit (May 2014) reported that the trust was below the English average in assessing the spiritual needs of the patient and friends/relatives.
- During the inspection, the Chaplain discussed the care of the dying audit figures. He explained the massive improvement since his employment. The Chaplain explained the Trust had employed a full time chaplain and since that time there had been major improvements in practice. The action plan was fully discussed with explanation of the input from the chaplain and a number of documents were shared including the submission to European Association of Palliative Care demonstrating the improvement and methodology and the raw data information from the audit completed by Trust Chaplain in October 2014 showing the 100% spiritual assessment. The consultant led audit of 200 sets of Palliative Care notes across the ICO supported this.
- We saw the Oasis room, which is a comfortable area for relatives of very sick patients to rest; 'comfort packs' are provided. Shower facilities had recently been provided for relatives staying overnight. This was described by one family as 'a cloud of comfort'. The use of the Oasis room was audited and found to be used frequently by families both day and night.
- The transform team facilitators had a non-clinical role and provided emotional support and information for patients at the end of life and their families.

- The entrance, waiting room and viewing room of the mortuary environment had been carefully considered so relatives visiting their loved ones experienced the minimum of distress.

Are end of life care services responsive?

Good



Patients at the end of life and their relatives were supported by the palliative care team to plan for their future, and a national system was in place to identify them when accessing emergency care in order to speed up admission and discharge.

85% of patients who had a documented preferred place of death died where they chose to, facilitated by an effective end of life rapid transfer programme.

The mortuary had close links with the local mosque and the manager was a regular attender at the local funeral directors forum.

Service planning and delivery to meet the needs of local people

- The trust had a very close relationship with Queens Court Hospice, sharing training and ensuring that medical and nursing support was available 24 hours a day, 7 days a week.
- From April to September 2014, there were 75 documented end of life transfer discussions, and 31 successful transfers home of those who were dying. During this period, of the 433 patients who died and were on the 'Gold standards framework', 92% had a documented preferred place of care and 85% died where they chose to.
- A patient satisfaction questionnaire had recently been completed by the palliative care team, there was a 68% return rate and results were very positive. Staff were highly praised and the service was described as "Wonderful" by a number of people. An area for improvement would be around the 12 people who said they were not given information on how to feedback compliments, comments, concerns or complaints?
- The mortuary had close links with the local mosque and the manager was a regular attender at the local funeral directors forum.

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Access and flow

- The 'National care of the dying' audit (May 2014) identified that multidisciplinary recognition that a patient was dying was below the England average.
- Patients were referred to the transform team as soon as they were thought to be at the end of life. Patients referred to the palliative care team were usually seen within 48 hours, or earlier for urgent cases.
- Ward staff told us that there was not a specific allocated bed space for patients who were likely to die on the ward, but they tried whenever possible to take patients' individual wishes into account by offering a side room or for them to remain in a bay.
- Patients on the 'Gold standards framework' carried a gold card and were flagged on the electronic admission system in order to make their admission to and discharge from emergency services faster.

Meeting people's individual needs

- The palliative care team had produced a 'planning for your future' pack which was given to all patients thought to be at the end of life. This pack included information for advance care planning, and provided prompts about finances, wills, pet care and so on. There was also practical information for families on what to do when someone dies.
- Mortuary staff demonstrated their awareness of and sensitivity to a wide range of cultural and faith practices.
- Spiritual and religious care was provided to dying patients and their families by a chaplaincy service, who also provided pastoral care to trust staff.
- In the accident and emergency department there was a relative's room and an empty room allocated for viewing any patient who had died there.

Learning from complaints and concerns

- All complaints were handled in line with trust policy.
- The trust had received 12 complaints about end of life care in the last year. The main themes were continuity of care and communication. All complaints were logged and coded on the trust complaints system, with the outcome and resulting action clearly described. All complaints were discussed at the end of life strategy group and were used for multidisciplinary teaching.
- When a senior member of the palliative care team was asked about learning from complaints, she was not aware that there had been any complaints about end of life care in the last year, which suggests that the learning from complaints is not being robustly cascaded.

Are end of life care services well-led?

Good



The culture within this service was one of effective, multidisciplinary working between ward staff trained in end of life care and the palliative care and transform team, who were reported to be responsive and approachable.

The trust had taken part in the 'National care of the dying' audit (May 2014). It achieved all the organisational key performance indicators and had plans in place to address the three areas in which it was benchmarked below the England average.

There was strong leadership within the service, however, there was a lack of clarity of roles with the palliative care consultants taking on clinical, educational, audit and managerial responsibilities. Although some succession planning to lead the service was evident, it still relied on two individuals.

Vision and strategy for this service

- The trust's strategy for this service in 2014/15 was to increase the number of patients who expressed a wish to die at home to do so, and to increase the number of support staff trained in caring for patients at the end of their life.
- The executive lead responsible for end of life care was the acting Director of Nursing.
- The vision for excellent end of life care was evident from the ward staff. Those who had achieved End of Life Skillset Challenge levels wore their bronze, silver and gold badges with pride and were easily identified as end of life care champions.
- The mortuary service had a clear vision of the service it wanted to provide for its patients, and this was demonstrated by its view that it was an extension of excellent patient care and innovative practice.

Governance, risk management and quality measurement

- There was a robust audit plan, which changed in response to feedback from the 'National care of the dying' audit (May 2014), complaints received and incidents reported. The trust provided several examples of audits and action plans that had been completed by clinical staff, the chaplaincy and the mortuary service.

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Leadership of service

- The service was led by two specialist palliative care consultants at the ICO and one, based at the local hospice near the Southport Hospital site. However, there was a lack of clarity of roles with the palliative care consultants taking on clinical, educational, audit and managerial responsibilities and there wasn't a clear reporting structure underneath them. An example of this is one of the palliative care consultant conducted the appraisal of a senior member of the Transform Team, instead of the manager of that service.
- The senior palliative care consultant appeared to be the main leader of the service, with evidence of succession planning by the recruitment of the second consultant.

Culture within the service

- Throughout the trust, staff demonstrated a caring and enthusiastic approach for supporting patients approaching the end of their life, and felt well supported and had positive working relationships with the palliative care team and the transform team. This was sometimes not reflected in the documentation in individual care pathways, some of which were found to be poorly completed.
- Staff in the transform team and palliative care team spoke positively about the care they provided for patients.

