Care Quality Commission

Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Accident and emergency	**Requires improvement**
Medical care	**Requires improvement**
Surgery	**Requires improvement**
Intensive/critical care	**Good**
Maternity and family planning	**Inadequate**
Services for children & young people	**Good**
End of life care	**Good**
Outpatients	**Requires improvement**

Summary of findings

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Overall summary

Blackpool Teaching Hospitals NHS Foundation Trust operates from three sites:

- Blackpool Victoria, which is the main hospital site and the focus of much of its work.
- Clifton Hospital, which currently has four wards, mainly for elderly care and rehabilitation (with one outpatient clinic).
- Fleetwood Hospital.

This report relates to the acute core services at the Victoria Hospital site.

Blackpool Victoria is a large acute hospital that treats more than 80,000 day-case and inpatients and more than 200,000 outpatients from across Blackpool, Fylde and Wyre every year. Its Emergency Department sees more than 80,000 attendances every year. The hospital has 767 beds and employs more than 3,000 members of staff. It provides a range of services from maternity to care of the elderly, and from cancer services to heart surgery.

Blackpool Victoria is one of four hospitals in the North West that provides specialist cardiac services and serves heart patients from Lancashire and south Cumbria.

We found that the trust had undertaken work on improving clinical pathways. This was engaging clinicians, and these were well used. This was having a positive impact on the mortality data that was being measured. Some pathways (e.g. heart failure) require further work.

The hospital's reporting of incidents was poor in some areas where some staff did not report near misses, and some staff reported incidents on behalf of others. This means that the hospital and trust could potentially miss out on valuable learning and therefore improve services.

The quality of patients' clinical records was poor; handwriting was sometimes illegible and often difficult to read. Accessing information was challenging because of the filing of case notes. This may delay access to important clinical information and impact on continuity of care. Delays in access to case notes is already a challenge, particularly in outpatients.

We saw good participation in clinical audit and use of the data from this. This is an important way for the trust to develop its clinical services.

The trust has a higher than expected rate of primary postpartum haemorrhage (significant bleeding after childbirth). There is also a high rate of hysterectomy in these patients. This is under investigation by the trust.

We observed good caring by all levels of clinical and medical staff, and high levels of patient satisfaction for the way that staff delivered treatment and care.

The trust had made improvements to its services following feedback from its patients (e.g. ward 12) although some areas, such as stroke services, still required additional action. It had also improved facilities for patients in children's and maternity services.

Many people we spoke to did not know how to share feedback or complaints with the trust. This is a valuable opportunity to develop services that is being lost to the trust.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Overall we found implementing patient new clinical pathways had a positive impact on the hospital's patient care management. This work engaged clinicians. We saw that the patient pathways were well used within the trust. Work on other pathways (e.g. heart failure) is required.

In some areas, incident reporting could be improved through both timely reporting and reporting near misses. Among junior grades, greater ownership of reporting is needed.

There were significant challenges with medical records. We observed a number of examples of illegible handwriting in patient notes. Delays in access to records lead to delays in care, and filing systems made accessing information within hospital records difficult.

Staffing levels were good in some areas (e.g. children's care services), but in other areas staffing levels were low or were designed to support poor systems.

The trust had upgraded and improved some facilities on the Blackpool Victoria site. We also noted areas of poor hand-washing and examples of dirty equipment. We also saw inappropriate use of some facilities such as a sluice room being used to see patients.

Are services effective?

Requires improvement

The hospital was using evidence-based clinical pathways. We also noted that Summary Hospital-level Mortality Indicator data showed an ongoing reduction in mortality. It is believed there is a strong link between these two elements. There is, however, further work to be done before mortality reduces to a level closer to the England average. The current efforts in some areas appear to be having a positive impact.

There was widespread use of the World Health Organisation surgical checklist. In addition, the surgical 'five steps to safer surgery' process has been recently implemented.

There was good audit participation and use of the data to amend or alter services in response to issues raised by audit.

We were concerned that the rate of primary postpartum haemorrhage (haemorrhage after birth) rate was high and that the number of patients subsequently requiring hysterectomy following this was also high. We note that the Royal College of Obstetrics and Gynaecology (RCOG) is involved in attempting to understand these high rates (this is at the request of the trust).

Good multidisciplinary working is evident in many areas.

Summary of findings

We heard of an ongoing investigation by the trust into diabetic care and patient management. We also heard of implementation of the recommendations of an external report on breast surgery and outpatient clinics following some issues identified by the trust's internal review processes.

Are services caring?

Good

We spoke to many patients who reported a positive experience of care within the trust. We noted specific examples, which supported the staff and the hospital's approach to patient care. We saw members of staff building good relationships with patients and their families.

Overall the hospital has tried hard to preserve the dignity and privacy of each patient.

There were good examples of end of life care and a strong input from the chaplaincy.

Are services responsive to people's needs?

Requires improvement

There are good facilities in areas where the trust has upgraded and invested, such as Ward 12 (Gastro), the children's unit and maternity. However, we also saw areas where improvements still need to be made. In some areas the trust has made improvements in response to audit results, such as stroke services. We also saw examples of facilities (e.g. outpatients services use of a sluice room for seeing patients) that were inappropriate for patients' needs or activity levels.

We saw good examples of how the trust has responded to the needs of individual patients by adjusting clinical lists (e.g. children's services). Also good examples of staff supporting vulnerable patients and patients being discharged in a supportive manner from accident and emergency and critical care.

Many patients do not understand how to give feedback or make a complaint to the trust.

Are services well-led?

Requires improvement

The executive team's visibility had increased within the trust, and the trust had taken many positive steps to achieve this. However, we found that in some areas there was a disconnect between the board and clinical services.

There was a positive culture among those working in the hospital, and many members of staff expressed strong loyalty. Staff expressed positive feelings towards the organisation and their work.

Staff also felt able to praise the work of other teams, and many were highly complementary of each other.

We heard examples of innovation that the trust was not assessing. One example of increased radiographer-led reporting and one of speech and language therapists supporting patients in their own home were both shared

Summary of findings

openly. We were unable to form a view of whether these innovations had merit, but note that they were worthy of formal evaluation. There does not appear to be an effective mechanism to evaluate and then either support or dismiss ideas or improvement opportunities.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Requires improvement

In the accident and emergency (A&E) department the majority of patients (over 95%) were seen within the four hour national waiting time standard. The trust had put in place measures to improve care for patients, particularly those who were frail and elderly. It had done this through partnership with volunteers, Red Cross discharge support and the enhanced discharge team working on the observation ward. Despite these efforts, patients' privacy was sometimes impeded due to the physical layout of the department.

Systems for the checking and cleaning of essential equipment (for example the defibrillator) were not in place. This would mean that the team would be unable to rely on them in an emergency situation.

Staff hand-washing practices were poor. We observed multiple occasions of staff not washing their hands between each patient. This represents a clear risk of cross infection.

Medical care (including older people's care)

Requires improvement

The systems and processes in place to maintain the safety and effectiveness of the service required improvement. Some staff relied on others to report incidents and others rarely reported 'near misses', believing it was not necessary to report an incident unless a patient came to harm or an incident actually occurred.

Record keeping was poor. Some patients' records were incomplete and difficult to read and interpret, and there were a large number of errors in the recording of medicines on one ward.

There was no mechanism for the identification and onward referral of patients with heart failure who were admitted to general medical wards. In addition, there was no treatment pathway in place for patients with heart failure.

Staffing levels were sufficient for staff to be able to provide safe and effective care. Patients were looked after by caring and compassionate staff, and the services were responsive to people's needs. We found that, generally, the wards and departments were well-led, although there was a disconnect reported to us between the staff providing hands-on care and the executive team.

Surgery

Requires improvement

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care.

National best practice guidance was not always followed. The trust followed best practice guidelines, such as those produced by the National Institute for Health and Care Excellence (NICE) and it participated in national clinical

audits. However, trust compliance with national guidelines (such as the hip fracture guidelines relating to pre-operative assessment by an orthopaedic geriatrician) could be further improved. We understand however that a review is being undertaken by an appropriately trained senior nurse in line with the trust's clinical pathways.

The staffing levels and skills mix was sufficient in the majority of areas we inspected. However, there were not enough appropriately trained nursing staff to meet patients' specialist needs in the surgical assessment unit and ward 15a, mainly due to staff sickness levels. The trust has identified that it needs to improve staffing levels, and it has plans in place to improve these.

We found that patients' notes were not always completed appropriately. Information such as daily reviews by doctors and discharge records were not always completed. Accurate medical records for each patient completed in a timely way are the basis for robust decision making. All staff should write in notes as soon as decisions are made.

Ward rounds by medical staff on some wards were not regularly undertaken. This made it difficult for staff to have regular and timely decision and discussions on the care of individual patients. This could cause delay in both care and discharge.

The surgical wards and theatres were clean, safe and well maintained. Staff worked effectively as a team within the specialties and across the surgical services. There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. The trust had action plans in place to improve waiting times for patients awaiting surgery and to reduce the number of cancelled operations. However, the actions had not yet been fully implemented and their effectiveness could not be measured.

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. There was effective teamwork and clearly visible leadership within the surgical services. Staff were appropriately supported with training and supervision and encouraged to learn from mistakes.

Intensive/critical care

Good

There were effective systems and processes in critical care services to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. The critical care services performed in line with similar-sized hospitals and performed within the national average for most measures.

There were not enough appropriately trained nursing staff to meet patients' specialist needs in the intensive therapy unit and the high dependency unit. The number of middle grade doctors was not sufficient to ensure that there was 24-hour cover available by at least one registrar. The trust had identified that it needed to improve staffing levels, and it had plans to do this.

Summary of findings

We found that there was room for improvement in communication between the cardiac ITU and the general ITU and HDU.

Care was provided by trained staff in accordance with national guidelines, and staff used enhanced care pathways. The critical care services were clean, safe and well maintained. There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Patients or their representatives spoke positively about their care and treatment. There were systems in place to support vulnerable patients.

There was effective teamwork and clearly visible leadership within the critical care services. Staff were appropriately supported with training and supervision and encouraged to learn from mistakes.

Maternity and family planning

Inadequate

Women using the service receive care and treatment from staff who have the knowledge and skills to meet individual needs. Staff treated patients with care and respect. Patients had a high regard for the staff and the clinical teams. However, the distribution of staff, staffing levels and the organisation of staffing were at times less than adequate. We found that at periods of high activity the management of some patients could be delayed.

Recent data shows a higher than expected rate of primary postpartum haemorrhage (haemorrhage after childbirth) and also of subsequent hysterectomy. We noted that the trust is investigating this. We were subsequently made aware of a request by the trust to the Royal College of Obstetricians and Gynaecologists for assistance in investigating these cases. This investigation is currently underway.

We saw the use of evidence-based guidance.

There are specialist midwifery leads in important clinical and supportive areas.

Services for children & young people

Good

Children care was safe, effective and well-led.

The environment provided excellent service for children and young people. The layout of the facilities and the thought in design of the building was seen by the team as an excellent example of a children's unit. There were appropriate toys, well equipped play areas and a sensory room for children with special needs. Children and young people received care from a range of staff who had specialist knowledge in caring and treating children and young people. Parents we spoke to reported that they had been kept informed and involved in the care of their child by the staff.

Children and young people were listened to and had the opportunity to shape the service for the future.

Summary of findings

End of life care

Good

The trust has a multi-professional approach to end of life care, working in partnership with Trinity Hospice and the trust's palliative care services. This means that good practice was shared across both the trust and Trinity Hospice. The trust continues to use the Liverpool Care Pathway for people in the last few days of their lives. Staff we spoke to within all areas visited were aware of the procedure to follow in end of life care, ensuring a good experience for patients and a safe approach to care.

The palliative care team focused on ensuring the provision of high quality services that meet the needs of the patients and their families who used their service. It underpinned its practices with the belief that care for the dying is part of the core business of the organisation. If care was necessary within the hospital environment, the palliative care team provided support and information to the patient, their families and the care team working on the ward.

People told us that they were satisfied with the care they received from the palliative care team. For patients who remained in hospital, plans were put in place to ensure that their wishes were respected. We spoke to one patient and two families of patients who were using palliative care services at the hospital. They told us they were satisfied with the care being provided. One patient told us they were happy with all of the care and support provided by staff. They said, "It's a wonderful place."

The evidence we found indicated that the 'care of the dying' pathway was being followed from diagnosis until after death and that patients were receiving appropriate support and compassionate care.

Outpatients

Requires improvement

Patients received effective, safe and appropriate care. The outpatient areas were clean and well maintained. However, we observed staff taking patients into sluice rooms to be weighed, which is not clinically appropriate.

Patients told us that waiting times were at times unacceptably long, up to 40 minutes in some departments. However, the 18 patients we spoke with told us that they were generally satisfied with the service they received.

We found that all of the outpatient areas respected patients' privacy and dignity, as people were seen in consultation rooms.

We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment. However, we were unable to meet with any interpreters at the time of our inspection.

Staff were aware of how to report an incident and the procedure for completing the report.

We saw there were clear leadership structures in place and staff were very supportive of their colleagues. All outpatient staff said that they were well supported in their roles.

Summary of findings

What people who use the hospital say

Inpatient Friends and Family Test

In October 2013, 722 people completed the test and 89.7% said that they were either 'likely' or 'extremely likely' to recommend the ward they stayed in to friends or family.

Accident and emergency Friends and Family Test

In October 2013, 190 people completed the test and 93.6% said that they were either 'likely' or 'extremely likely' to recommend the trust's accident and emergency department to friends or family.

Patient views during the inspection

We spoke to many patients during our visit. Overall, the comments we received were highly complimentary and supportive of the care they had or were receiving.

Listening event

We held a public listening event on 14 January 2014 and over 40 residents of the Blackpool and surrounding areas attended.

Some participants at the event told us of difficult problems they or a relative had experienced at the trust. Some of these were still part of ongoing discussion or investigation by the trust. However, some people attended to tell us about the good care they had received. All of the stories we heard were recorded on paper and were used to inform the inspection team's visit on the following days.

People told us that staff in outpatients approached them in a very friendly manner, that they treated them with dignity and listened to them.

They also told us that there were challenges for those people who had hearing difficulties, as they were sometimes unable to hear their name being called for their appointment.

Survey data

The Care Quality Commission undertook a detailed survey of the people from the Blackpool area who had recently used the services of Blackpool Teaching Hospitals NHS Foundation Trust. The survey was undertaken by RAISE who have significant experience with Health and Social Care along with community and voluntary services.

They received 60 responses from people who had used that services of Blackpool Teaching Hospitals NHS Foundation Trust. Their survey focused on the key domains that the CQC inspection team also look at. They found that of the 60 responses; 59 people (97%) had used services within the last 12 months.

Against the five key questions that CQC looks at:

- 58% said they felt services were safe
- 56% said they felt services were effective
- 63% said they felt services were caring
- 60% said they felt services were responsive to their needs
- 53% said they felt services were well led.

63% of people knew how to make a complaint to the trust; 17 people had made a complaint in the past 12 months; and of those, nine people (53%) felt it had not been properly investigated; a further four people were not sure (don't know).