- The mortuary and bereavement staff culture was very caring and innovative about the care they provided at the end of a patient's life. This was demonstrated through their approach to patient care.






Public and staff engagement

- The trust had taken part in the 'National care of the dying' audit (May 2014) and demonstrated how it was responding to the outcomes identified.
- We saw an analysis of the SPCS patient survey which had a 68% return rate and results were very positive. Staff were highly praised and the service was described as "Wonderful" by a number of people. An area for improvement would be around the 12 people who said they were not given information on how to feedback compliments, comments, concerns or complaints?

Innovation, improvement and sustainability

- The transform team was only funded for 1 year on May 2014, and further funding to continue this service had not been identified.
- The mortuary team demonstrated innovative practice, bidding for funding outside of its budget for items (for example cloth bags for patient's effects and seed cards) from trust central funds.

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

Information about the service

Outpatient services are provided by the trust primarily from its two main hospital sites, Southport and Formby District General Hospital and Ormskirk District General Hospital. The trust provides a large range of outpatient and diagnostic imaging services at both sites.

During the course of our 3 day inspection we visited both sites. We spoke with a total of 27 patients and 35 staff about outpatient and diagnostic services. We also received information before and during the inspection from staff and patients who contacted us through the 'share your experience' link on the CQC website.

We visited general medical clinics and specialist clinics including ear nose and throat (ENT), fracture, dressings, hysteroscopy, ophthalmology, orthopaedic physiotherapy, urology, neurology and phlebotomy clinics.

We liaised with external organisations and checked information we were given against national statistical information.

Summary of findings

Overall, we found that outpatient and diagnostic services required improvement in the area of patient safety. This was because we could not be sure that all matters of concern were properly recorded or that the trust had clear oversight of the issues. This was demonstrated by the monthly 'discrepancies' meeting, which is held at Southport's diagnostic imaging department. We were told that there had been no involvement of the trust risk team at these meetings. Issues are discussed and learning was shared, but only within the group.

Concerns had been raised by staff about the safety of the ophthalmology clinic at Southport. These had been taken to the risk management team and the trust risk manager had been to the clinic, but no action appeared to have been taken, and the staff who raised the issue had been given no feedback about proposed action or why action was not required.

In all other respects we found that the services were safe. Staff were trained in infection prevention and control and understood their responsibilities. Safeguarding processes were in place to identify and prevent abuse. Other equipment had been properly maintained, serviced and cleaned.

We found that services were effective. National targets for referral to appointment times were exceeded in all areas. Staff were well trained and encouraged to do

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additional training or broaden their skills. Outpatient staff of band 5 and below were rotated between departments and sites to increase their skill base and provide greater flexibility for the department.

Multidisciplinary working was evident both at a local level and within the wider health community. Specialist consultants from neighbouring trusts ran clinics which were staffed by Southport and Ormskirk staff, enabling patients to receive a first appointment nearer to home.

Services were caring. We observed staff at all levels interacting with their patients. All the encounters we saw involved friendly and helpful interactions.

Patients could not speak highly enough of the nursing staff who cared for them. We witnessed staff assisting patients and walking them to their destinations.

Patients told us how doctors, nurses and receptionists had all taken time to explain things to them, in ways that they understood.

Diagnostic services had identified how they could improve privacy and dignity for patients who are brought to the department in beds.

Services were responsive. Audits were completed and services were reviewed. We saw how information was used to identify areas for improvement; changes had been made to the waiting rooms at both sites, improving the environment for patients and staff.

Children's activity boards were being put up to occupy young people while they or their parents waited to be seen. A video was being produced to show young children or patients with learning disabilities what it would be like when they attend the department. This was to be published on the trust website.

Additional services had been created, such as the 'dressings' clinics, which had freed up consultants' time and reduced delays in fracture and orthopaedic clinics.

Clinics that consistently ran late were reviewed to identify blocks in patient flow.

Services were well led. We found that staff respected their local managers; they were supported in the decisions they made and encouraged to develop.

Managers had a good understanding of their teams and recognised where improvements could be made, and led on the issues on behalf of the teams.

<Summary hGovernance systems were in place, which in most instances, ensured that staff were informed about trust issues and could share their thoughts and concerns.

Innovation was encouraged, which was demonstrated by the improvements to help children and patients with learning disabilities settle into the department, and proposals submitted by porters to improve waste services.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We were concerned that information about issues or incidents that impacted on patient safety was not escalated to the Board. Although diagnostic imaging services held monthly meetings and issues were discussed and learning was shared within the team the lack of engagement with the trust risk management meant that learning was not shared outside the meeting.

We spoke with staff who had highlighted patient safety issues during eye clinics at Southport. The concerns had been highlighted to the trust risk management team, which was asked to visit the clinic to review it. The risk manager had visited the clinic, but the staff member who had highlighted the issues did not receive any feedback and did not know if anything was planned to address the concerns. We have requested a copy of the trust risk manager's findings and report.

The general environment was safe, passageways and waiting rooms were free from clutter and trip hazards. Staff were trained in and understood how to prevent or control infection but patients infrequently used the hand gel provided. Equipment was clean, well maintained and ready for use.

Incidents

- The trust used an electronic incident reporting system. The system was used to record all incident types. Staff were familiar with the reporting system, and most staff told us that they found the system easy to use.
- Staff we spoke with told us that they did not always receive feedback after submitting incidents. They told us that the system had changed recently and feedback on incident trends was now a regular feature at handover and team meetings.
- The clinical lead for diagnostic services told how they held monthly discrepancy meetings where the team discussed in an open forum any issues that had arisen. However, the trust risk management team did not take part in these meetings, and mis-diagnosis is only fed

back to radiologists and not escalated outside the meeting. This meant that important safety information may not always receive the analysis and oversight it requires.

- The chief executive of the trust described how breast screening services had been suspended at the trust to ensure patient safety.