When asked to rate the services they had experienced, the people responding to the survey said:

- Outstanding 37%
- Good 10%
- Satisfactory 3%
- Requires improvement 50%

Summary of findings

Areas for improvement

Action the hospital MUST take to improve

- The hospital must improve its medical records. Both in terms of record keeping and timely access to notes. This must be ahead of a permanent electronic solution.
- The hospital must progress an understanding (and action if necessary) of the high rates of primary postpartum haemorrhage and subsequent high rates of hysterectomy.
- The hospital must ensure that appropriate and timely pre-operative assessment is undertaken by an orthogeriatric specialist.
- The hospital must improve its incident reporting service. All staff must be aware of their responsibilities to report both incidents and near misses. The hospital must continue with its plans to improve incident reporting (as identified in the Keogh Action Plan)
- The hospital must ensure staffing levels in all clinical areas are appropriate for the level of care provided.

Action the hospital SHOULD take to improve

- The hospital should continue to improve the awareness of the trust's complaints and comments processes and encourage patients to use it.
- The hospital should stop using sluice areas as surrogate clinic rooms.
- The hospital should review the waiting area for patients on trolleys in A&E to ensure that these are appropriate for their care.
- The hospital should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing activity and the responses to demand for services.
- The hospital should review sickness rates in some areas where these are higher than expected.
- The hospital should review activity levels in the diabetic foot clinic to avoid overcrowding.
- The hospital should progress and resolve concerns over endocrinology and diabetes data suggesting higher levels of amputation than other areas.
- The hospital should review the opportunities of observation for vulnerable adolescents on the new children's unit.

Good practice

Our inspection team highlighted the following areas of good practice:

- Patient care in the hospital is recognised as good by the patients we spoke to and the staff were praised by many who use the service.
- The trust wide chaplaincy and end of life care service is recognised as highly responsive and valued by those who use it.
- The new facilities for the children and maternity service were recognised as a good development.

Blackpool Victoria Hospital

Detailed findings

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

Our inspection team

Our inspection team was led by:

Chair: Professor Sir Mike Richards, Chief Inspector of Hospitals, Care Quality Commission

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team had 36 members, including experts by experience, lay representatives, medical and nursing clinical specialists and Care Quality Commission (CQC) inspectors.

All members of the team attended the Blackpool Victoria site.

Background to Blackpool Victoria Hospital

Blackpool Teaching Hospitals NHS Foundation Trust operates from three sites:

- Blackpool Victoria, which is the main hospital site and the focus of much of its work
- Clifton Hospital, which currently has four wards, mainly for elderly care and rehabilitation (with one outpatient clinic)
- Fleetwood Hospital,

This report relates to the Victoria Hospital site.

Blackpool Victoria is a large acute hospital that treats more than 80,000 day-case and inpatients and more than 200,000 outpatients from across Blackpool, Fylde and Wyre every year. Its Emergency Department sees more than 80,000 attendances every year. The hospital has 767 beds and employs more than 3,000 members of staff. It provides a range of services from maternity to care of the elderly, and from cancer services to heart surgery.

Blackpool Victoria is one of four hospitals in the North West that provides specialist cardiac services and serves heart patients from Lancashire and south Cumbria.

Why we carried out this inspection

Blackpool Teaching Hospitals NHS Foundation Trust was originally inspected by Professor Sir Bruce Keogh and his team during June 2013. This was part of a selected review process informed by higher than expected mortality rates. The data for the Keogh review informed the planning for this visit.

The Secretary of State for Health has asked that all trusts in the original Keogh inspection were included early in the new CQC process.

In planning for this visit, the Care Quality Commission sought the latest data from multiple national sources, as well as information from the trust.

Detailed findings

We inspected this trust as part of our new in-depth hospital inspection programme. We chose this trust because it represented the variation in hospital care according to our new Intelligent Monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

How we carried out this inspection

In planning for this visit we identified information from local and national data sources. Some of these are widely in the public domain. We developed 111 pages of detailed data analysis which informed the thinking of the inspection team. The trust had the opportunity to review these data for factual accuracy, and corrections were made to the data pack from their input.

We sought information in advance of the visit from national and professional bodies (for example the Royal Colleges and central NHS organisations). We also sought views locally from commissioners and local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our thinking. We therefore held a well-publicised listening event on 14 January 2014. This was held before the inspection began and helped inform the thinking of the inspection team. Over 40 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We received information and supporting data from staff and stakeholders both before and during the visit.

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

During our visit we held a number of well attended staff focus groups. These were well publicised by the trust in advance.

During our visit we also spoke with patients in each of the service areas, where this was possible. We actively sought their views on the service they were attending. We aimed to talk to a large enough number in each area to develop a representative view of those who may use the service.

During our visit we examined notes and medical records. We checked departmental records for cleaning and maintenance checks and also for staffing levels.

During our visit we undertook individual interviews with the trust's senior management and directors. We also undertook ad hoc interviews with a number of staff throughout the visit where we felt this may clarify or add weight to a line of enquiry.

We also undertook three unannounced visits during a two-week period following the initial inspection. These were to accident and emergency services, surgical services and medical services.

Requires improvement

Accident and emergency

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

Information about the service

The accident and emergency (A&E) department is open 24 hours a day, seven days a week. The department sees around 80,000 patients (adults and children) each year. The department has two entrances, one for ambulances and one for walk-in patients. Reception staff receive the patient and start the patient's pathway. Within the clinical environment there is a triage and ambulatory care area, cubicle and side room areas and a 'majors' area. The reception staff also signpost patients to the urgent care centre, which is on the hospital site but operated by a different provider (FCMS (NW) Ltd). A&E includes the observation ward. This is a short-stay ward with two bayed areas which accommodate four patients each, two side rooms and a treatment room, making 10 beds in total. The ward is intended for:

- short-stay patients who do not require formal admission to hospital, such as those who require longer observation that can be provided in the A&E (for example patients with head injuries), and
- patients awaiting transfer home or for other services to commence.

We talked to 24 patients and six relatives or carers and 32 staff including doctors, nurses, consultants, senior managers, a therapist, support staff and ambulance staff. We observed care and treatment and looked at care records, returning to the department at a variety of times and on a number of occasions. We reviewed comments from our listening event and from people who contacted us to tell us about their experiences. We also reviewed many items from the trust's own quality monitoring information and data.

Summary of findings

We visited the department continually throughout the two-day site visit, both during the day and early evening. We also visited it between 10pm and 3am during our Friday night unannounced visit.

In the accident and emergency (A&E) department the majority of patients (over 95%) were seen within the four hour national waiting time standard. The trust had put in place measures to improve care for patients, particularly those who were frail and elderly. It had done this through partnership with volunteers, Red Cross discharge support and the enhanced discharge team working on the observation ward. Despite these efforts, patients' privacy was sometimes impeded due to the physical layout of the department.

Systems for the checking and cleaning of essential equipment were not in place.

Staff hand washing practices were poor. We observed multiple occasions of staff not washing their hands between each patient. This represents a clear risk of cross infection.

Requires improvement

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Safety and performance

Overall the A&E department performs well when compared against the England average to a number of important measures such as waiting times to be seen.

Incidents were reported using the trust incident reporting system, trends and themes were identified by the governance lead for the division and shared with the senior team.

Between December 2012 and November 2013, the trust had three serious untoward incidents in the A&E department. Staff knew how to report incidents and could describe what action they would take. In addition staff with whom we spoke were able to describe recent incidents and clearly outline what action had been taken to reduce the risk of the same incident reoccurring.

Staff in the A&E department had had training in safeguarding reporting procedures. Completion of mandatory training is noted as a risk on the risk register, with completion for October 2013 and November 2014 remaining largely static with almost 40% of staff having completed less than 79% of their mandatory training. We saw evidence that staff who had failed to complete training were highlighted to the relevant department lead nurse who would follow this up and ensure training was done.

Systems, processes and practices

The main department was clean and tidy. However, essential equipment such as commodes were not cleaned to an acceptable standard. Staff hand washing practices did not follow recognised best practice and we observed several occasions where staff failed to wash their hands after caring for people. This creates a significant risk of cross infection.

Equipment was available for use but was not checked regularly and the trust did not have standard procedures which identified responsibilities for checking important equipment such as defibrillators. Records were reviewed and staff we spoke to verified that whilst checks happened it was ad hoc, not routine. This equipment should be checked on a regular basis to ensure that it is ready for use. This equipment is required in an emergency situation and regular checks are designed to ensure it can be relied up when required.

The department does not have a full complement of nursing staff (according to the trust's own figures) with a shortfall ranging between nine and three whole time (full time) equivalents during 2013. The trust has an active recruitment plan to address this and the department relies on temporary staff to deliver patient care. However, the majority of staff we spoke to were satisfied that A&E had sufficient numbers of suitably qualified staff (both medical and nursing) to provide good standards of care to patients. One person told us that medical staffing levels were not sufficient at weekends and nights. However, this was not a view shared by other medical staff we spoke to or patients. An external report has been produced which addresses clinical staffing within the department.

The majority of the staff we spoke to described high levels of satisfaction with their role, support and workload.

The General Medical Council Survey 2013 of trainees found that F2 grade (doctors training grade) satisfaction overall was rated as 'red' in relation to workload. This means that the trust was above (worse than) the national average for F2 grade workload, with 40% rating the workload heavy and a further 40% rating the workload as very heavy. There was little difference overall between the day and night time levels.

Patients who require a stay in the hospital but not a full admission are accommodated on the observation ward. The observation ward is led by a nursing sister and in-reach support is provided by the enhanced discharge team. This is a specific team of physiotherapy and occupational therapy staff who provide prompt and focused care to support rapid discharge. Staff and patients that we spoke to were positive about the leadership on this ward and the standards of care received. However during our night time visit we found that a member of staff allocated to the observation ward had been moved to the A&E department due to a short term increase in attendances within the A&E. We were told by a member of staff that this had happened before when A&E was busy. Staff told us that it can be difficult to

Accident and emergency

supervise patients adequately when the staffing is reduced due to the layout of the ward; for example, if the two staff are in one bay, the second bay cannot be observed.

The main department is separated into three areas: ambulatory care, minors and majors. Due to the geographical layout of the department staff could not easily observe patients in the minors area but high risk patients were moved closest to the nursing station.

A&E is able to use 10 short stay beds on the observation ward should a patient require further monitoring and medical admissions are admitted to Acute Medical Unit. Admission to the observation ward required a member of the medical team to complete a pathway booklet which was linked to the relevant condition or reason for hospital stay. Admission to the ward was linked by those documents rather than a risk management protocol (however, this document does include a risk assessment) . It is not clear how admissions to the ward were managed or risks identified when the hospital was short of beds and the ward was used for patients who did not meet the pathway criteria.

Monitoring safety and responding to risk

There are mechanisms in place to monitor patient safety within the department, including a variety of quality and safety meetings along with nursing and medical meetings. The unscheduled care (the division that A&E belongs to) risk register includes risks and ratings identified for the A&E department. Progress and improvements are monitored through a committee and are fed back at divisional, department and clinical leader meetings. Information on safety was also cascaded through the trust computer system and through newsletters. Staff told us they felt they were kept informed. We spoke to staff, observed the environment and looked at records, and we saw that the trust identified and managed risks and took remedial action to reduce the likelihood of reoccurrence where patients were affected.

Reception staff are in a position to observe patients waiting whose condition deteriorates. The staff were clear on the need to escalate patients who needed immediate attention, and they had guidance to support this.

Anticipation and planning

There was a slight (0.1%) fall in the number of patients attending the A&E department during 2013, but the trust has identified an increased pressure on the available medical care beds and the complexity of patients requiring admission. The trust commissioned a report into the future plans for the A&E staffing model and clinical staffing for the acute medical unit. A recommendation was made and accepted by the executive team in December 2013. When implemented it means more consultant staff and senior nursing staff in the department out of hours and at the weekend. It would also result in improved training and education opportunities.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Using evidence-based guidance

Patients were seen and treated effectively by appropriate staff.

The department monitored the quality and safety of care to ensure on-going improvements and participated in national audits (such as the severe trauma audit).

Performance, monitoring and improvement of outcomes

A recent trust-wide focus on reducing mortality and the introduction of pathways had demonstrated improved outcomes for patients. For example, the number of patients who die due to pneumonia is reducing. Much of this work was at an early stage of development (having started in late Summer 2013) and requires embedding.

Staff, equipment and facilities

We spoke to staff from a wide range of disciplines including nursing, medical, therapy and support staff. The majority of staff felt positive about working in the department and described access to ongoing training support as good. The patients we talked with at the hospital were complimentary about the staff in A&E. One patient said 'It was the quickest ever and the advice given on driving was five star'. Another patient told us that he 'had a short wait, all tests were done quickly, I have no complaints whatsoever'.

Requires improvement

Accident and emergency

Staff told us that it can be difficult to supervise patients adequately when the staffing is reduced due to the layout of the ward; for example, if the two staff are in one bay, the second bay cannot be observed.

The main route into the department for children and patients brought in by ambulance was along a corridor. A small alcove area had been converted for the triage of ambulance or trolley patients. The area was small and cramped, and whilst the staff had attempted to manage the impact on patient's privacy and dignity, we concluded that this could impact on patient wellbeing. Staff told us that this alcove area could be expanded to accommodate two patients. At the time of the inspections this area was not in use. However, from the description given by staff it is unclear how this arrangement could meet infection control, privacy and dignity needs.

The main corridor area (within the A&E department) is used as a 'waiting' area for patients on trolleys. Although told us that this would be for short periods while areas in the main department was made available, the area would not meet patients' privacy and dignity. During our visits the department had sufficient capacity (numbers of beds and trolleys), so the corridor area was not used to accommodate patients.

Multidisciplinary working and support

A new role of GP liaison nurse had been established. The nurse had been seconded to a pilot project to manage GP referrals. Staff told us that this had resulted in around 80% of potential GP admissions being managed in the community. Full evaluation of the pilot has not yet taken place as the project was still underway. Other roles which have impacted on patients' experience and were described and identified as good practice included the specialist cardiac nurses who are available from 8am to 10pm and the enhanced discharge scheme which supports rapid discharge from the observation ward.

Are accident and emergency services caring?

Good

Compassion, dignity and empathy

Patients we spoke to described a positive experience attending the A&E department and receiving treatment.

Staff respected patients' privacy and dignity and we observed staff speaking to frail and elderly patients in a calm and respectful way. We saw staff working in the department offer drinks and snacks to patients when appropriate. Volunteers work collaboratively with the staff to ensure that patients receive adequate drinks and snacks whilst they are in the department. We saw patients and their relatives and carers being offered refreshments.

Patients told us that staff knew how to care for them and they felt safe. Comments included 'They do a great job' and 'It was really quick'. Most patients told us they received a good explanation about what their plan of care was and what the likely waiting times would be. However, one patient told us that it was difficult to understand what the doctor had told him.

Involvement in care and decision making

We spoke to five patients who had been treated in the A&E department and been discharged straight home and to10 patients who had required admission to hospital following attendance at A&E. All the patients we spoke to felt that they had been involved in the planning of their care and treatment. Two relatives confirmed that staff had spent time keeping family members up to date with progress around treatment plans.

Trust and communication

Patients told us they felt the trust had communicated with them. Staff we spoke to described how they ensured that patients had sufficient information to assist them on discharge home.