Cleanliness, infection control and hygiene

- We noted that the hospital had hand gel stations throughout the departments and at all entrances to clinics. Some of the gel stations had signs directing people towards them and there was information on notice boards encouraging staff and patients to use them.
- Despite the availability of the hand gel stations we saw that most patients and people who accompanied them did not use the gel. We asked some patients and their families why they hadn't used the gel; some told us they hadn't noticed them and others said that they thought they would be alright as they hadn't touched anything. People told us they had not received any information before attending the hospital to advise them about hand hygiene or encouraging them to look for and use the gel.
- We saw that staff in clinical areas observed the National Institute for Health and Care Excellence (NICE) guidance on infection control:
 - Staff were bare below the elbow.
 - Staff washed their hands before and after examinations.
 - Staff wore protective gloves and aprons when appropriate.
- The trust employed housekeeping staff who completed most cleaning tasks, but staff we spoke with told us they always ensured areas were clean and equipment had been ready for use before inviting the next patient in. We saw that disposable wipes were used to clean spills or wipe furniture.
- We saw that there were supplies of gloves and aprons available.
- We spoke with a housekeeping manager and waste control manager about cleaning routines and schedules and saw how these were audited. We spoke with a member of the trust's housekeeping 'task team'. The

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task team is called to deal with more difficult or larger cleaning issues. They explained their role and how they could be called to any department of the hospital to assist general housekeeping staff.

Environment and equipment

- Throughout the inspection we checked equipment and found that it had been properly checked, cleaned and maintained ready for use.
- Resuscitation trolleys had log books showing that they had been properly checked regularly. We did see occasions where the daily checks had not been marked as completed, but these were very few, and none were recent.
- Imaging equipment had been maintained under a long-term contract with an external provider. We saw that log books were maintained with details of any faults or routine maintenance that had been carried out. We checked a number of entries against the manifest sheets provided by the maintenance engineers and saw that they had been completed correctly.
- Staff told us that they did not experience problems with equipment. Broken or damaged equipment had been repaired or replaced quickly.
- There were three main routes into the hospital for patients going to the outpatient or diagnostic imaging services. We found that signs were clear and relatively easy to follow.
- Routes were uncluttered and free from trip hazards. Staff told us that before our planned visit the corridors had been cluttered with trolleys and cages containing bags of laundry, fresh linen or supplies. When we asked managers about this we were assured that these changes were not put in place simply for our visit.
- They told us that they had conducted a review of the services and in order to improve safety they had initiated a number of improvements.
 - They had reminded staff of the importance of using designated storage areas.
 - A member of staff had been re-assigned to regularly empty the stores throughout the day to ensure there was always sufficient space.
 - Supplies and clean linen were delivered and unloaded rather than being left in cages on or outside wards for nursing staff to unpack throughout the day.
- Waste and laundry were correctly packed in coloured bags to enable them to be clearly identified. Clinical

waste was handled and disposed of differently from domestic waste. Porters had suggested that they move all waste and linen from storage areas to the service yard and sort the bags there. Managers told us this had not been possible because transportation of clinical waste had to be done in fully enclosed bins. If other bagged waste were placed in these bins there was no safe method of separating the bags when they reached the service yard because of manual handling issues. It had not been possible to identify a suitable bin or trolley which would allow them to transfer and safely sort the bags. This showed that the trust ensured that health and safety regulations were complied with.

Medicines

- We did not find any problems with safe handling, storage or administration of medicines in the areas we inspected at Southport.

Records

- Doctors or specialist nurses updated patient records during consultations. This meant that information had been recorded properly and was correct and up to date. Patients we spoke with confirmed that they had seen both written notes and electronic records updated. We were able to observe a small number of consultations between clinicians and patients, during which appropriate notes were taken.
- Staff told us that they rarely experienced problems obtaining patient health records. If patients' main records were not available, clinics were provided with temporary notes. The temporary notes were then used to update the main records.
- Patients told us that staff appeared to understand why they were there and what their condition was. They told us that staff always confirmed who they were when they were called into the consultation rooms.
- We spoke with a patient at Southport who had experienced problems the previous day when they had attended an appointment at Ormskirk District General hospital. It appeared that the hospital had been sent the wrong set of notes from the patient's GP, which had meant the consultation could not go ahead. Staff had obtained the correct notes and arranged for the patient to attend the next available clinic, which had been at Southport. The patient was very pleased how the two hospitals had worked together to correct the problem and organised the new appointment so quickly.

Outpatients and diagnostic imaging

Safeguarding

- The trust had a comprehensive safeguarding policy. Staff had had safeguarding training in line with their role, and had a clear understanding of how to recognise different forms of abuse and how to escalate or report issues.
- The trust had a whistle blowing policy. Not all staff understood the policy but they did know that they could report any concerns they had about behaviour or practice to their managers.

Mandatory training

- All the staff we spoke with had completed their mandatory training.
- Supervisors and managers kept a matrix of their staff to show when training was due.
- Staff explained how additional training and incremental pay had been linked to mandatory training attendance. Staff had to prove that they had attended their mandatory training before they were allowed to do any external or additional training. Those staff who received incremental pay increases couldn't progress to the higher pay rate if they had not completed mandatory training. Most staff thought this process acted as a good incentive. However, some complained that the trust training records were not updated quickly enough, which had led to delays in payments or authorisation for additional courses or further development, and affected morale.

Assessing and responding to patient risk

- The matron explained how all nursing staff and healthcare workers up to band 5 had additional training which meant they were able to support clinicians in any of the clinic disciplines. This also meant that staff were able to provide cover for absences from within their own workforce, which provided continuity for patients.
- We saw how patients' personal details and health issues were checked when they were called into consultations, which ensured that the doctors and specialist nurses had the correct records and were dealing with the correct person.

Nursing staffing

- Nursing staff and healthcare workers in the general outpatient department explained how they had been trained in all competencies within the department, which meant that they could assist in any of the clinics.

- Staff in the department also rotated with colleagues on one of the wards, which enabled them to understand each other's difficulties and needs.
- The flexibility of staff also meant that vacancies could be covered from within the department. We were told that no agency staff had been employed in the department for a number of years and only occasionally did they need to resort to bank staff.
- The outpatient department matron explained that there were some staff who were approaching retirement. This meant that a number of very experienced and skilled staff would be lost. In order to encourage new staff to join, the matron had been liaising with senior board members to introduce additional staffing grades, which would encourage staff to develop and progress as well as encourage other staff to work in the area.
- We received information during the inspection about issues experienced in the eye clinic at Southport. We were told that the clinics were very overcrowded, nurse leadership was said to be poor and there were not enough nurses in the clinics to provide a safe service. The trust risk team had been asked to attend the clinic. The trust risk manager had apparently recently visited the clinic, but no feedback had been received and nothing had changed. We have asked the trust for a copy of the risk manager's report and recommendations.