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

(for example, to feedback?)

Good

Meeting people's needs

We spoke to patients attending A&E both during our announced and unannounced visit. The majority of people spoke of high levels of satisfaction with the service (both during the day and at night). However, one family were dissatisfied that staff had not attended their child swiftly on admission. We informed the nurse in charge, who immediately went and spoke with the family.

Requires improvement

Accident and emergency

Vulnerable patients and capacity

Staff attended a variety of training to equip them to support vulnerable people who attend A&E. A training coordinator monitored attendance of key training such Mental Capacity Act, deprivation of liberty safeguards, safeguarding children and vulnerable adults. Staff we spoke to described the department policy and were able to describe an recent event when the policy had been put into place to safeguard a vulnerable person. We were shown a checklist which staff complete which would be used as part of the alert process if staff suspected abuse of a vulnerable adult. All the staff we spoke to were clear on of the actions they would take to ensure vulnerable people were safeguarded.

Access to services

From January 2013 to December 2013 the A&E department performed better than the England average for A&E attendances waiting less than four hours. However there have been instances when this did not happen, for example between January 2013 and April 2013.

Ambulance turnaround times were good, with almost 80% of turnaround within 15 minutes. Ambulance staff we spoke to were complimentary regarding the commitment shown by staff at all levels to accepting patients swiftly into the department. The department performs better than the England average for the time taken for a decision to admit.

The number of patients who left the department before being seen for treatment was higher than the national average from April 2013 to August 2013, with performance reported around 4%. We looked into this during the inspection and found that the trust's own figures were reflective of the national picture at 2%. Staff we spoke to at the time of our inspection were unable to explain this discrepancy. It is important for the trust to ensure that local data can be reconciled with data they report nationally.

Discharge home from the department was supported by the Red Cross discharge team who are able to access shopping for a vulnerable or frail person and make sure they are safe and settled back at home. An enhanced discharge team worked on the observation and acute medical units. The team, comprised of physiotherapy and occupational therapists, implements swift action to facilitate discharge and avoid hospital admission

Diagnostic tests were reviewed promptly, treatment was not delayed and plans were put in place for discharge or transfer for further care and treatment. Two people told us they had test or investigations whilst in the department and both received the results within an hour with a full explanation from the doctor. Out of hours access to some diagnostic tests (such as ultrasound) can be limited.

Leaving hospital

Patients whom we spoke with told us they felt the trust had communicated with them. Staff we spoke to described how they ensured that patients had sufficient information to assist them on discharge home. The Red Cross were available to support patients who required support or assistance from hospital to home.

Learning from experiences, concerns and complaints

Action resulting from complaints or serious incidents were cascaded to the department and a variety of methods used to ensure that information had been cascaded. Staff were able to demonstrate changes in practice as a result, for example patients identified as being at high risk of falls were given a different coloured wrist band. This meant that all staff could easily see which patients required additional care or support.

We conducted a number of telephone interviews with patients who had previously attended the department and had been discharged. One person we spoke to was dissatisfied that they had waited for four hours within the department to be discharged home without requiring treatment.

Complaints are reported monthly at a clinical governance meeting and cascaded to the department. Trust reports demonstrated that changes in process for responding to complaints have resulted in a swifter response time (reduced to 22 days in December 2013).

However, the trust's own system could be developed to focus more on the outcome of complaints and the impact on people than on the system of reporting. The trust has commissioned the services of Age UK, who in partnership with the Trust conduct monthly visits and surveys, with patients providing feedback to the trust on areas of improvement.

Results of the Friends and Family Test in October 2013 found that 93.6% of patients were either likely or

extremely likely to recommend A&E. It should be noted that the trust overall response rate to the survey is low compared to the number of attendances. The trust had identified this as an area for improvement.

Are accident and emergency services well-led?

Good

Governance arrangements

The A& E department is part of the Unscheduled Care Division. Each division has an associate chief nurse, divisional director and associate director of operations. The department has a nursing matron and a medical clinical lead who in turn are supported by their teams. The department has access to and support from clinical governance (quality and safety standards), patient experience and human resource (personnel) support.

Leadership and culture

The A&E services were well-led. The team was motivated, with good team working and good communication between all grades of staff. Staff said they felt supported by their colleagues and mangers. A member of the executive team is allocated with specific responsibility as a link for the department (buddy system) and staff told how the Chief Executive had visited on Christmas day and thanked staff.

Staff reported that they felt able to challenge senior medical and nursing staff if needed and that they felt able to share ideas and practice. We visited the department at a weekend outside of normal working hours. The duty matron was easily contacted and the department was under the ongoing management of a senior nursing sister.

Learning, improvement, innovation and sustainability

The service monitored the safety and quality of care, and action was taken to address immediate concerns. Performance information was used to improve the service and we found good evidence to support that A&E was working hard to meet the needs of the local community. Senior clinical staff we spoke to were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators such as the nursing key performance indicators. A review of the future staffing arrangements for the department had been completed. However not all senior staff we spoke to were clear of the current status of the review, timescales or impact on the unit. We found a number of initiatives in place, such as the enhanced discharge team and GP liaison nurse pilot, which demonstrate the trust is working hard to manage patients' admission and discharge from the unit.

The e-rostering system was felt to be beneficial by some staff and not effective for A&E by others, although the majority of staff told us that they felt the department was adequately staffed. The trust had invested in a computerised patient record system that had failed to deliver the required results; as a result the trust currently relies on a paper based system for clinical record keeping. It was unclear how the trust plans to address these issues.

Requires improvement

Medical care (including older people's care)

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

Information about the service

The acute medical care services at Blackpool Victoria Hospital are provided on the Acute Medical Unit and wards 2, 8, 10, 11, 12, 18, 19, 23, 24, 25, 26 and 37; also Cardiology Ward (Lancashire Cardiac Centre). We visited all these wards during the inspection, in addition to Coronary Care Unit and the Stroke Unit. Over the course of a two day announced inspection and a further unannounced visit, we observed care, looked at records for 17 people and spoke with 33 patients, 3 relatives and 22 staff across all disciplines.

Summary of findings

Systems and processes to maintain the safety and effectiveness of the service required improvement. Some staff relied on others to report incidents and others rarely reported 'near misses', believing it was not necessary to report an incident unless a patient came to harm or an incident actually occurred. Record keeping was poor. Some patient records were incomplete and difficult to read and interpret.

There were a large number of errors in the recording of medicines on one ward.

There was no mechanism for the identification and onward referral of patients with heart failure who were admitted to general medical wards. In addition, there was no treatment pathway in place for patients with heart failure.

Staffing levels were sufficient for staff to be able to provide safe and effective care. Patients were looked after by caring and compassionate staff, and the services were responsive to people's needs. We found that, generally, the wards/departments were well-led, although there was a disconnect between the staff providing hands-on care and the executive team, where staff were not clear that the board understood the issues being faced by the service.

Requires improvement

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety and performance

It is mandatory for all NHS Trusts in England to report all patient safety incidents. An analysis of the data submitted by the Trust revealed that it was reporting incidents as we would expect when compared with other Trusts in England.

Nursing and medical staff were encouraged to report incidents and were familiar with the incident reporting system. All staff should report incidents and near misses. It is considered good practice that 'near misses' as well as incidents are reported so that action can be taken to prevent future adverse incidents taking place. On four wards only the band 5 staff nurses and above used the electronic incident reporting system. Other staff would inform the senior nurses, who would report the incident on their behalf. The majority of the staff we spoke with told us they rarely reported 'near misses', believing it was not necessary to report an incident unless a patient came to harm, or an incident actually occurred. This meant that some staff members were reliant on others to report incidents, which may result in a delay or inaccuracies in reporting incidents. Valuable learning and opportunities to prevent errors may be missed. We note that the Trust is working on improving incident reporting and review processes in line with the Keogh Action plan

The service was managing patient risks well, such as falls, pressure ulcers, bloods clots, catheter and urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. Staff said that they felt that safety huddles (where staff meet in the service for a brief focused discussion on key issues) were beneficial, as they enabled them to discuss in detail patients who were most at risk. This meant that those risks recorded and reported were being monitored through the trust's systems. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these types of harm once a month. The medical directorate monitored these indicators and displayed information on the ward performance boards. Ways in which scores could be improved were discussed at ward meetings and daily 'safety huddles'.

Learning and improvement

In an analysis of the data submitted by the trust, improvements in the number of falls with harm were noticeable from July 2013, and wards and departments we visited discussed actions the staff had taken in order to reduce the number of falls. On the stroke unit this included the introduction of a system for staff which meant that no patient areas were left unsupervised by staff throughout the day, which had resulted in a decrease in falls.

Staff received feedback from the ward manager regarding the outcome of incidents. They also informed us that, should learning from an adverse incident be relevant to other wards and departments, this was disseminated via staff meetings and a safety bulletin.

Systems, processes and practices

Data submitted by the trust revealed that the instance of pressure ulcers acquired by patients subsequent to admission had been consistently lower than the average for other trusts in England for the duration of the period November 2012 to November 2013. We were informed that there used to be delays of up to one week in the acquisition of a pressure-relieving mattress once a patient had been assessed and identified as needing one. This had been reduced significantly and staff informed us that they could normally expect a pressure-relieving mattress to be available within two to four hours. Staff on all wards told us that other equipment was readily available and any faulty equipment was either repaired or replaced the same day.

Wards were visibly clean and well maintained, however the wet room on one ward flooded the surrounding floor and represented a risk to patients and staff. Patients we talked to spoke positively about the general level of cleanliness throughout the hospital. Alcohol hand gel was available in several places throughout the service and we saw that all staff used it regularly. There were also ample hand washing facilities and liquid soap and hand towel dispensers were adequately stocked.

Storage for equipment and linen was not always adequate. Several wards, including wards 18, 19 and 25, did not have a linen room and relied on large, storage lockers for linen, which took up large areas of space on the ward. The trust have identified that this is a design feature (using storage lockers rather than building additional rooms) and that this complies with infection control policies. Another ward stored equipment in bathrooms and oxygen cylinders in toilets, which represented a risk regarding the prevention

and control of infection. In addition, it would be difficult to ensure that equipment was not inappropriately tampered with. Access to this equipment would also be difficult should a patient be using the room when the equipment is needed.

Throughout the medical directorate we found that medicines were stored securely and that arrangements were in place to ensure that they were stored at the correct temperature. All the patients we spoke with told us that they were not left in pain and that their medicines were usually administered on time, although occasionally they were late if the staff were particularly busy. On one ward staff were occasionally re-deployed to other wards, which meant that the administration of intravenous antibiotics was delayed, as two people were required to check the dosage. None of the patients we spoke with were administering their own medicines. Staff we spoke with told us that "no-one really self-administers here".

We spoke with one diabetic patient who needed to have their insulin prior to breakfast. This person had received their breakfast over an hour previously and had not been given their insulin. We brought this to the attention of the nurse administering the medicines, who was unaware that this person was diabetic. This patient routinely administered their own insulin at home and would have been capable of self-administering their medicines during their stay in hospital. Nursing staff must be aware of the concurrent medication needs of patients and deliver them in a timely manner.

We noted that ward 25 had previously recorded medication errors on nine days during January 2014, with several errors made by the same person on one day. The errors were all related to incomplete recording on the medical administration records (MARs), which meant staff were unable to ascertain from these MARs whether patients had received their prescribed medication or not. Many of the patients on this ward had a diagnosis of dementia. It is particularly important that there is robust recording of care and treatment for patients with dementia, as their own recollection can be unreliable. We discussed the action taken to address the frequency with which medication errors were happening with the acting ward manager during our inspection. We were informed that one agency nurse had been responsible for a significant number of these errors and the trust had taken action to address this with the agency and also to ensure that this nurse would not work at the trust again. The trust ought consider whether further notification of this individual is required to the nursing agency or professional bodies to support training needs. Additional measures had been taken around staff training and awareness, including reinforcing the importance of the correct documentation of medicines administered during safety briefings.

Patient records were kept securely and could be located when needed. However the content of some of the records was incomplete and some of the records we reviewed were illegible. The records we reviewed on some wards, such as the stroke unit and coronary care unit, were well kept, up to date, completed accurately and the plan and progress of patient care and treatment was easy to review. The records on other wards, such as ward 26 and ward 37, were not fit for purpose. We found care pathways for four patients that were either undated or incomplete, or they contained gaps. This meant it was difficult to follow the record of the care and treatment delivered. We reviewed two sets of patient records with one of the senior nurses. The handwriting was so poor that neither person could interpret some of what was written in the records, predominantly by the medical staff, but occasionally the nursing notes were also difficult to read. The senior nurse said that "usually a nurse is with the doctor and we rely on them to interpret what is written in the notes". Patient records need to be legible and complete in order for patients to be cared for safely and effectively.

The resuscitation trolleys on most wards were checked appropriately. On two wards we visited the trolley had not been checked either that morning or during the night shift. It is important that the resuscitation trolleys are checked to ensure that, should they be needed, they are fully stocked and the equipment is in good working order as these are required in an emergency situation where great reliance will be placed on all equipment being in full working order.

On six wards we observed staff hand hygiene procedures. A range of staff in four of the six wards were not following safe hand washing procedures. Some staff assisted one patient then moved to another patient without washing their hands; others entered or left wards without using gel or washing their hands. We saw that there were hand washing soaps and gels throughout the six wards.

Monitoring safety and responding to risk

Reducing the number of patients who develop venous thromboembolism (VTE) is a patient safety target for the

Medical care (including older people's care)

trust. Staff knew about the importance of risk assessment for the prevention of VTE and we saw these were being completed on the wards we visited. Data shows that overall the trusts new VTE episodes are lower than the England average (although we noted a case of incorrect data reporting in November 2013, which has now been corrected).

Are medical care services effective?
(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

An analysis of the Summary Hospital-level Indicator Mortality (SHMI) data submitted by the trust indicated that there was a higher than expected mortality from heart failure. The trust was aware of this and beginning to implement improved pathways to address this. During our inspection we spoke with a senior member of the cardiology team, who informed us that there was no mechanism for the identification and onward referral of patients with heart failure who were admitted to general medical wards. In addition, there was yet no treatment pathway in place for patients with heart failure. This meant that patients with heart failure may not be identified and referred to the appropriate cardiologist in a timely manner. It also meant that, once diagnosed with heart failure, patients may not always be treated in a consistent manner, in line with the latest evidence based guidance.

The Myocardial Ischaemia National Audit Project data showed the trust was within expectations during 2011/12.

Performance, monitoring and improvement of outcomes

Data submitted by the trust in January 2013 as part of the Sentinel Stroke National Audit Programme revealed that there were some aspects of the care provided to stroke patients that required improvement. Since this audit several improvements had been made which included the employment of an additional stroke consultant and a stroke registrar and the active recruitment of another consultant. The frequency of multidisciplinary team meetings had increased in line with national guidance and the frequency of clinics for people who have experienced a transient ischaemic attack had increased to every weekday.

Data for January 2014 had been submitted by the trust but was not available at the time of our inspection, we are informed that these data show improvement but are not yet published nationally.

We were informed of an ongoing investigation by the medical director into endocrinology services and diabetic clinics. We were informed of concerns from members of the clinical team. Against a backdrop of high local amputation rates for patients with diabetes, CQC was concerned to hear from local staff that the diabetic foot clinic is overcrowded and staff felt this was compromising patient care.