Medical staffing

- Clinical staffing in all outpatient and imaging departments was good. Some specialist clinics were run by consultants from neighbouring trusts. This enabled people to be seen closer to home, and then if required they would then be transferred to clinics at the consultant's own trust for follow-up treatment. We saw that clinical staff worked well with the local Southport and Ormskirk nursing staff.
- The radiology clinical lead told us that the department was working to its capacity. There were seven radiologists, but a high workload, which in his opinion would be carried by ten radiologists in another trust. Despite this the department had been able to maintain and often exceed national targets for urgent and routine imaging.
- Following the exclusion of a radiologist from the diagnostic imaging department, the trust was unable to comply with best practice guidance for breast services

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and could not guarantee patient safety, and so withdrew the service. Nursing staff were concerned about the effect this had on patients who then faced longer journeys to unfamiliar locations.

- Imaging services provided a 7 days a week service to the inpatient wards.

Major incident awareness and training

- Senior nursing staff had a good knowledge of the trust's emergency planning. Plans were available on the computer system and copies had been printed off and were available in the sisters' office and matron's office. The matron described how updates or changes were communicated and replacement copies were produced to ensure the printed copies always reflected the most recent advice. Paper copies were kept so that they had instant access to information and guidance.
- We were told how part of the major incident planning had been implemented to enable senior staff and managers to monitor and respond to issues caused by national industrial action by some groups of healthcare professionals in October 2014.

Are outpatient and diagnostic imaging services effective?

Care pathways followed national guidance and best practice, resulting in anticipated outcomes for patients. Processes were in place that encouraged staff to fulfil their training obligations. Staff were encouraged to increase their knowledge and skills, and supported by their managers to do so. Audits were completed locally and services were reviewed, which had resulted in changes to and improvements in services.

Patients told us they had understood the advice and guidance they were given and believed that staff had a genuine interest in their wellbeing. They told us they had confidence in the medical and nursing staff.

None of the outpatient services we inspected had plans to provide 7 day working in the near future. Most clinic staff described occasions when additional clinics had been operated at weekends or later into the evening in response to requests from commissioning groups to target specific groups of patients. Services were not always available at times which were convenient to all sections of the public.

Patients described having to take time off work in order to attend clinics, although some patients had contacted the hospital and been given appointments at more convenient times.

Evidence-based care and treatment

- Diagnostic services were delivered in accordance with Department of Health and Royal College of Radiologists guidance.
- Breast services had been withdrawn on the basis of patient safety, which meant that patients now had to travel to neighbouring trusts for diagnostic services. We were not able to speak with anyone who had been affected by this, but some staff said that patients having to travel outside the area caused them increased anxiety in addition to the inconvenience.
- We saw how changes were being made to outpatient departments as a result of audits and reviews that the matron had completed. Many of the changes affected outpatient sites across the trust.
- The matron had reviewed the services and environment of the department along similar lines to the Royal College of Physicians' 'patient shadowing framework'. This had involved following the whole patient experience through the service, looking at the environment, staff interactions, the expectations of patients, the timeliness and the effectiveness of services. A member of the trust board and a patient had been asked to accompany the matron on a walk-through of the department. As a result of the audits and reviews the following improvements had been implemented at Southport:
 - The outpatient department waiting rooms and treatment rooms had been decorated, improving the environment for patients while they waited.
 - A dressings clinic had been introduced to support the fracture and orthopaedic clinics. Following approval by clinical leads, the dressings clinic meant that patients who needed routine dressing changes or who required tight or loose plaster casts to be replaced no longer needed to make appointments or be seen by a clinician. Experienced staff could see people on a drop-in basis and deal with their issues. If during the session a health issue was identified then the patient could be seen by the consultant. This had reduced pressure on the clinics, freed up consultants' time, and generated additional income for the trust from commissioners.

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- Improvements on both sites included:
 - Activity boards for children.
 - Authorisation for the production of a film to help reduce anxiety for children or patients with learning disabilities.
 - Uniforms for reception staff, to provide a more professional image and make them feel more like part of the team.

Pain relief

- Chronic pain clinics were provided by the trust at both Southport and Ormskirk outpatient departments. There were no pain clinics operating on the days of our inspection, so we were unable to inspect this service.

Patient outcomes

- Patient referral to appointment times met or exceeded national averages for all outpatient and diagnostic service disciplines. For example, all urgent cancer patients were seen within the national target time of 2 weeks.
- Outpatient and diagnostic imaging services participated in national audits of its services; for example, the outpatient diagnostic service waiting list for September 2014 for Southport and Ormskirk compiled by the Department of Health showed that the trust had a total of 2150 patients on its waiting list. Of these only seven patients had waited longer than 6 weeks, which represented 0.3%. No patients had waited longer than 8 weeks.
- Diagnostic imaging services provided a 7 days a week service to inpatient and emergency services. Services to outpatient departments operated on working days between 8am to 8pm.
- Patients told us they had received their initial appointments quickly after being referred by their GP. Some patients told us that on occasions they had experienced long waits when attending clinics, some up to 2 hours. However, we were told that they had been kept updated by staff about delays and understood that emergencies occurred which impacted on clinic times.
- Patients said they understood the advice and guidance they had been given. They had confidence in the medical and nursing staff and they believed they had a genuine interest in their wellbeing.
- The matron described the matrons' monthly check sheet which enabled the services to be monitored and

reviewed. The audits that had been completed led to improvements in the overall environment of the outpatient clinics and the introduction of additional services such as the dressings clinic.

Competent staff

- All staff had completed mandatory and statutory training. We saw how the trust linked performance-related pay and access to additional training with each staff member's training record. This meant that staff were encouraged to complete their training.
- Specialist training had been completed in line with professional registration requirements. Some staff told us it had been difficult to maintain their professional registrations without needing to work in their own time.
- We saw how staff discussed issues as they arose and sought assistance from more experienced colleagues. During our inspection a patient in a clinic became unwell. Staff dealt immediately with the patient and informed senior staff so that they were aware and could oversee and assist with the situation.
- All staff had completed appraisals with their line managers, and we were told how supervisions of clinical practice took place. We saw evidence of regular staff meetings, and staff told us that they could approach colleagues or managers at any time for advice if they needed it.

Multidisciplinary working

- We saw and were told about good examples of multidisciplinary working. We saw how clinics took place that were run by consultants from neighbouring trusts. These enabled people to be assessed locally to determine if they would need to travel to the neighbouring trust for treatment. Nursing and support staff were all local and provided the same level of care and support as they did to the locally run clinics.
- We saw how patients had been able to attend a number of clinics including blood tests, physiotherapy or occupational therapy sessions, and diagnostic imaging services during one visit, reducing the number of visits patients needed to make. Patients who had visited several services were very complimentary of the way their care had been planned.

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- We saw how nursing staff were trained to work in all the clinic areas. The matron described how staff rotate between the clinics and also work on one of the inpatient wards; this had enabled them to create a flexible and responsive workforce.

Seven-day services

- None of the outpatient services we inspected had plans to provide 7 day working in the near future. Most clinic staff described occasions when additional clinics had been operated at weekends or later into the evening in response to requests from commissioning groups to target specific groups of patients.
- Some clinics operated until 8pm for people who could not attend during normal working hours.
- Diagnostic imaging services provided a 7 day service to inpatient and emergency services.

Access to information

- Patient health records were prepared in advance and delivered to outpatient clinics on the day of the clinics. Notes were delivered in locked trolleys, which were unlocked at the start of the clinics.
- If original records were not available, temporary notes were prepared from electronic records, which enabled patients to be seen at the discretion of the consultant. Staff told us they could not recall any incidents where patients had not been seen due to the absence of the original notes.
- Doctors could also access clinic letters and notes on the computer terminals in consulting rooms.
- Nurses and healthcare workers also had access to computer terminals at the nurse stations, where they could access information or print necessary documents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most of the patients we spoke with told us that they had not been asked to sign their consent for the treatments they had received. They told us that the doctor or nurse had fully explained the proposed care and treatment, and had confirmed with them that they consented before any examination or treatment had taken place.
- Staff had a good understanding of the Mental Capacity Act (2005). They were able to describe how people who could not make important decisions for themselves due to illness or incapacity should be supported.
- We were told that people with dementia, learning disabilities or mental health conditions were always

accompanied by relatives or carers when they attended clinics. A member of staff said, "If I had any doubt about someone's ability to consent I would seek advice, I wouldn't just leave them on their own".

Are outpatient and diagnostic imaging services caring?

Good



We observed how staff interacted with patients in all areas of outpatient and diagnostic imaging services. Nursing staff and healthcare workers were professional, caring and proud of their work. Doctors and consultants were polite and respectful and spoke to patients in a way that enabled them to understand sometimes complex conditions. Receptionists were polite, friendly and helpful. We saw housekeepers and porters assisting people.

Patients told us how nursing staff had helped them understand their treatment and given them time to consider what had been said.

We observed staff assisting people even when this had taken them out of their way.

Patients' privacy and dignity was respected by staff, although issues had been identified in areas of diagnostic imaging: patients in beds from emergency departments or wards were left at the front of the waiting room while they waited for their x-ray, where they could be seen by other patients. Work had been proposed to address this and create a curtained area.

Compassionate care

- Staff we spoke with were very proud of the care and support they provided to patients and their families.
- Before our inspection we received information suggesting that staff were not always polite and courteous towards patients. During our inspection, patients told us that the staff had been very polite and appeared genuinely interested in their welfare. Patients who had attended outpatient appointments on a number of occasions told us that they had always found staff to be the same.
- Because of the availability of services at both Ormskirk and Southport hospitals, some patients told us they had

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attended clinics at both locations. These patients told us that they had found staff equally as polite at both locations, although they found that staff at Southport had less time because the clinics were busier.

- We observed a number of instances at Southport where staff were seen to provide excellent support and compassionate care. On one occasion an elderly patient had entered the hospital and was clearly confused about where they needed to go. We observed a member of staff (who would not have known we were present) recognise that the patient needed assistance. They approached and in a very friendly manner asked if they could help. The patient explained where they were trying to find. The member of staff told them they would take them. They took the patient's arm and walked with them, even though they had been going in the opposite direction. The patient was clearly uplifted and smiled and chatted as they walked away.
- We observed interactions between patients and staff in the clinics and imaging areas we visited. We saw that staff were respectful, polite and listened attentively to patients and their families.
- All the patients we spoke with were very complimentary of the nursing staff. They told us how they had been able to ask about their treatment or clarify things the doctor had said. Patients told us that staff had given them time to consider and understand what had been said. Many told us they thought the staff were "brilliant", "angels", "fantastic" and similar terms.
- We saw that doctors and consultants were polite and respectful, speaking with people in a way that enabled them to understand very complex conditions.
- Receptionist were welcoming, friendly and helpful. We saw housekeeping staff and porters going about their work but interacting with patients, giving directions or exchanging pleasantries.

Understanding and involvement of patients and those close to them

- From our observations and comments from patients it was clear that patients were fully involved in and informed about their condition and the options for treatment.
- Patients described how doctors or specialist nurses had explained how their condition could be treated or how it

might progress over time, and how that might impact on their lives. Patients described being able to question the diagnosis and suggested treatments. They felt the issues had been explained to them in a way they understood.

- Some patients said they hadn't really been given options about treatment – they had been told what was proposed and had accepted it. However, they did say that had they not been happy with what they had been told they would have challenged it.
- Staff told us that they always took people's views into account and that alternative options were always discussed and documented in patients' records.
- People's privacy and dignity were for the most part respected. We saw that reception areas had notices asking patients to wait a short distance away so that patients at the desk could not be overheard. Consultations were always conducted in closed rooms.
- The directorate manager of diagnostic imaging services had only been in post for a few weeks. They had identified that in some areas of the department patients could be left in embarrassing positions while waiting for their x-ray or scan. Patients from wards or emergency departments were transferred on hospital beds or trolleys. The only place these could be left was at the front of the waiting rooms, which meant patients could be seen by all the seated patients in the area. As patients in beds wore pyjamas, nightdresses or hospital gowns, this compromised their privacy and dignity. The waiting area had been reviewed, and a block of changing cubicles at the side had been identified which could be removed and replaced by a curtained area where beds or trolleys could be parked. This would also make it easier to get into and out of the area in an emergency. The work had been authorised and was waiting to be completed.
- The service had a chaperone policy to protect patients and staff.