Staff, equipment and facilities

Staff working within the medical directorate felt that staffing levels were sufficient to allow them to provide safe care to patients and recognised the importance of safe staffing and the impact it had on providing care. An analysis of the data submitted by the trust revealed that the ratio across the trust of full-time equivalent nurses per patient was 2.2, compared with a national average for England of 1.9. Some wards had vacancies, and the managers with staff vacancies informed us that the trust was actively recruiting to fill vacancies as soon as possible.

Several ward managers expressed concern about the skill mix on the wards. They told us that there were insufficient senior experienced nurses. This meant that potentially additional workload would be placed on these nurses as they were the only people able to undertake more complex procedures.

We spoke individually with 20 members of staff, at all levels, during the inspection. All the nursing staff felt that they worked well together as a team and supported each other. We saw evidence of this during our inspection. Several people made comments such as "we are a good team" and "we are more like a family, we help each other out".

The microbiology team described a "quadrupling" of their workload which has had an adverse effect on the level of support they can give to the wards. They expressed their concerns about their service being "overstretched". They also felt disconnected from the infection protection and control nursing team. This has significant potential to degrade the service supporting control of infections in the hospital. However, we noted that the Director of Infection Prevention and Control is a Microbiologist with the scope and responsibility to take action.

Requires improvement

Medical care (including older people's care)

Nursing staff on one medical ward (ward 18) informed us that there were not enough junior doctors to "get all the jobs done". Nurses were frustrated that there were frequently outstanding tasks in the 'doctors job book' after the doctors had left the ward for the day. It was not uncommon for patients who required a change in their medication to wait for more than a day to have their prescriptions amended. We were informed that recently a patient had waited three days and an incident form had been completed. This may lead to patients staying in hospital longer than they need to, and will delay access to prescribed medication.

Multidisciplinary working and support

We observed that on all the wards we visited staff worked well together as a cohesive team. The handover process between shifts was efficient and effective and we noted that members of the team respected and valued the work of others within the team.

We were informed by staff on one cardiology ward (Ward 37) that patients were sometimes re-admitted as the dosage of a particular medicine had not been monitored appropriately by the patient's GP. This resulted in a deterioration in the patient's condition leading to re-admission. The senior nurse we spoke with was not aware of any discussion between GPs and the cardiologists regarding ways to address this, or any plans to resolve this in the future.

We attended a 'bed management' meeting which took place daily at 11am. Much of this meeting consisted of senior nurses waiting their turn to identify patient discharges and those with the potential for discharge. There was already a process in place (which was seen to be effective) whereby the night bed manager could assess and predict likely bed availability on each ward.

Are medical care services caring?

Good

Compassion, dignity and empathy

All the patients and visitors we spoke to said that they felt well cared for and that they thought staff were kind and caring. We saw many examples of this during our visit. One family requested to speak to us regarding the care received by their relative. They told us that their relative had received excellent care and the family had been treated with compassion and respect. We spoke with 33 patients and everyone spoke very positively about the care they had received. Some comments made were "The care has been fantastic", "I have been really well looked after" and " The staff have all been very attentive".

During a breakfast meal on one of the wards where frail elderly people were being cared for, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed many good interactions between staff and patients both prior to and during the meal. Some examples of the interactions included patients being made comfortable so that they could enjoy their food and staff assisting people who required help sensitively and patiently.

We spoke with 33 patients and three relatives during our inspection of the medical directorate. Everyone we spoke with felt there were enough staff to meet people's needs, but almost everyone commented that staff were very busy. We saw staff working extremely hard on the wards, and they were clearly very busy. We did not find evidence that patients' needs were not being met. We also noted that staff were very visible in patient areas and anticipated people's needs well, which meant that patients rarely had to use the nurse call system. However, we observed that when the nurse call system was used, calls were answered promptly.

Involvement in care and decision making

Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care. Patients we spoke with told us they felt involved in their care and treatment and felt that they had been consulted, where appropriate, on most aspects of their care and treatment.

We received correspondence from one patient who had been involved in the development of the stroke care pathway. They spoke very positively about the way in which stroke patients had been involved in both the pathway and the development of the stroke unit.

Trust and communication

All the patients we spoke with told us they felt safe within the trust. However, some felt that communication could be

Requires improvement

Medical care (including older people's care)

improved. Some of the patients, particularly those on the acute medical and frail elderly wards, did not have a clear idea of when they would be likely to be discharged, or the progress they would need to make in order to be well enough for discharge.

Emotional support

Relatives we spoke with commented on the emotional support given by staff to families. One person told us, "They are caring for the whole family, not just the patient."

Are medical care services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

Most of the patients we spoke with were complimentary about the meals served at the Trust. 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.

The stroke unit had been relocated to an area where there were only wet rooms for patients to use. Staff on the unit informed us that stroke survivors who did not have the ability to maintain their balance when sitting upright, which is not uncommon following a stroke, could not make use of the wet rooms. This was because a shower chair specifically designed to support the patient was needed to ensure they were safely supported during a shower. There were none of these shower chairs available on the stroke unit at the time of our visit, which meant that some patients did not have the option of a shower and were assisted to wash in bed. There was also a shortage of armchairs specifically designed to support people who have had a stroke. This meant that any available chairs were shared and some people spent longer in bed when there was no chair available to meet their needs.

One ward, which had a large proportion of patients with cognitive impairment, had colour co-ordinated areas within the ward. This made it easier for patients will memory loss to navigate around the ward.

Vulnerable patients and capacity

We reviewed the records for one patient who lacked capacity to make decisions for themselves and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNA CPR). We saw that the appropriate people had been involved in the decision making process and that the decision had been clearly documented in the patient's notes.

We found that the Trust had supported staff in developing skills for caring for people with dementia who may be admitted to the Trust. All staff were able to explain the implications of the Mental Capacity Act 2005 and how they would make decisions in the best interests of a patient.

Access to services

During our inspection there were medical patients being cared for and treated in the cardiac day case unit. This had prevented admissions to the unit for two weeks prior to our visit (we are informed that alternative beds were utilised in the Cardiac Centre during this period to minimise cancellations).

Leaving hospital

We saw that there were systems in place to ensure that discharge arrangements met the needs of patients. Staff with specific responsibilities to manage the discharge process were available throughout the Trust and staff we spoke with confirmed that, generally, patient discharges were managed effectively. This is supported by national data; the CQC 2012 audit of delayed discharges supports this and shows the trust as being similar to that expected for delayed discharges when compared with other trusts.

Learning from experiences, concerns and complaints

Staff were aware of the Trust complaints system and how to advise patients and relatives to make a complaint, should they wish to do so.

Changes to ward 12 and Gastroenterology had been made from listening to patients feedback. The patients we spoke to during our visit were pleased with the new environment.

Requires improvement

Medical care (including older people's care)

Are medical care services well-led?

Good

Leadership and culture

Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust.

Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable. However, they told us they felt disconnected from the executive team and did not feel that the executive team understood the day to day operational challenges involved in delivering direct care and treatment to patients. Two nurses told us that a podcast from the executive team was available on the intranet if anyone wanted to look at it, but commented that ,"no-one bothers as you would have to do it in your own time and it doesn't really relate to us".

During a consultant discussion group we were informed that they perceived that there had been a change of management style, from one where they felt included, to one where management feel remote and disconnected. In the opinion of some consultants, this had disenfranchised them of the ability to develop services, to the detriment of patient care, due to an over focus on finances.

Patient experiences, staff involvement and engagement

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment using the Friends and Family Test. Four wards were identified where people would be extremely unlikely to recommend them to friends and family, which were all from the medical directorate. Ward 12 had a negative overall score, which means that the number of negative comments was greater that the number of positive comments, and we explored the reasons for this with the ward manager during our visit. We found that the negative comments had all been related to the refurbishment work that had taken place recently, when the ward had remained open. This had resulted in increased levels of noise and inconvenience regarding the bathroom facilities while the building work was taking place. The refurbishment was now completed. Ward 18 had also received some negative comments from the Friends and Family Test. We found that action had been taken to address the issues highlighted by patients. Measures such as the moving of a hand gel dispenser so that staff and visitors no longer looked directly into one of the side rooms when applying hand gel, and staff education regarding the provision of care during the night had addressed most of the concerns identified in the Friends and Family Test.

Learning, improvement, innovation and sustainability

All the staff we spoke with during our inspection had received an annual appraisal and had set learning and development objectives for the following year. Mandatory training was up to date or programmed to take place in most areas we visited. Staff were happy with the access to training within the trust. They were informed in advance of any mandatory training they needed and the training would be scheduled in. The training was competency based and everyone thought the training provided within the trust was of a good standard. One person told us, "they make sure you participate and that you understand, you can't just sit there and collect your certificate on the way out". Occasionally staff, particularly senior nursing staff, were unable to attend training due to shortages of staff on the ward, however this was unusual.

Requires improvement

Surgery

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

Information about the service

There were approximately 195 in-patient surgical beds and 12 theatres, including three day surgery theatres. A range of surgical services were provided, including general surgery, urology, trauma and orthopaedics, ear, nose and throat (ENT), ophthalmology, oral surgery, cardiothoracic surgery and breast surgery.

As part of the inspection, we visited the surgical assessment unit (SAU), male and female emergency surgery and vascular wards (wards 5 and 6), orthopaedics ward (ward 15a), general surgery including gynaecology (ward 15b), urology (ward 16), trauma and orthopaedics wards (wards 34 and 35), cardiac ward (ward 37). We also inspected the pre-operative assessment unit, day surgery unit, urology day surgery unit, day surgery theatres and general theatres. We also visited the trust on an unannounced visit on 28 January 2014.

We spoke with 11 patients. 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 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.

Summary of findings

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care.

The staffing levels and skills mix was sufficient in the majority of areas we inspected. However, there were not enough appropriately trained nursing staff to meet patients' specialist needs in the surgical assessment unit and ward 15a, mainly due to staff sickness levels. The trust has identified that it needs to improve staffing levels, and it has plans in place to improve these. We found that patient records and clinical notes were not always completed appropriately.

The trust followed best practice guidelines, such as those produced by the National Institute for Health and Clinical Excellence (NICE) and it participated in national clinical audits. However, trust compliance with national guidelines (such as the hip fracture guidelines relating to pre-operative assessment by an orthopaedic geriatrician) could be further improved.

The surgical wards and theatres were clean, safe and well maintained. Staff worked effectively as a team within the specialties and across the surgical services. There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. The trust had action plans in place to improve waiting times for patients awaiting surgery and to reduce the number of cancelled operations. However, the actions had not yet been fully implemented and their effectiveness could not be measured.

Requires improvement

Surgery

Patients spoke positively about their care and treatment. There were systems in place to support vulnerable patients. There was effective teamwork and clearly visible leadership within the surgical services. Staff were appropriately supported with training and supervision and encouraged to learn from mistakes. This allows staff to alter practice and avoid repetition of near misses and errors.

Are surgery services safe?

Good

Safety and performance

The surgical wards and theatres at Blackpool Victoria Hospital had a number of measures in place to monitor patient safety and reduce the risk of harm to patients. We looked at information about patient safety held by the trust, the Care Quality commission (CQC) and other external organisations.

There had been no 'Never Events' (mistakes that are so serious they should never happen) reported by the trust between December 2012 and December 2013. It is mandatory for trusts to submit patient safety alerts data on incidents where an outcome may have been preventable, this is through the National Reporting and Learning System (NRLS). Between July 2012 and June 2013, the trust submitted four patient safety alerts for patients who had died. Two of these took place in surgical specialties. During the inspection, we saw evidence that these incidents were investigated, processes changed and action plans were implemented to improve patient care.

The infection rates for methicillin-resistant staphylococcus aureus (MRSA) and for clostridium difficile (C. difficile) infections were within an acceptable range for the size of the trust.

Trust mortality data for surgical services showed that there had been a steady reduction in overall mortality rates between October 2011 and December 2013. Mortality reviews were carried out by specialty and each incident was reviewed and investigated. The trust had a mortality reduction action plan for 2013–14 and was working towards reducing mortality rates. Overall, trust mortality rates had fallen from 125 in April 2012 to just over 110 by December 2013. Staff told us the trust was on trajectory to meet its internal Summary Hospital-level Mortality Indicator by April 2014.

[Note: The SHMI is the ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there].

Requires improvement

Surgery

The NHS Safety Thermometer measures people who fall, or who develop pressure sores, venous thromboembolism (blood clot in the veins) or a catheter urinary tract infection. The trust performed better than the national average for the number of patients with new pressure ulcers and catheter or urinary tract infection over the past 12 months. The number of patients with falls fluctuated above and below the national average. The number of patients with venous thromboembolism had risen slightly above the national average since September 2013. The staff we spoke with during the inspection could not attribute this rise to a specific cause as risk assessments for venous thromboembolism were carried out and care pathways were in use for patients identified at high risk.

Learning and improvement

The surgical departments we inspected monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents, near misses, never events, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system.

All incidents were investigated and remedial actions were put into place to minimise reoccurrence. There was a learning culture in place. Staff told us they received feedback if they had made an error to aid future learning and they were supported by the management team within their specific area.

There was a clear process for investigating staff errors, complaints and patient safety incidents, including serious untoward incidents. The ward managers or the matron carried out root cause analysis (RCA) investigations following any serious incidents. We looked at two completed RCA reports for serious untoward incidents and saw action plans were put in place to aid improvement.

Systems, processes and practices

The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients. However, we saw that ward 5 (female general surgical ward) was not purpose built, and there were not enough toilets and sinks. There were plans in place to refurbish the ward and staff had been able to contribute to the proposed changes.

The areas 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 was a sufficient number of 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, whilst delivering care. Gowning procedures were adhered to in the theatre areas.

Medicines, including controlled drugs, were securely stored. Medicines were stored in a dedicated fridge and staff were responsible for recording fridge temperatures daily. Staff also carried out daily checks on controlled drugs, medication stocks and emergency equipment.

The patients we spoke with did not highlight any concerns relating to cleanliness or safety in the surgical wards or theatres.

The trust had identified the staffing levels as a concern and this was logged on the divisional risk register. The Associate Director of Nursing for Scheduled Care had carried out a gap analysis to identify the shortfalls in staffing and a proposed plan to recruit additional staff was scheduled for ratification by the divisional and trust board during February 2014.

Monitoring safety and responding to risk

Information relating to patient safety was displayed on notice boards in each of 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, medication errors and other incidents. The information showed performance against targets over the past year or longer and was updated monthly by the ward managers in each area. The ward managers also carried out NHS Safety Thermometer audits on a monthly basis and any issues identified were followed up.

There were clinical pathways in place for acutely unwell patients, and staff used early warning systems and pathways to provide timely treatment that is appropriate for individual patients.

Requires improvement

Surgery

Staff were aware of how to escalate concerns relating to patient safety. Patient records showed that the risk of patients developing blood clots, pressure sores, catheter and urinary tract infections were managed. Patients identified as a high risk were placed on care pathways and monitored by staff to minimise the risk of harm.

Anticipation and planning

The trusts' strategic framework incorporated patient safety. There was a strategic aim of zero harm to patients with a target of 95% harm free care by 2016. There were specific targets in place for improving patient safety, such as reducing the number of pressure ulcers, falls and VTE rates.