Emotional support

- We asked staff how they would deal with patients who were distressed or were disruptive. They told us they would speak with them and suggest they might be more comfortable in the 'quiet room'. They showed us the quiet room, which was furnished in a more homely way and provided a more informal and less clinical atmosphere.

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- If further emotional support was required, staff could refer people to counselling services appropriate to their needs.
- Disruptive patients would be spoken with and reminded how their behaviour affected both staff and patients, and they would be asked to cooperate with procedures. Staff told us that ultimately if someone was threatening they would ask them to leave and porters or police would be called to escort them out.
- Specialist nurses and clinicians had received additional training, in line with their roles, to enable them to deal with patients who had received distressing news or an unexpected diagnosis.

Are outpatient and diagnostic imaging services responsive?

Good



Outpatient and diagnostic services were meeting national targets for referral to treatment times.

Services were planned to meet local need but some patients were attending appointments and diagnostic appointments at both hospitals for the same condition. Local and national audits were completed and reviewed, and services were tailored according to results.

For example, the outpatient department had reviewed the waiting rooms and facilities for young children or people with learning disabilities. This resulted in the purchase of activity boards for the waiting rooms.

The trust operated from a number of sites, including community-based locations, in addition to the two main hospitals. Some services had been centralised at a particular site, but most outpatient disciplines held clinics at both of the main hospitals, which enabled patients a choice of days and locations to be seen.

Breast screening services had been discontinued in the trust, which meant that patients had to travel outside the area for this service.

Complaints and incidents were discussed at team meetings and learning was shared.

Service planning and delivery to meet the needs of local people

- Services were reviewed to ensure they met local needs. This was demonstrated by the introduction of the dressings clinics, which provided a drop-in service, reducing the need for people to make appointments.
- We saw the analysis of a recent outpatient satisfaction survey, to which 95 patient responses had been received. We saw how the information had been used to identify and target areas for improvement; these included providing better information before appointments and improving visibility of staff infection control measures such as using hand gel and hand washing.
- The removal of the breast screening service meant that patients had to travel to neighbouring trusts. We were told that the difficulty in recruiting suitably qualified radiologists meant that the service would not be reinstated in the near future.
- We spoke with a number of patients who described having to visit clinics or diagnostic imaging services at both the Southport and Ormskirk sites. One patient had been given an appointment for a scan at Ormskirk and then had to attend a clinic in Southport to discuss the results with the consultant. Other patients told us that as clinics operated on different days at the two sites it gave them the flexibility to choose where they wanted to be seen.

Access and flow

- Waiting times for first outpatient appointments were within NHS England target times. Before our inspection we received information suggesting that the trust was not providing accurate figures about waiting times. When we spoke with patients, they confirmed that they had been seen within a few weeks of being referred to the hospital.
- Several patients we spoke with described having been contacted by phone and offered earlier appointments. Staff explained this had been because other patients had contacted the trust asking to change their appointment for personal reasons. The trust proactively responded by contacting patients on the waiting list to fill the newly available appointments.
- When patients attended clinics, most were seen quickly – often within 10 or 15 minutes of their allotted time.
- Patients had timed appointments and in some clinics it was not unusual for appointments to run over as the

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day progressed. Notice boards were updated to keep patients informed, and if large delays occurred, patients were informed and invited to go to the cafeteria rather than having to sit in the clinic waiting rooms.

- We asked patients about their experiences on previous visits to clinics and we were told that in most cases they had not been kept waiting for excessive periods. One patient described having to wait for 2 hours on one occasion. However, they told us that they had been kept informed about the wait and they hadn't seen it as a problem; they said, "You know you are going to have to wait when you come to the hospital". Similar comments were made by a number of patients, which suggested that public expectations of the service were quite low, and so when they had waited for a short period of time they considered this to be good.
- The matron explained how they were reviewing ways of reducing waiting times. She described how each patient appointment had a fixed consultation period which was set by the commissioning service that funds the service. Some patients may not require all the time allotted for their consultation, whereas some patients may require more support or have more complex needs which meant their appointment would take longer.
- To enable her to assess the impact on patient flow, the matron was working with the senior clinicians to conduct a survey of the doctors' and consultants' start and finish times in all the outpatient clinics. The results were still awaiting analysis, but we were told that they would enable more accurate planning.
- We asked patients about attendance at appointments. Some patients told us that they had cancelled appointments in the past due to personal commitments and availability. They told us that when they had contacted the clinics they had been dealt with politely and alternative appointments had been offered.
- We asked patients if they had ever had appointments cancelled by the trust. A small number of patients said they had been contacted by the trust and asked if they could attend on alternative dates. The patients who told us this said they saw this as acceptable practice, and because they had been given an alternative date they didn't think of it as a cancelled appointment.
- We saw that regular audits were completed along with the monthly matron's checklist. Staff were very

supportive of the matron and were aware of the reviews and audits that were done, but we were told that they didn't get feedback about what the audits had identified.

Meeting people's individual needs

- We saw that wheelchairs were available inside the main entrances of the hospital for patients and carers to use.
- Hearing loops were available to assist people with hearing disabilities, and interpreter services were available for people for whom English was not their first language. Staff explained that most patients who need assistance to communicate attend the clinic with a relative or carer. They could use telephone interpreter services, but if they were aware that an interpreter was needed, this could be arranged in advance of the appointment. We were able to observe the interpreter service in the ear, nose and throat clinic; we spoke with a patient through the interpreter who had been provided by the trust to support them. They told us they had been impressed by the service. They were able to tell us that they had previously used the telephone service, which had been good, but they preferred face to face contact with the interpreter.
- Southport outpatient department had a large waiting room where people waited to be called through to smaller waiting areas next to their clinics. We saw that there was enough seating for all the patients and their family members or carers. We also saw that there were various types of seating; some people find it difficult to raise and lower themselves into low chairs or chairs without arm rests.
- Staff told us that people with complex needs, learning disabilities, mental health problems or dementia always attended clinics with a carer or family member who understood their needs. Patient health records also contained information to help staff understand who they were and how best to support them. Staff had received dementia awareness training.
- Children's activity boards had been purchased and were being mounted on the walls in waiting rooms, to provide children and young people with activities while waiting to be seen or when accompanying parents.
- Authorisation had been given for the production of an access film aimed at young children and people with learning disabilities. The film will be available on the trust website for parents or carers. It will show the journey through the outpatient department from arrival

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at the hospital, reception areas, waiting rooms, activities, and consultation and diagnostic services. The matron explained how this would reduce anxiety for patients and their families and carers as they would have some idea of what the hospital looked like, who they would meet and what they would be doing.

Learning from complaints and concerns

- Staff confirmed that incidents and complaints were discussed at team meetings and issues were shared to prevent them being repeated.
- Issues were escalated through the management teams to the matron and superintendent radiographers who took them to senior management meetings with board representation, and cascaded results back to teams. An example had been the recent introduction of a new electronic patient record system. The system had been piloted on some wards of the hospital, but when it had been rolled out to the outpatient clinics approximately 3 weeks before our inspection, it failed. Staff were encouraged to report the issues on the electronic incident reporting system. The matron took the issue to the management meeting, and as a result the issues were identified and corrected.
- We saw that complaints leaflets were available throughout the different waiting rooms in outpatient and diagnostic services. The leaflets contained guidance on how to make a complaint, although there was no section on the leaflet to allow people to complete and return it there and then.
- In some areas it had been difficult to see the complaints leaflets because the display holders were larger than the leaflets.
- Comments boxes were evident on notice boards around the hospital along with comment sheets for people to complete.
- We were told that most complaints and comments related to waiting times, which had prompted the matron's review of all the clinics.

Are outpatient and diagnostic imaging services well-led?

Good



Local leadership at Southport was good. Staff respected and trusted their managers. The trust values were known to

and understood by staff, although efforts to reinforce these with mandatory professional standards had not been well received by staff, who saw them as repetitive and unnecessary.

Staff understood their roles and were supported to develop their skills and experience. Staff were able to influence the service and felt part of it.

Governance systems were in place which in most instances ensured that staff were informed about trust issues and could share their thoughts and concerns.

Innovation was encouraged, demonstrated by the improvements to help children and patients with learning disabilities settle into the department, and the proposals submitted by porters to improve waste services.

Vision and strategy for this service

- The trust values were to provide safe, clean and friendly care, which was supportive, caring open and honest, professional and efficient (SCOPE). The outpatients matron provided us with a copy of the department's 2 year plan which had been produced under the trust SCOPE for change agenda.
- Elements of the plan had already been introduced, some at Southport and some at Ormskirk. The intention was to review progress and consider mirroring the elements at both sites if they proved to be sustainable.
- Diagnostic services were in the process of commissioning a newly fitted MRI scanner, which would increase capacity at the Southport site.

Governance, risk management and quality measurement

- There were clearly defined processes for staff to raise concerns, which ensured that matters were recorded and escalated as appropriate.
- Oversight at the trust level was not always evident, as demonstrated by the monthly discrepancy meetings held in the diagnostic imaging service. Issues were properly discussed and learning was shared within the team, but we could not see how this had been supported by the risk management team or board.
- Local managers regularly reviewed and audited both departments. In the outpatient department, the matron was reviewing all the local policies and procedures to ensure they were still relevant and fit for purpose. The

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directorate head of diagnostic services had been in post for only a few weeks and had identified privacy and dignity issues for patients beds, which were being addressed.

- Staff at all levels understood their roles and how they and their department enabled the trust to meet its goals and targets. Staff were proud of their contribution and proud of the trust.

Leadership of service

- Staff we spoke with were very complimentary about their managers. Staff told us they felt supported and could approach their own line manager or senior department managers for assistance, advice and guidance.
- Regular team meetings took place where managers shared performance information, cascaded trust intelligence and provided feedback on incidents and complaints. Staff told us they were able to discuss issues openly and knew they would be supported.
- Managers had good oversight of their teams, encouraged staff to develop and prompted them to complete training.
- Non-specialist nursing staff and healthcare workers were rotated between departments and sites so they saw all aspects of the service and developed skills in all areas.

Culture within the service

- Staff told us that they did not know most of the trust executive team. Most staff knew the chief executive by name and many told us that they regularly saw him and spoke with him as he toured the hospital. Other members of the executive team were less visible or unknown to grass roots staff.
- We spoke with members of the housekeeping team and they told us they received little or no recognition of their work. One member of the team told us that they had worked at the trust for several years, and the day of our inspection had been the first time they had been acknowledge by a senior member of staff. They said, “We are invisible to them”. Despite this they told us they felt supported and valued by their own managers.
- We saw notices with pictures of the executive team in various locations around the hospital. Staff told us these had only recently been put up, together with the trust’s SCOPE values, although most staff were familiar with the trust values.

Public and staff engagement

- The trust had introduced a number of mandatory professional standards, which they encouraged staff to adhere to. Most staff we spoke with did not understand what these were; they either hadn’t heard of them, or had heard about them but had not been told what the individual standards were. Some staff were able to describe the standards but commented that they were things that staff did automatically as part of their jobs or would be expected of a healthcare professional, such as ensuring they were properly dressed and attending work on time. Staff told us the mandatory professional standards were an unnecessary distraction.
- The NHS Friends and Family Test is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. They are not compulsory in outpatient departments until April 2015, however we found that a large number of staff were familiar with the test and applied it informally to their own performance. We spoke with one member of staff who commented that they had tried to influence members of their family to use the trust services rather than a neighbouring area, because they were so proud of the trust’s work and the outcomes people experienced.
- The trust provided us with details of how it engaged with the public and patients. Although none of the patients we spoke with quoted specific events, they all spoke of Southport and Ormskirk as being ‘their’ hospitals and part of their community. Most people only engaged with the hospital when they or a family member needed to use the services.
- Local patient satisfaction surveys were completed in the outpatient department. We were provided with the results and analysis of the November 2014 survey. The results showed the department performed well in most areas. The areas identified and targeted for improvement were, giving a choice of appointment time; being told that you could bring a significant other to your appointment; Patients not being told how long they would have to wait and Did you witness our staff washing/applying alcohol gel to their hands?
- Staff satisfaction surveys were completed and data were submitted to NHS England.
- Staff told us that the chief executive attended all staff induction courses to introduce himself and describe the trust’s work.