There was an audit programme in place, which included clinical audit, nursing care indicators, infection control and health and safety processes and audits took place on a routine basis. Patient safety performance data across the surgical departments was collated into a divisional dashboard and this highlighted where performance levels fell below acceptable levels (less than 95%).

Data submitted by the trust showed that compliance in nursing care and clinical care indicators had improved significantly since April 2013. The data also showed that further improvements were needed in antibiotic prescribing records and medical notes. Compliance levels were monitored and reviewed on a monthly basis within the scheduled care division and information was cascaded to staff across the departments to aid improvement.

Information was reviewed in real-time a number of times per day to identify issues and staff were able to react to concerns in a timely manner. Effective systems were in place to manage staffing and capacity issues that could impact on patient safety.

Where staff identified potential concerns relating to patient safety, these were assessed and placed on departmental or divisional risk registers, so the risks could be assessed and minimised through action plans. This appeared to be working effectively

Upon admission to the critical care services, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, 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 in the surgical wards were using enhanced care and recovery pathways, in line with national guidance. We observed a theatre team 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.

We identified that not all staff who are required to, individually confirmed patient identification during the 'time out phase'. We discussed this with the theatre manager, who told us best practice guidelines were routinely reviewed and patient identification checks were carried out in line with WHO guidelines. The national guidance states that during the time out phase: Surgeon, Anaesthetist and Registered Practitioner verbally confirm patient, site and procedure "confirmation of the name of the patient using the wristband, the surgery to be performed using reliable documentation and imaging (if applicable), the site of surgery and, where appropriate, the positioning of the patient in order to avoid operating on the wrong patient or the wrong site"

Are surgery services effective?
(for example, treatment is effective)

Requires improvement

Using evidence-based guidance

Patients received care according to national guidelines. Clinical audits included monitoring of compliance with National Institute for Health and Clinical Excellence (NICE) and other professional guidelines. There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the Trust.

There was a good understanding of current best practice guidance among the medical and nursing staff in the areas we inspected. There was participation in national audits such as the National Bowel Cancer Audit, hip surgery audit and the Myocardial Ischaemia National Audit Project. Clinical audit completion, performance and action plans were reviewed at monthly divisional board meetings.

The national hip fracture database report 2013 showed that trust's performance was comparable with England average for data completeness of reporting fields, the percentage of patients admitted to orthopaedic care within four hours

mean length of acute stay. The trust was below the average for the percentage of patients undergoing hip surgery within 48hrs (84.5% compared to a national average of 87.3%).

The hip fracture report also highlighted that only 1.4% of patients had undergone a pre-operative assessment by an orthopaedic geriatrician compared with a national average of 53.8%. This meant that best practice guidelines were not being followed effectively. We understand however that a review is being undertaken by an appropriately trained senior nurse in line with the trusts clinical pathways.

The National Bowel Cancer Audit 2013 showed that the trust was performing better than the national average for case ascertainment (96% compared with national average of 95%) and for the number of patients had a computerised tomography scan (92.2% compared with national average of 87%).

The National Bowel Cancer Audit 2013 highlighted that the trust's performance was below the national average: there were 101 cases having major surgery. For these cases, the level of data completeness for patients undergoing major surgery is 55% (compared to the national average of 71%). The audit also highlighted that 79.3% of patients were seen by a clinical nurse specialist compared to the national rate of 87%.

Patient records included information about nutritional needs. Staff carried out nutritional risk assessments following the Malnutrition Universal Screening Tool guidelines and care plans were put in place for high risk patients. The majority of patients told us they were given a choice of food and drinks were provided regularly. Where a patient was identified with learning disabilities, staff could contact a trust-wide specialist nurse for advice and support.

Performance, monitoring and improvement of outcomes

There was a clinical governance system in place and routine clinical audits took place to monitor staff practice. Clinical audits conducted in the surgical departments were based on national audits and local concerns. Action plans were put in place where gaps were identified.

Staff, equipment and facilities

In the majority of areas, there were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care. However, we saw that there were not enough appropriately trained nursing staff to meet patients' specialist needs in the surgical assessment unit and ward 15b (general surgical ward), specifically during the evenings and nights. This meant that patients with specific needs may have delays in accessing care until a member of staff became available.

Staff sickness levels were over 8% compared with the overall trust target of 3.2%. This was due to some staff being on long term sickness. Staffing cover was provided by temporary staff (which comprised of existing staff from the trust or trained agency staff), this led to improvements in staffing levels.

One patient on Ward 15a (general surgical ward) told us the ward was short staffed overnight and this had led to a delay in the administration of intravenous antibiotics. The majority of patients we spoke with told us they were happy with the care and treatment received and that they had received regular checks from doctors and ward staff.

Staff told us they used single-patient-use, sterile instruments where possible. Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit. Staff told us they always had access to the equipment they needed to meet patients' needs. The equipment we saw was clean, safe and well maintained.

Multidisciplinary working and support

There was an effective system in place for monitoring patients within the surgical areas and theatres. Staff carried out 'intentional rounding' (reviewing patients at set intervals) to ensure that changes to their condition could be managed effectively. Staff handover meetings and safety huddles took place during shift changes on a daily basis to ensure all staff had up-to-date information about risks and concerns.

We saw that multi-disciplinary staff worked well in the majority of areas we inspected. There was effective communication between the teams within the surgical specialties. Trainee doctors and nurses we spoke with told us they were supported well.

Staff on wards 34 and 35 (trauma wards) told us there were no formal consultant ward rounds and consultants. A staff nurse commented that "they come when it suits them. I've been here for two years and couldn't tell you on what day they come". The ward sister also commented that "they often come and don't write in the notes".

Requires improvement

Surgery

The junior doctors on the trauma wards told us that each of the consultants had different ways of working. There were no clear clinical protocols or departmental agreed practice in place. The junior doctors had a hand written chart of each consultant's preferred practice. The junior doctors told us this was needed as the consultants did not regularly communicate with them as to how patients should be treated. If a clear clinical pathway is followed, the need for individual consultant preferences is greatly reduced. Clear pathways bring certainty to all those staff involved in care and remove (or significantly reduce) ambiguity.

The orthogeriatric service was provided on the trauma wards on a daily basis by a staff grade doctor, as well as a consultant ward round twice a week. This did not occur on ward 15a (orthopaedic ward), which at the time of the inspection had seven trauma patients (who often are post-operative neck of femur). Staff on ward 15a also told us it was difficult to get the consultants to see their patients on these wards.

The national hip surgery database national report 2013 also highlighted that only 1.4% of patients had undergone a pre-operative assessment by an orthopaedic geriatrician compared with a national average of 53.8%. This meant that best practice guidelines were not followed effectively.

Patient records were not always maintained effectively. The patient files we looked at were large, unstructured and patient notes were incomplete, loose and unorganised. We found that information such as daily reviews by doctors and patient discharge records had not always been completed. Lack of structure and accurate recording in medical and clinical case notes makes records difficult and can impact on the quality of decision making and continuity of care.

Are surgery services caring?

Good

Compassion, dignity and empathy

The majority of patients we spoke with told us they were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care in a kind, calm, friendly and patient manner. The patients we spoke with were complimentary about staff attitude and engagement. The comments received included "staff are very helpful, kind, could not do enough" and "nurses are good, very caring, and approachable". This demonstrated that staff cared about meeting patients' individual needs.

However, we received negative comments from three patients in SAU relating to how staff responded to their needs. One patient told us the staff did not offer them food and they waited 25 minutes for staff to respond to their call. The patient told us the staff encouraged them to make a complaint as this would help with staffing. Another patient told us that although the overall care they received was good, they had requested a dressing change and this was not addressed by the staff. Another patient told us they had been offered pain relief medication but this was not given by the staff.

Patients' privacy and dignity were maintained. The areas we visited complied with same-sex accommodation guidelines. Where this was not possible, patients were cared for in side rooms. We saw that patients' bed curtains were drawn and staff spoke with patients in private. Staff in the urology unit provided patients with modesty blankets during examinations. Staff respected patient dignity whilst transferring patients between wards. One patient commented that they were "treated with dignity on the way to the theatre".

Involvement in care and decision making

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent. The patients we spoke with confirmed that staff had sought consent verbally and in writing prior to performing surgical procedures.

Staff respected patients' right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. Patients told us staff spoke with them before and after surgery to inform them of the outcome.

Trust and communication

The majority of patients we spoke with told us they would recommend the trust to others. One patient told us they had a negative experience in the surgical assessment unit but they were very happy with the way they were treated when they were transferred to ward 15a.

Requires improvement

Surgery

Patients were treated with respect and were encouraged to ask questions if they didn't understand any aspect of their care. The comments received from patients included "doctors did not mind patients asking them to repeat explanation" and "was encouraged to ask questions by the doctor". The patients we spoke with were able to describe their treatment in detail, which demonstrated that staff had explained their care and treatment to them.

Emotional support

We observed staff providing reassurance and comfort to patients. One member of staff was relaying a telephone call from a patient's relative and encouraging them to contact their relative to tell them how they were doing.

Staff told us they regularly interacted with the trust's palliative (end of life care) team who provided support and advice during bereavement. Relatives of patients were also given bereavement booklets that provided additional information. Patients could be transferred to side rooms to provide privacy and to respect their dignity. Patients could also access the multi-faith chaplaincy service for support.

Are surgery services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Meeting people's needs

We did not identify any concerns relating to bed occupancy during the inspection. There was a winter escalation plan in use. The trust did not use a surgical escalation ward for increased bed capacity during busy periods. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty. There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation.

Patients could be admitted for surgical treatment through GP referral. There was routine involvement from organisations within the community in the clinical governance processes, including commissioners and GPs.

The trust had arrangements with local community-based hospitals where orthopaedic and trauma patients were transferred to receive rehabilitation services. These services were nurse-led and patients could be seen by consultants from the trust and GPs from the community. Reviewing these facilities was outside the scope of this visit.

Trust data showed national targets for 18-week Referral to Treatment standards for admitted and non-admitted patients between January 2013 and December 2013 were being met for most specialties. The data for December 2013 showed that the trust failed to meet waiting time targets for the cardiothoracic (86.99%) and orthopaedics (90.65%) specialties. There were a number of actions in place to address waiting times, including the deployment of specialist consultants (e.g. for foot and ankle surgery) and the use of theatres on Saturdays.

Department of Health data showed that the trust performed worse than expected for the proportion of patients whose operation was cancelled. Between July and September 2013, 102 patients had an operation cancelled, compared with the England average of 86. Cancellation data supplied by the trust (2012 and 2013 data) showed that the three main causes for cancellation were 'did not attend' (30%), patient choice (14%) and bed availability (10%). The trust had carried out its own benchmarking comparison with other similar sized trusts and had placed itself at 94 out 175 in terms of performance, slightly higher than the average. Data we were shown (for example in orthopaedic surgery) also had a broad category of 'hospital reasons' that we were unable to interrogate further. Understanding greater data granularity may assist with the analysis of these events.

The Deputy Director of Operations for Scheduled Care was aware that further improvements were needed and a number of actions had been identified to improve the number of cancelled operations. This included the creation of a Theatre Utilisation Group (TUG), which met on a weekly basis and reviewed theatre lists for the next week to identify and resolve any operational constrictions, such as staff or bed availability. The TUG had been in place for seven weeks and its objective was to improve theatre utilisation by 10%. It was too early to identify if this was effective.

The theatre department also planned to implement a system where all patients awaiting surgery would be contacted prior to the day of surgery to confirm their

attendance. This had been trialled in the outpatients' department for one month and had led to a 2% reduction in 'did not attend' rates and increased rebooking of appointments by 58%.

The actions to improve cancellation rates had only recently been implemented or were yet to take place, so it was too early to measure if these actions were effective and had yet led to an improvement in the rate of cancelled operations. A high rate of cancelled operations leads not only to ineffective use of resources, but importantly patients lacking certainty about surgical procedures and delays accessing care they need.

Vulnerable patients and capacity

Staff received mandatory training in consent, safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties' safeguards. Staff understood the legal requirements of the Mental Capacity Act 2005.

There was a trust-wide coordinator who participated in best interest meetings and provided support and guidance for staff.

Access to services

The surgical services were accessible for people with wheelchairs. Information about care and treatment was provided verbally by staff. The staff we spoke with told us patients were given written information and leaflets for specific procedures, and in different accessible formats if needed. Information leaflets were not publicly displayed in the majority of the ward areas we visited. We did not see written information readily available in different languages or other formats, such as braille in the areas we inspected. Staff could access a language interpreter if needed.

Leaving hospital

The systems in place for the discharge of patients were effective. Information relating to the average length of stay was displayed on notice boards in each area we visited. The patients we spoke with told us the staff had given them clear information relating to their discharge from the trust. Patients were informed when they were likely to be discharged or transferred to other wards.

The patients we spoke with told us staff kept them informed if their discharge was delayed. Staff were supported by a discharge team for support relating to patient discharge. Patients were discharged from the wards, so staff could monitor them during their wait. There was an escalation process in place for staff to escalate to the clinical matron if a patient's discharge was likely to be delayed.

Learning from experiences, concerns and complaints

Staff in the surgical division told us all complaints were recorded on a centralised trust-wide system. Ward staff investigated formal complaints relating to their specialty. The trust target was to respond to formal complaints within 25 days. We looked at surgery services complaints data over the past year, which showed that the majority of complaints had been responded to within 25 days. Information about complaints was fed back to staff through routine meetings and divisional newsletters to raise staff awareness and improve services.

We saw that Patient Advice and Liaison Service (PALS) leaflets were available but information about how to raise complaints was not always clearly displayed in the areas we visited. The patients we spoke with were aware they could raise a complaint by speaking with the staff or the PALS team.

Between July 2013 and October 2013, the trust had an above average result for the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. In October 2013, 89.7% of patients asked were either 'likely' or 'extremely likely' to recommend the ward they stayed in to friends or family. Within the surgical department, one ward (ward 6 – general surgical ward) scored below the trust average (two patients had selected 'don't know' and one patient had selected 'neither').

Are surgery services well-led?

Good

Vision, strategy and risks

The trust had a clear vision and strategy with clear aims and objectives. The trust vision, values and objectives had been cascaded across the surgical departments and staff in surgery had a clear understanding of what these involved. Information relating to core objectives and performance targets were visibly displayed in the majority of areas we visited.

Requires improvement

Surgery

The trusts' core objectives were focused on patient safety. There were specific objectives relating to patient involvement, compliance with standard pathways, inappropriate admissions, patient harm and delays to treatment. We saw that routine audit and monitoring of key processes took place within the areas we inspected.

We looked at performance and quality data. This showed that information relating to patient safety and risks and concerns were accurately documented, reviewed and updated at least monthly within the departments and at divisional level. Incidents, capacity issues and patient feedback were monitored at both board and divisional level.

Governance arrangements

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. In each area we inspected, there were routine staff meetings to discuss the day to day issues and to share information. Specific risks with scores above 12 were managed at divisional level and risks greater than 20 were incorporated into the corporate risk register.