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Innovation, improvement and sustainability

- As part of the 2 year outpatients plan the matron is undertaking a feasibility study to assess the potential introduction of a band 4 role to encourage staff to progress and make the service more inviting to wider staff base. Currently staff that do not have a nursing qualification can only progress to band 3. The theory was that adding an additional level of advancement would attract high performing staff into the department.
- The outpatients matron had identified that the department had an aging staff group. Many valuable members of staff were reaching retirement age and if/when they leave there would be heavy loss of experience and skill. In order to cushion the effect of these staff leaving, the matron was looking at ways to attract new staff. She told us how she was “trying to raise the profile of the department to demonstrate the importance of outpatient services to the trust”.
- Diagnostic services had long-term contracts ending in 2027 covering the maintenance and replacement of most of the imaging equipment in the department.
- Porters had made suggestions to their management team for improving waste disposal systems. They had made enquiries with health and safety staff and infection control staff before submitting their proposals. Unfortunately there had been logistical problems that had prevented the plans from being adopted.

Outstanding practice and areas for improvement

Outstanding practice

- 85% of patients who had a documented preferred place of death died where they chose to, facilitated by an effective end of life rapid transfer programme.
- An access film showing the experience of a child attending an outpatient department is to be posted on the trust website. This will allow parents of young children or carers of patients with learning difficulties to view the film with them and explain the process and what to expect before they attend for their own appointment.
- The introduction of dressing clinics to complement fracture and orthopaedic clinics, reducing the need for formal appointments and freeing up consultants' time.

Areas for improvement

Action the hospital MUST take to improve

- Ensure adequate medical and nurse staffing levels and an appropriate skill mix in all areas
- Ensure all equipment used is fit for purpose and older equipment is replaced under a planned replacement schedule, including the bleep system.
- Ensure medicines management meets national standards in the critical care unit and in the Accident and Emergency department.
- Improve infection prevention and control processes within the medical directorate.
- Improve the number of staff completing their mandatory training in a timely manner.
- Improve the assistance given to those patients who require support to eat and drink and improve the maintenance of IV fluids in those patients unable to hydrate orally.
- Improve local leadership which was not robust and did not always address known risks in a timely way to ensure patient safety.

Action the hospital SHOULD take to improve

Medicine

- Take immediate action to prevent the sharing of computer passwords between medical staff.
- Improve storage on medical wards for essential pieces of equipment and staffs' personal clothing and belongings.
- Improve feedback and learning from incidents.
- Increase 7 day working for all disciplines across the medical directorate.
- Improve the flow of medical patients within the hospital.

- Improve learning from complaints.
- Improve the way risks are communicated to nursing staff within the medical directorate.

Surgery

- Reduce clutter in the theatres.
- Improve compliance with the national hip fracture audit.
- Reduce the number of patients that are readmitted to hospital after having elective urology and general surgery.
- Improve performance relating to the patient length of stay at the hospital.
- Reduce delays to admitted patients awaiting surgery in the theatres.
- Improve bed capacity on the surgical wards.
- Improve the full use of the WHO checklist.

Urgent and emergency services

- Have a list of appropriate staff that have been trained with the required scene safety and awareness training.
- Ensure the environment in the triage area can allow patient conversations to be private.
- Designate a lead for education in the department.
- Look to improve and maintain the location target to treat 95% of patients within 4 hours.
- Tackle the issue of junior medical staff who felt bullied by senior staff.

Outpatients

- Ensure concerns raised about outpatient services are addressed appropriately and in a timely manner

Outstanding practice and areas for improvement

End of Life

- Improve the system for reviewing do not attempt cardiopulmonary resuscitation (DNACPR) forms.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity

Regulation

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

People who use the medical and critical care services were not always protected against identifiable risks of infection. Regulation 12 (1) (a) (b) (c).

Regulated activity

Regulation

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

The management of medicines on critical care and in A&E did not always protect patients from risks associated with the unsafe use or management of medicines. Regulation 13

Regulated activity

Regulation

Surgical procedures

Treatment of disease, disorder or injury

Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

Patients were supported with the right equipment; however there was no approved schedule for replacing older equipment used in the theatres and records of service status in the hospital were inconsistent. Regulation 16 (1)(a)

Regulated activity

Regulation

This section is primarily information for the provider

Compliance actions

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities) Regulations
2010 Staffing

Medical and nurse staffing did not always meet the needs of the patients and in one area there were insufficient numbers of suitable qualified skilled and experienced nursing staff to safeguard the health, safety and welfare of service users. This was supported by high use of locum, agency and bank staff which affected skill mix. Regulation 22

Regulated activity

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Nursing care

Personal care

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations
2010 Supporting staff

The percentage of staff completing mandatory training in a timely way was inconsistent and in some areas well below expected levels.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA 2008 (Regulated Activities) Regulations
2010 Meeting nutritional needs

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.

Regulated activity

Accommodation for persons who require nursing or personal care

Nursing care

Surgical procedures

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations
2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Local leadership was not robust and did not always address known risks in a timely way to ensure patient safety.

On the NWRSIC there were not enough senior nurse managers to be able to provide effective leadership for this service. Nursing roles and responsibilities lacked clarity. Poor local decision making regarding the staff allocation resulted in some patients being exposed to unnecessary risk.

There was no clear strategy for the development of the centre and no effective methods of staff engagement.
Regulation 10 (1) (a)(b) (2) (d)(i)(ii) (e)

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Nursing care

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Care and treatment was not delivered in such as way as to ensure the welfare and safety of service user's or to meet their individual needs. Regulation 9 (b) (I) (ii).<Provide Judgement Summary>

Regulated activity

Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

On the NWRSIC patients dignity was not always respected. Regulation 17 (1)(a) (2) (a)