Leadership and culture

There were clearly defined and visible leadership roles in the wards and theatre areas we inspected. Staff were aware of the reporting structures in place. The senior management team were highly visible in each area, and all staff recognised them. The scheduled care divisional leadership consisted of a clinical lead (Clinical Director), a nursing lead (Associate Director of Nursing) and an operational lead (Director of Operations). This management structure was also in place at departmental level.

The ward staff were led by ward managers and a clinical matron, who reported to the Associate Director of Nursing for Scheduled Care. The theatres were anaesthetist-led and junior medical staff reported to consultants in each of the ward areas. The staff we spoke with told us they received good support from their managers. The majority of staff were aware of or had met members of the trust's executive team.

Patient experiences, staff involvement and engagement

The majority of patients we spoke with were complimentary towards the staff and had received good care. The staff we spoke with were passionate about the care they offered to patients. There was positive communication and team work between medical and nursing staff in most areas. We saw that staff were involved in discussions about patient safety in the areas we inspected.

Learning, improvement, innovation and sustainability

Staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data showed that the majority of staff had completed their mandatory training and annual appraisals.

There was an open culture that supported learning within surgical services. Staff were encouraged to report incidents and errors. Staff received feedback to aid learning. The staff we spoke with told us they had been fully supported when they made an error.

Information was cascaded within the teams and across the surgical departments to improve patient care and treatment. This was done via staff meetings and through staff newsletters. Staff said they were supported with additional learning and practice development.

There was a clear strategy for the future of the scheduled care services at the trust. The Divisional Director of Operations for Scheduled Care was the project lead for a number of initiatives aimed at improving the quality of care by learning from other organisations and improving staff training. The surgical services had a number of advanced nurse practitioners in place and had identified further staff to undergo advanced practitioner training to improve care across the services. Six staff were currently undergoing this training in the surgical assessment unit.

The scheduled care division launched a '7 day safe' programme during March 2013. This formed part of the strategy for surgical services which aimed to reduce the number of patients needing surgical beds or operations at the trust by creating more community-based services.

A rapid improvement event was attended by staff from the trust as well as community healthcare representatives including GPs, commissioners, community nurses and

patients. This led to the development of approximately 46 community care pathways, including urology catheter insertion, cataract treatment and hip replacement. A pilot scheme is currently in place until May 2014.

Good

Intensive/critical care

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

Information about the service

The main critical care unit includes an intensive therapy unit (ITU) which has eight beds and a high dependency unit (HDU) with six beds, which could be increased to eight beds if needed. The units were located separately from each other, divided by a several sets of doors and a main hospital corridor .

The trust's cardiac centre is a regional centre of excellence for cardiac care and provides support for the local area, as well as the surrounding areas across Lancashire and South Cumbria. The cardiac centre also included a cardiac intensive therapy unit (CITU), which had 20 beds, and the coronary care unit (CCU), which had 10 beds. The trust provided care and treatment to patients of all ages with a range of serious life-threatening illnesses.

As part of the inspection, we visited the critical care services and spoke with three patients and the relatives of another two patients. 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 and the senior management team. We received comments from our public 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

There were effective systems and processes in critical care services to provide safe care and treatment for patients. Patient safety was monitored and incidents were investigated to assist learning and improve care. The critical care services performed in line with similar-sized hospitals and performed within the national average for most measures.

There were not enough appropriately trained nursing staff to meet patients' specialist needs in the intensive therapy unit and the high dependency unit. The number of middle grade doctors was not sufficient to ensure that there was 24-hour cover available by a registrar. The trust had identified that it needed to improve staffing levels, and it had plans to do this. We found that there was room for improvement in communication between the services and the standard of patient records.

Care was provided by trained staff in accordance with national guidelines, and staff used enhanced care pathways. The critical care services were clean, safe and well maintained. There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Patients or their representatives spoke positively about their care and treatment. There were systems in place to support vulnerable patients.

There was effective teamwork and clearly visible leadership within the critical care services. Staff were appropriately supported with training and supervision and encouraged to learn from mistakes. All staff are encouraged to review both incidents and near misses and use these as opportunities to prevent a recurrence.

Good

Intensive/critical care

Are intensive/critical services safe?

Requires improvement

Safety and performance

There were a number of measures in place to monitor patient safety and reduce the risk of harm to patients. There were no 'Never Events' (mistakes that are so serious they should never happen) or patient safety alerts which were classified as deaths in the critical care services between December 2012 and December 2013.

Prior to the inspection we looked at the Intensive Care National Audit and Research Centre (ICNARC) data provided to us by the trust. It told us that the trust had had eight cases of unit acquired Methicillin-resistant Staphylococcus aureus (MRSA) between 2012 and 2013. This is a significantly higher number than expected for a unit of this size. During the inspection the trust told us that this was a data error and that those figures were not reflective of the unit's performance the previous year.

Information supplied to us during the inspection by the trust showed there had been no cases of methicillin-resistant staphylococcus aureus (MRSA) infections between April 2013 and December 2013 across the critical care services. There was one case of clostridium difficile (C.diff) reported in October 2013 within ITU. We looked at the investigation report for this incident and saw that there was clear involvement from nursing and clinical staff, as well as the trust's infection control team and consultant microbiologist. Overall, infection rates were within an acceptable range for the size of the trust.

NHS Safety Thermometer and safety performance data such as infection control compliance was displayed in each area. The information showed that there was a high level of compliance in infection control processes and the overall numbers of pressure ulcers, falls and medication errors reported over the past year were not significant and were well managed

Learning and improvement

The critical care services monitored and minimised risks effectively. Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents, near misses, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system.

Within CCU, only the band 5 staff nurses or above used the electronic incident reporting system. Other staff would inform the staff nurses, who would report the incident on their behalf. This meant that some staff members were reliant on others to report incidents, which may result in a delay or inaccuracies in reporting. The staff on the CCU unit that we spoke with told us they rarely reported 'near misses'. This means that incidents or near misses may never be reported (or be delayed in being reported) and valuable lessons may not be quickly learned.

All incidents were investigated and remedial actions were put into place to minimise reoccurrence. There was a learning culture in place. Staff told us they received feedback if they had made an error to facilitate future learning and that they were supported by the management team. There were systems in place to reduce medication errors by staff. For example, if a member of staff carried out a medication error twice, they underwent supervision to assess competency before they were allowed to administer medication unsupervised.

Systems, processes and practices

The critical care services we inspected were clean, safe and well maintained. Staff were aware of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment. The patients we spoke with did not highlight any concerns relating to cleanliness or safety

There was a sufficient number of 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, whilst delivering care.

Medicines, including controlled drugs, were securely stored. Staff also carried out daily checks on controlled drugs, medication stocks and emergency equipment. Patients told us they received their medicines on time and understood what medicines they were taking and what

they were for. They told us they were never without adequate pain control. The comments received included "the nurses are always asking me if I am in pain, so I never have to ask them".

We were concerned about both the medical and nursing staffing on both the ITU and HDU. Both units were staffed by two separate consultants between 8am and 6pm weekdays. Both consultants were based on the units and were free from other clinical commitments. In addition there were two junior doctors supporting the ITU. Out of hours and at the weekend there was a single doctor (usually a ST5 or above) covering both units.

The Core Standards for Intensive Care Units recommend that Consultant work patterns deliver continuity of care by having a single Consultant cover the unit for five days in a row. Staff rotas showed that different consultants were on call during the day and night and from one day to the next. Due to the fact that there were not enough middle grade doctors, consultants being required on the unit for a significant amount of time during the day and at night. We noted that according to the rota, during the previous weekend there was not a middle grade doctor present in the unit. We spoke with Consultants who stated that if there was only a junior trainee covering the units then they would stay on the unit to work with the trainee. They admitted to us that this may not be sustainable.

The equipment we observed was clean, safe and well maintained. The areas we visited were clean, safe and well maintained

Staff working within the CCU told us that staffing levels were sufficient to allow them to provide safe and effective care to patients.

Monitoring safety and responding to risk

Upon admission to the critical care services, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, 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. These pathways were seen to be effective.

The trust have implemented clinical care pathways in place for acutely unwell patients and staff were using these effectively. Staff used early warning systems and pathways to provide timely treatment to patients at risk.

Patient safety was discussed during routine meetings within the critical care departments and performance was reviewed at divisional and board level. Mortality rates, patient harm and incident reporting were monitored through monthly mortality and morbidity meetings.

Anticipation and planning

There were effective systems in place to manage staffing and bed capacity issues that could otherwise impact on patient safety. Information was reviewed in real-time a number of times per day to identify issues and staff were able to react to concerns in a timely manner.

The trust was able to identify and plan for patient safety issues in advance through routine meetings and analysis. Where staff identified potential concerns relating to patient safety, these were assessed and placed on departmental or divisional risk registers, so the risks could be assessed and minimised through action plans.

Staff received mandatory training in areas such as infection prevention, moving and handling, medicines management and health and safety so they could provide safe care to patients.

We found that there was not enough appropriately trained nursing staff to meet patients' specialist needs in the ITU and HDU. Staff in the units felt more staff was needed during the day and night shifts to ensure patients received the right level of care. Staff told us it was difficult to get regular breaks during the day or take time to participate in training. The Trust had already identified that additional nursing staff were needed in the ITU and HDU units. The associate director of nursing for unscheduled care told us they were in the process of recruiting five additional nurses to ensure staffing levels would be sufficient to cover for staff sickness or absence.

Staff handover meetings and safety huddles took place during shift changes on a daily basis in a number of areas to ensure all staff had up-to-date information about risks and concerns. This allowed safety issues and planning issues to be raised and dealt with appropriately.

The Cardiac ITU had a sufficient number of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

There was insufficient or inconsistent medical cover to the units.

Good

Intensive/critical care

Are intensive/critical services effective?
(for example, treatment is effective)

Good

Using evidence-based guidance
Patients received care according to national guidelines. Clinical audits included monitoring of compliance with National Institute for Health and Clinical Excellence (NICE) and other professional guidelines. There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the trust.

Within the CCU, pathways for several conditions such as pneumonia and stroke were used. We saw, through trust audit, that these pathways were completed appropriately.

Performance, monitoring and improvement of outcomes
Trust mortality data for critical care services showed that there had been a steady reduction in overall mortality rates between October 2011 and December 2013. Mortality reviews were carried out by specialty and each incident was reviewed and investigated. A consultant anaesthetist was the mortality lead for critical care services. Overall, the trust has a high focus on mortality data.

The trust submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The data for adult critical care for 2012/2013 showed that trust performance was within acceptable levels for out-of-hours discharges, non-clinical transfers out and for discharge four hours within 48 hours.

The trust was above the Clinical Reference Group threshold for unplanned readmissions within 48 hours.

The CCU admitted patients from the surrounding area for percutaneous coronary intervention (PCI). PCI is used to treat patients with narrowed or blocked arteries that supply the heart muscle with blood. We saw that the unit was achieving the target times for treatment. Two patients who had recently undergone PCI treatment spoke positively about their experience. One patient commented that “they were all waiting for me when I arrived and got straight on with the job” and the other patient commented that “everything was very slick, everyone knew exactly what they had to do and they just got on with it”.

Staff, equipment and facilities
Training data showed that the majority of staff had completed their mandatory training and annual appraisals.

Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.

Multidisciplinary working and support
Trainee doctors and nurses we spoke with told us they received good support.

From looking at notes on the ITU and HDU and talking to the nursing staff we noted that Consultants undertook one ward round per day. The Core Standards for Intensive Care Units recommend that twice daily consultant ward rounds are undertaken – including during weekends. The trust did not use standardised ward round proforma that are often in place in trusts to communicate the daily plan, nor could we find any evidence of a formal admissions clerking. A discharge summary had recently been instigated, but nursing staff told us that this was not always completed, but depended on the Consultant on the unit at the time of discharge. Formal and standardised methods of communication improve the communication and reduce error.

Patients received daily physiotherapy Monday to Friday, by either a medical or surgical Physio, depending on their admitting diagnosis. At weekends surgical patients would be seen by a physiotherapist, but the medical patients would not be routinely reviewed

We were told that a fully multidisciplinary ward round with physiotherapists, microbiologists, pharmacists and medical and nursing staff took place only once a week. Best practice guidelines suggest this should be occurring daily.

We found that communication between departments was not as effective as it could be. There appeared to be limited shared learning or working between the cardiac ITU and the general ITU and HDU. These were located at opposite ends of the hospital and significantly, incorporated into separate divisions. In addition, staff on ward 37 (cardiac surgical ward) told us it was difficult to access the records for patients that had been transferred out of cardiac ITU. They told us the unit retained their patient notes and did not transfer these with the patient making it difficult for ward staff to access the records.

Good

Intensive/critical care

Are intensive/critical services caring?

Good

Compassion, dignity and empathy

Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. 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. This demonstrated that staff cared about meeting patients' individual needs.

Patients' privacy and dignity were maintained. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality.

Involvement in care and decision making

Staff had the appropriate skills and knowledge to seek consent from patients and had received mandatory training in consent. The patients and representatives we spoke with confirmed that staff had sought verbal and written consent prior to delivering care and treatment.

Staff respected patients' right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision.

The critical care services did not participate in the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. The staff we spoke with told us they received feedback from individual patients or their representatives. The clinical matron for cardiac ITU told us that they carried out a transparency audit and spoke with 10 patients or relatives if there had been an incident of patient harm, such as a fall.

Trust and communication

Information about care and treatment was provided verbally by staff to patients or their representatives. The staff we spoke with told us patients or their representatives were given written information and leaflets upon request. Staff could access a language interpreter if needed.

Patients had confidence in the team caring for them and told us that communication was good. They knew when they were likely to leave the unit and what needed to happen before that would be possible. One patient told us they consultant had explained what they had found and what they had done to treat the patient, giving them reassurance.

Emotional support

The HDU provided support for the relatives of patients. This included overnight accommodation and food and drink. We spoke with the relatives of a patient in the HDU and they spoke positively about the support they had received. They told us staff kept them informed at all stages of their relative's care. They also told us the staff were able to accommodate their customs and cultural needs. We also looked at patients' notes. Despite optimal medical care one patient was still deteriorating. There was clear documentation of very regular communication with the family throughout the patient's admission. Conversations had been well documented, including the questions which had been asked by the family and the answers given by the doctors. Nursing staff had been involved in the discussions and we witnessed them treating the patient with care and compassion.

Staff told us they regularly interacted with the trust's palliative (end of life care) team who provided support and advice during bereavement. Relatives of patients were also given bereavement booklets that provided additional information. Patients could be transferred to side rooms to provide privacy and to respect their dignity.

Are intensive/critical services responsive to people's needs?

(for example, to feedback?)

Good

Meeting people's needs

The trust's cardiac centre was a regional centre of excellence for cardiac care and provided for support for the local area, as well as the surrounding areas across Lancashire and Cumbria. The unit had specialist trained staff so patient needs could be met effectively.

Staff were responsive to patients' needs and provided the right level of care and support. Staff monitored patients using care pathways in line with national guidance. Staff carried out 'intentional rounding' (reviewing patients at set intervals) to ensure that changes to their condition could

be managed effectively. Patients at high risk were monitored more frequently and staff could provide one-to-one care to patients if needed. This was a challenge for the teams given the staffing levels discussed above.

Patient records included information about nutritional needs. Staff carried out nutritional risk assessments following the Malnutrition Universal Screening Tool guidelines and care plans were put in place for high risk patients. Staff supported patients who had difficulties with eating or drinking. Fluid charts were monitored routinely by staff. A patient that had arrived on the critical care unit at 11pm had been offered food and a hot drink on arrival. The patient told us they were "very surprised to get fed at that time of night, but very pleased".

Vulnerable patients and capacity

Staff received mandatory training in consent, safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards. Staff understood the legal requirements of the Mental Capacity Act 2005. There was a trust-wide coordinator who participated in best interest meetings and provided support and guidance for staff.

Access to services

The ITU and HDU were incorporated into the unscheduled care services, linked with accident and emergency and the SAU. The cardiac ITU and CCU were part of the scheduled care divisions, which included the surgical and medical wards. This meant that patients with specific needs could be admitted to critical care in a timely manner, either as emergency admissions or referral from the wards. We did not identify any bed occupancy concerns during the inspection.

Where a patient was identified with learning disabilities, staff could contact a trust-wide specialist nurse for advice and support. Staff involved carers, social workers and others involved in the patient's care and specific care plans were put into place. The critical care services also provided accommodation for carers to ensure patients with special needs received the appropriate level of care.

Leaving the unit

The process for the discharge and transfer of patients was well managed within the critical care services. Information relating to the average length of stay and time to discharge was displayed on notice boards in each area we visited. Performance data showed that the average length of stay was two days and the majority of patients were discharged within four hours in line with national guidance.

The patients we spoke with told us the staff had given them clear information relating to their discharge from the units. Patients were informed when they were likely to be discharged or transferred to other wards. Where patients discharge was delayed, they were kept informed by staff.

On discharge from the HDU or ITU patients were seen within 36 hours by the CCOT (Critical Care Outreach Team). As they only were available Monday to Friday patients would be seen over the weekend by a senior member of the nursing team

Learning from experiences, concerns and complaints

The patients we spoke with were aware they could raise a complaint by speaking with the ward staff or the PALS team.

Are intensive/critical services well-led?

Good

Vision, strategy and risks

We looked at performance and quality data. This showed that information relating to patient safety and risks and concerns were accurately documented, reviewed and updated at least monthly within the departments and at divisional level. Incidents, capacity issues and patient feedback were monitored at both board and divisional level.

Governance arrangements

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. In each area we inspected, there were routine staff meetings to discuss the day to day issues and to share information.

Leadership and culture

There were clearly defined and visible leadership roles in the critical care services we inspected. Staff were aware of the reporting structures in place. The senior management

team were highly visible in each area, and all staff recognised them. The ward staff were led by ward managers and a clinical matron, who reported to the Associate Director of Nursing for Scheduled Care. The critical care services were led by consultants and junior medical staff reported to consultants in each specialty.

The staff we spoke with were happy with the access to training within the trust. The training was competency based and staff told us the training provided within the trust was of a good standard. One staff member comments that "this trust has supported me through my maths and English exams and I am hoping to do my nurse training soon, they have been wonderful".

The executive directors had a scheduled programme for conducting ward visits across the trust. The staff we spoke with told us they attended regular staff meetings and that their immediate line managers were accessible and approachable. However, there was a mixed response from staff in relation to engagement by senior or executive management. Some staff told us they had met members of the executive team and others told us they felt disconnected from the executive team.

Patient experiences, staff involvement and engagement

The majority of patients we spoke with were complimentary towards the staff and had received good care. The staff we spoke with were passionate about the care they offered to patients. There was positive communication and team work between medical and nursing staff in most areas. We saw that staff were involved in discussions about patient safety in the areas we inspected.

The trust's overall staff sickness levels were within the national average over the past year. Nursing staff sickness levels within critical care services were above the Trust target of 3.2% in the HDU and ITU. The Associate Director of Nursing for Unscheduled Care could not attribute this to any one factor as there was a combination of short-term and long-term sickness. We saw that staff sickness levels were reviewed and staffing levels were maintained through the use of bank (or agency) staff to ensure patient safety was not compromised.

Learning, improvement, innovation and sustainability

Staff had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data showed that the majority staff had completed their mandatory training. The majority of staff received an annual appraisal and had set learning and development objectives for the following year. The staff we spoke with told us the quality and standard of training was good.

There was an open culture that supported learning within the critical care services. Staff were encouraged to report incidents and errors. Staff received feedback to aid in learning. The staff we spoke with told us they had been fully supported when they made an error.

Information was cascaded within the teams and across the critical care services to improve patient care and treatment. This was done via staff meetings and through staff newsletters. Staff said they were supported with additional learning and practice development.

The critical care services had clear objectives to ensure a sustainable service could be provided. Issues relating to staffing had been identified and there were plans in place to address this. The Associate Director of Nursing and Deputy Director for Unscheduled Care told us the main focus would be to ensure that improvements made to patient safety are maintained in line with Trust and national targets.

Inadequate

Maternity and family planning

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

Information about the service

The trust offers pregnant women and their families antenatal, delivery and postnatal care at Blackpool Victoria Hospital. The department delivers approximately 3,000 babies every year. The newly opened Midwifery-led Unit offers four birthing suites, two with birthing pools, and the atmosphere is relaxed and family centred. The consultant-led unit has is a dedicated operating theatre, an antenatal/postnatal ward, several spacious delivery rooms, a family room and a water birthing pool. The Early Pregnancy and Foetal Assessment Unit provides a specialist service for women in their first 20 weeks of pregnancy or those who require extra care while they are pregnant. The unit is situated on the third floor of the Women's Unit.

Ward D is situated in the Women's Unit. It is a mixed antenatal and postnatal ward area.

Summary of findings

We found that women using the service receive care and treatment from staff who have the knowledge and skills to meet individual needs. Staff treated patients with care and respect. Patients had a high regard for the staff and the clinical teams. However, we found that the distribution of staff, staffing levels and the organisation of staffing were at times less than adequate. We found that at periods of high activity the management of some patients could be delayed.

The trust had a higher than expected rate of postpartum haemorrhage (haemorrhage after childbirth) and subsequent hysterectomy. The trust was aware of this and had requested an investigation by the Royal College of Obstetricians and Gynaecologists. This investigation was currently underway.

The trust has several specialist midwifery leads in important clinical and supportive areas such as obesity, and smoking prevention.

Inadequate

Maternity and family planning

Are maternity and family planning services safe?

Requires improvement

Women using the service were receiving care and treatment from staff that had the knowledge and skills to meet their individual needs.

The use of staff was inconsistent at times of peak activity. Staff were regularly drawn from other areas of the unit to assist in the delivery suite. Staff were concerned about the disruption and lack of continuity of care. This meant that staff may be used in an area that they were unfamiliar with that day, or that other areas may then become short staffed. This could impact on both the patient care in the area from which the member of staff moved but also a lack of continuity of the patient thus reducing their experience of care.

All incidents and near misses should be recorded and shared so that valuable learning can be gained by the whole team. A serious untoward incident that had taken place had not been reported or recorded on the maternity 'dashboard' which monitors clinical data. This had the potential to affect patient safety by creating a risk that a matter that needed to be identified and learned from had not been reported

During periods of high bed occupancy there were occasions when women presented for induction were either sent home or had the process cancelled until later in the day. This happened twice in the week we were in the trust. Some women required induction for medical reasons. This system had the potential to put people at risk in that women who were prepared for induction were being delayed. Planned induction of labour is based on a clinical need. Additionally, women who had psychologically prepared themselves for labour were not able to begin as planned.

Safety and performance

Maternity and family planning had systems in place to focus and report on risk. These included incidents affecting patient safety, safeguarding people and using clinical governance reporting on safety as a 'dashboard tool'.

Serious incident reporting information was not always accurate. The trust's maternity 'dashboard', which records clinical performance and when serious untoward incidents occur, reported one incident between September and November 2013. Records we saw showed there had been two. By not maintaining accurate risk reporting, the trust was not accurately measuring its performance for safety and risk. Understanding the level of risk and managing it appropriately is important to assure action and mitigation are in place. (Note the maternity dashboard is a tool for monitoring trends, not the formal incident reporting tool).

The trust's maternity bed occupancy was reported as 97.3%. This was above the national average of around 60%. This had resulted in occasions when some women had been rescheduled due to capacity.

By looking at information gathered via intelligent data monitoring we found there was an elevated risk in sickness levels in the maternity unit. The national average was 4.3%. The trust's average was 5.8%. Staff told us sickness levels were having a negative impact on how the unit was being staffed. Staffing establishment for the delivery suite was monitored and managed on a daily basis by the matron. Daily contingency planning for staff shortage was in place. This was a daily record of the actions taken to cover absence. It reflected risk and was reviewed throughout the day. This meant staffing levels were being monitored throughout maternity unit in order to ensure safety. The Head of Midwifery acknowledged issues relating to the distribution of staff within the unit and told us it was being monitored.

There was a skills mix review each day. However, the demand on the unit meant that staff were drawn from other areas of maternity including maternity assessment, and ante/post natal ward (trust policy is that all staff rotate between these clinical areas depending on demand, activity and risk). Staff told us they were concerned about stress due to responsibility and tiredness. They told us the volume of deliveries was increasing, especially due to the development of the midwifery led unit. There was also concern that more 'high risk' mums were presenting within the unit. Comments included "staffing numbers are dire at times".

Consultants were available and on call during night and weekends. There was a resident obstetric anaesthetist in post and out of hours service was covered by cardiology. We were not able to identify a clear plan of what would happen if the cardiology anaesthetist was unable to attend.

Inadequate

Maternity and family planning

Five middle level midwives vacancies had recently affected staffing levels. Staff told us that the posts were not advertised until after people left. By not advertising the posts until staff left meant that there was potential for negative impact on the unit. Three of those posts had been recruited and should be in post shortly. However, the way the department managed staffing levels and recruitment was not always well organised and was having a negative impact on staff morale. The midwife to birth ratio is at least consistent with the national average.

Intelligent data monitoring highlighted an elevated risk in incidents which had potential for a severe major harm impact. The trust had a higher than expected level of primary postpartum haemorrhage, and also in these patients a higher than expected level of hysterectomy. Additionally, we were unable to identify a pathway for access to Interventional Radiology as per RCOG clinical good practice guidelines. The service had recognised the safety and quality issues and responded by elevating to the trust board and Medical Director, investigating them as serious untoward incidents. They carried out an internal investigation and concluded with a range of recommendations. In addition the trust requested an external investigation by the Royal College of Obstetricians and Gynaecologists. This was in order to carry out an independent review of the raised clinical indicators. This review is currently ongoing.

We visited all areas of the maternity unit. It was found to be visibly clean. There was good provision of protective gloves, hand washing equipment and gels. Staff were seen to use hand hygiene gel whenever the moved between one clinical area and another; thereby limiting the infection risk..

Learning and improvement

Weekly governance meetings and incident reviews were taking place. This ensured issues could be looked at by a multidisciplinary team and action taken to address concerns. This is an open forum available to all staff. Staff were able to discuss lessons learned with us and improvements to care audited. Examples of this included changes being made in recording information in records to ensure continuity of actions taken and to reduce risk factors.

Systems, processes and practices

Patients using the service were protected from the risk of abuse because almost 100% of staff had received training in safeguarding procedures. The trust had recently introduced a policy and protocol based on good practice guidelines. Some staff we spoke with talked about the safeguarding processes and were able to demonstrate their responsibility in following procedures to ensure safety. Where safeguarding issues had been raised they were clearly evidenced in the case notes using colour coded formats. Nursing staff told us they found the records very visible and would act as an alert for them.

Incident reporting systems were reviewed by the clinical governance board of the Trust to review actions taken in individual incidents. In one example the Trust asked for external investigation relating to outcomes following surgery.

All areas in the maternity unit were visibly clean. Hand hygiene gel was available and used throughout the maternity unit.

Monitoring safety and responding to risk

The service had a range of monitoring and safety indicators to respond to risk. These included the trust's 'dashboard', a tool used to monitor clinical performance and governance. It recognised the trust's own performance in these areas measured against national ratings. This provides a benchmark for the trust to use in order to monitor and respond to clinical effectiveness.

Anticipation and planning

The service used a range of available data, such as NHS England performance indicators as well as the trust's own quality governance reporting to plan service delivery.

Are maternity and family planning services effective?

(for example, treatment is effective)

Inadequate

Using evidence-based guidance

To ensure that women using the maternity and family planning service at Blackpool Teaching Hospitals NHS Trust hospitals, (including the Blackpool Victoria) were receiving good outcomes and a positive experience, there was a range of guidelines for good practice from the National Institute for Health and Care Excellence (NICE).

Inadequate

Maternity and family planning

We were unable to identify pathways for access to interventional radiology for patients with primary post-partum haemorrhage. Given the high rate of this and subsequent hysterectomy; access to this as set out in the RCOG Guidance - The Role of Emergency and Elective Interventional Radiology in Postpartum Haemorrhage (Good Practice No. 6) – Published 2007.

The trust recognised specific population conditions having a potential impact on women in pregnancy. To meet the needs of the local population the trust used evidenced-based guidelines for managing weight and obesity for women with a body mass index of 35+, managing diabetes in pregnancy, cardiac conditions, endocrine, substance and alcohol use in pregnancy, smoking cessation and current family planning guidance. Women we spoke with told us they had benefited from the advice and support provided. One said, "They identified a problem early on in my pregnancy and have supported me all the way through."

The head of midwifery told us how they used governance group meetings to analyse current good practice against their own indicators so that they can respond to change where necessary.

Performance, monitoring and improvement of outcomes

Midwives told us supervision, appraisal and support were good. Statutory supervision was taking place in accordance with NHS England Nursing and Midwifery Council (Midwives) Rules 2013. A specialist midwife who is also a supervisor of midwives at the Trust told us the trust takes supervision seriously to monitor the safety of midwives' practice and encourage them to develop their skills and knowledge. Movement of midwives within the department meant they had the opportunity to implement their skills across the maternity pathway.

Staff, equipment and facilities

A number of midwives had specialist areas of expertise to meet the diverse needs of women using the service. The team included specialists in diabetes, obesity, safeguarding, breastfeeding and smoking cessation. There was also a midwife with mental health training. Staff across the department were able to describe their procedures for protecting women and babies at risk of abuse. Staff valued the support they received from the safeguarding team, which was developing and making a visible impact on the service.

There had been a programme of development in the maternity unit during the previous two years. Access to call bells was in a number of areas around the rooms and en suite bathrooms. There were two sites for gas and air equipment, which meant women had more flexibility about where they wanted to be for their own comfort.

The ante/post natal ward had received limited development but had the necessary facilities to meet the needs of women using it.

Overall, a skilled staff team were providing an effective service. Women's needs were being met by a good skill mix. However, there were times of staff shortage which had the potential to have a negative impact on the quality and safety of the service. The trust would need in these circumstances to ensure safety in all areas is maintained through risk assessment; we understand that this is carried out.

The service used national guidelines to ensure staff were responding to current good practice. They met the needs of the local population by providing specialist support for women with specific medical conditions.

The range of services available to women meant they could make choices in their birthing plan supported by a multidisciplinary staff team.

We made a random check on an emergency trolley on the ante/post natal ward. It had been checked daily in line with the department's own procedures. This ensured that this piece of equipment would be available when needed.

Each unit within the maternity service included maternity support workers. Staffing establishment included maternity support workers within each unit to support midwives in their roles. There was no evidence maternity support workers were acting outside their role other than support for qualified midwives.

Multidisciplinary working and support

Rotas demonstrated each unit was staffed using a skills mix. Staff told us team work was important in order to make sure the needs of women and their babies were met. However there was evidence of shortages of staff at various times in departments within maternity were causing concerns. One person said, "There are not enough staff. We work well as a team but rely on the good will of colleagues."

Staff worked as part of multi-disciplinary teams and connected with maternity, neonatal and children's services.

Inadequate

Maternity and family planning

Support networks were in place for patients and staff. Staff we spoke with felt there were good networks in place for them, including peer support to senior management support. Comments included "If we did not work as a team more issues or incidents would probably arise" and "The head of midwifery is very supportive, especially around career progression".

Whilst there was evidence of good teamwork, communication and support networks the service needed to recognise pressures on all levels of staff in order to maintain morale and keep the lines of communication open in order for staff to feel confident in raising concerns regarding staffing levels.

Are maternity and family planning services caring?

Good

Compassion, dignity and empathy

Women could maintain their privacy, dignity and independence. In maternity assessment we saw women in individual rooms with closed door and appropriate screening. Comments were positive and included "[Staff] always speak in a quiet voice so not everyone knows your business". On the antenatal and postnatal wards, curtains could be drawn around their beds for privacy. We observed staff speaking respectfully with women and their families and acting with compassion and kindness.

We saw staff assisting patients and ensuring their dignity was upheld. Curtains were drawn and staff members spoke in a low tone to ensure privacy. Staff enabled patients to move in their own time, and patients were not rushed. The way care was being delivered demonstrated compassion.

A survey of women's experience in maternity care was undertaken in 2013. It showed the proportion of women who said they were always spoken with in a way they could understand during ante natal care, labour and birth had improved. This meant communication was now more effective than when previously measured.

Staff responded to women's individual needs in a respectful and dignified manner. The maternity unit was designed to ensure privacy and dignity was upheld. The unit's new facilities had improved the physical environment. Women felt well cared for by staff, who understood their needs.

Involvement in care and decision making

Women had access to the maternity assessment centre if they had any concerns about their condition after 14 weeks into pregnancy. This helped them to discuss any issues or concerns they may have. Staff were providing support either by phone or caring for women visiting the centre. Women told us that staff were "attentive and caring" and that they "put my mind at rest".

Women felt involved in developing their birthing plans. They were provided with enough information to make informed decisions about the type of birth they would like, pain relief and use of facilities including birthing pools. Where risk factors limited this, women told us they had been provided with all the information they needed to make an informed decision. An example of this was a women who had been diagnosed with a medical condition early in pregnancy. She told us the consultant and midwife had worked as a team to enable her and her husband to make an informed decision based on risk factors: "They identified a problem early in my pregnancy and have supported me all the way through."

Trust and communication

Women spoke highly of the trust they had in their midwife. They felt it was important to have such trust at this important time in their lives. Communication with their midwife and staff in the unit had been a positive experience. One patient told us they had had concerns about how their pregnancy was progressing: "I rang the assessment unit. They were very good and put my mind at rest." We spoke with another patient who had visited the centre that morning and staff were communicating with them as soon as they arrived. Staff demonstrated that they see communication as essential at all times to inform and reassure expectant mothers.

Emotional support

One mother told us they had experienced a 'roller coaster of emotions' throughout pregnancy. They told us their support team had 'gone over and above' when it came to supporting them emotionally. Another mother told us they

had concerns about breastfeeding. However, they had been supported by a specialist midwife who had made them more relaxed about it. This demonstrated emotional support was evident throughout the service.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Good

Meeting people's needs

There were a number of specialist midwives who delivered support to meet the diverse needs of patients. These included services to address diabetes, obesity, teenage pregnancy, smoking cessation, substance misuse and alcohol abuse, mental health and cardiac and endocrinology problems. Some of these areas were a response to the specific diverse needs of the local population. Supporting diverse needs meant that risk factors could be monitored and managed more effectively.

The midwifery led unit provided women with a range of facilities including two birthing pools and other facilities to provide women with a choice of how to give birth. Rooms were spacious, light and had good ventilation

The diverse and specialist medical needs were responded to by a staff team who understood them and could respond to them effectively. Staff had the knowledge and skills to ensure women and their babies were protected. By taking account of what women say about the service, the trust has been able to develop and improve its services.

The maternity assessment centre was sited on the ground floor in the refurbished women and children's unit. Access was good and available for people with disabilities. People we spoke with commented positively on the facilities. Comments included "very nice environment" and "a welcoming environment".

Vulnerable patients and capacity

Staff had training in safeguarding procedures and reporting. Records showed most staff had received safeguarding training at either level 2 or 3, in some instances both. Records showed where updates were due. This meant staff were keeping up to date with good practice in this area.

There was evidence that systems were in place to respond when safeguarding issues were evident. Colour coded notes in medical records informed staff. There were guidelines in place to share with partner agencies. Monthly safeguarding meetings were held by the trust. These updated and highlighted concerns and actions taken in order to protect patients.

Expectant mothers or mothers who lacked capacity were supported by a lead nurse. In addition the trust worked with outside agencies for support. The trust was developing mental capacity training for staff alongside safeguarding training. This would ensure staff would have a better understanding of the issues and what support patients may require.

Access to services

Patients had access to a range of services within the maternity department. As well as departments and wards, there were specialist clinics including family planning and termination of pregnancy. Information about a range of associated topics for pregnancy, screening, breastfeeding and other support services were available in reception, clinical areas and wards. For women whose first language was not English there was a telephone interpreting service.

Leaving hospital

Discharge from the maternity unit was planned. However, we did see records showing that women had self-discharged. Staff told us that in such instances risks were always explained so that women could make an informed choice. A mother told us they were keen to go home and felt the staff had provided them with the best advice. They told us they were supported with the discharge and were told when the community midwife would visit. They also told us they had been provided with written information about breastfeeding: "[Staff] put me at ease… it's my second but they are never the same." In some instances discharge can be delayed due to medical needs or safeguarding issues. Staff said it can be difficult to free up beds due to waiting for external services to be coordinated.

Inadequate

Maternity and family planning

Learning from experiences, concerns and complaints

The Trust have used a national maternity survey during 2013 carried out by an invited external body. Results were reviewed and the Trust was working to improve areas for patients using the maternity service. Concerns and complaints were listened to, responded and actioned in order to improve the service outcomes for women.

Are maternity and family planning services well-led?

Requires improvement

Vision, strategy and risks

The maternity unit had been fully operational since 2013 following redevelopment. It had been designed based on key trends in midwifery and obstetrics. The unit promoted choice to women in respect of birthing options and provided services for high risk childbirth as well as other women's services.

Governance arrangements

There was a clear line of governance for maternity and neonatal services. There was ongoing monitoring of quality and performance of maternity services. Governance leads presented weekly incident meetings. This was led by the head of governance for women and family services.

Monthly meetings were taking place between the Head of Midwifery and Director of Nursing. The meeings were an opportunity to raise issues to chief executive level. Board minutes we looked at recorded that staff morale was good. This does not correlate with the evidence provided during this review of the service.

There was no recognition of the impact on staffing when posts of middle grade midwives are not advertised until the posts were vacant.

Leadership and culture

The maternity unit had a defined leadership structure. The matron and senior nursing staff reported to the Head of Midwifery. There is a clear tier of managers within the leadership framework. Some staff felt communication between the management structure was good. Staff told us senior staff were approachable and supportive.

Communication systems between senior staff and midwifery staff were in place. However, we were told of a disconnect between management and board levels. Staff felt issues resulting in high ratio sickness levels and the utilisation of staff were not being addressed at board level. Some staff felt that the trust board was not aware of the situation. They felt this was impacting negatively on a unit which they felt proud to work in.

Patient experiences, staff involvement and engagement

Systems were in place to measure the experiences of care though patient surveys and via complaints and comments. Women using the service were asked to complete surveys about the service they had received at time of discharge. Those we spoke with commented on how good the new facilities were in the midwifery led unit. All women we spoke with told us they had a positive experience.

Learning, improvement, innovation and sustainability

The trust used a variety of resources to evaluate and respond to the challenges of service development. Records of board meetings showed development in training for the recognition and management of domestic abuse.100% of new staff had competed this training during induction and 77% of all staff had completed the training. This meant staff had the knowledge and skills to identify triggers and that they knew of the reporting procedures.

Women were provided with a choice of facilities within the maternity unit as part of the birthing experience.

Communication was good between nursing staff and senior midwives. However, the trust board meetings had not recognised staffing issues within maternity services.

Good

Services for children & young people

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

Information about the service

The department has 12 consultant paediatricians across the trust. It also has a matron, directorate manager, clinical nurse specialist, six play specialists and a number of other nursing and administrative staff.

As part of child health services, there is a:

- Children's ward
- Adolescent ward
- Children's assessment unit
- Paediatric clinic
- Paediatric outreach service
- Paediatric epilepsy service
- Paediatric diabetes service
- Paediatric bereavement service.
- Patient experience officer.

The special care baby unit at the hospital cares for babies with a number of medical conditions. Also known as the neonatal unit, it admits approximately 250 babies each year. It has 16 cots, which are split into three areas of intensive care, high dependency and special care.

The children's ward has two four-bed bays and six single cubicles, some with en suite bathrooms. One of these cubicles has a track and hoist system to allow disabled children to be lifted and moved safely from the bed to the bathroom and back. The bathroom also has adaptations for disabled use. Children aged between 0 and 11 years of age who require inpatient treatment would stay in this ward area. Along the same corridor are the high dependency unit (HDU) and another four-bed bay area.

The adolescent ward is also on the first floor and has seven separate cubicles, all with en suite facilities. One of these has adaptations for disabled use. Cubicles have a track and hoist system to allowed disabled children to be lifted and moved safely

In 2011 Blackpool Victoria Hospital became established as a centre for shared care for oncology patients. When a child is diagnosed with cancer, they will be cared for by a specialised team within a primary treatment centre. Children with shared care between Blackpool Victoria and Manchester Children's Hospital have open access to the children's assessment unit and the ward. So if a child is ill, they can access the hospital and be treated promptly and subsequently either transferred to Manchester or admitted to a ward in Victoria Hospital.

Between 9am and 10.30pm children were seen and treated within the children's A&E department by appropriately trained and qualified children's nurses who demonstrated the required knowledge and understanding of safeguarding procedures. Outside these hours, children were cared for within the main A&E unit by the core A&E staff.

Good

Services for children & young people

Summary of findings

Children care was safe, effective and well led. The environment provided excellent service for children and young people. There were appropriate toys, well equipped play areas and a sensory room for children with special needs. Children and young people received care from a range of staff who had specialist knowledge in caring and treating children and young people.

Children and young people were listened to and had the opportunity to shape the service for the future.

Are services for children & young people safe?

Good

Safety and performance

The parents and children we spoke with told us they felt the service was "second to none". They said they felt very confident in staff providing care to their child.

Children received assessments as soon as they on the ward. This took into account of their condition and the environment in order to address any risks.

Staffing levels within children's services were good. There was a good skills mix on all shifts. Staffing levels were consistent and there had been no need to rely on locum doctors in the previous six months. In order to ensure the children's unit was being staffed safely there had been an analysis of defining staffing levels for children and young people in June 2013. This was based on a risk assessment using Royal College of Nursing Guidelines. Junior doctors told us paediatric consultants were always available and supportive.

There were systems in place to identify and learn from incidents. There were weekly open incident meetings open to all staff. Where incidents occurred, an action plan was put in place and monitored. The process managed risk and kept patients safe. This was seen as important to improve and promote safety.

Children were receiving safe treatment in a timely manner from staff who had the qualifications and skills to treat and care for them.

Ward areas were bright, clean and hygienic

Learning and improvement

Staff caring for children had the necessary qualifications and skills to care and treat them. Staff told us they were encouraged to develop their skills with access to internal and external courses to develop specialist skills in children's care and neonatal care. Specialist training had taken place in conditions for diabetes and epilepsy. These staff worked across the department so their specialist skills could be utilised where necessary.

Good

Services for children & young people

Incidents were investigated and acted upon to ensure risk was being managed and to ensure children and young people were safe.

By using good planning processes the service could identify where improvements could be made.

Systems, processes and practices

In order to safeguard children there were systems in place for child protection. 100% of staff had completed this training at induction and at least 77% of all trust staff had also completed child protection training. There was emphasis on ensuring all staff members maintained awareness and recognised those at risk of abuse. Staff we spoke with were familiar with the systems for reporting. This meant children were protected.

Monitoring safety and responding to risk

There had been several occasions when staff had responded to incidents which required one-to-one support as well as specialist referral. Records we looked at demonstrated the service had responded appropriately in order to minimise risk to the patient. The service had reported and carried out a root cause analysis (RCA) so that the issue would be monitored. This meant staff had the knowledge and skills to respond to risk and keep patients safe.

There was evidence the department had responded to a serious untoward incident affecting an adolescent. By carrying out an investigation using an RCA the department had put procedures in place to respond to the risk and ensure safety.

Staff in the children's A&E department had had training in safeguarding reporting procedures.

Anticipation and planning

The service used a range of available data, such as NHS England performance indicators as well as the trust's own quality governance reporting to plan service delivery.

Are services for children & young people effective?

(for example, treatment is effective)

Good

Using evidence based guidance

By using evidence-based guidance the children's and young people's department were able to apply best practice to ensure good treatment and care. National Institute For Health and Care Governance had released guidelines for new-born sepsis. The department had responded to this by updating its own policy. This meant practice would reflect current guidance. Policy guidelines are usually discussed at the Children and Women's Governance Group so that good practice guidance can be followed and updated.

Performance, monitoring and improvement of outcomes

The department undertook regular reviews of its services in order to monitor its performance. A recent review of paediatric day case surgery had been undertaken in order to demonstrate to the directorate and board that the service was meeting its objectives and providing a quality and safe service. By taking into account the views of patients and families it was able to measure its effectiveness and identify areas of improvement. Children and young people benefited from a service which reviewed its performance and took account of people's views. Children and young people benefited from a well-designed facility with a range of service and equipment to meet their holistic needs.

Staff, equipment and facilities

The children's A&E department opened from 9:00am to 10:30pm and was staffed by a dedicated team of children's' nurses. Outside of these hours children were accommodated with the main department. We found staff qualified to meet the needs of children, and they had received relevant training such as advanced paediatric life support. Staff felt supported in their role and reported effective levels of communication between the A&E and paediatric departments.

Day surgery was staffed by nurses, surgeons and anaesthetists who specialise in children's care and

Good

Services for children & young people

treatment. A&E, although not a specific children's department, had paediatric staff on duty at all times to treat children. The Paediatric consultant was usually in the department until late evening. In addition to nursing staff the department employed a play specialist for a soft play area.

This department has been developed over the last few years. It was only completed in 2013. Senior staff were involved in the design and planning of the service. This had resulted in an environment which was child friendly. Time had been taken to take away the clinical model of hospitals wherever possible.

The ground floor assessment centre was light and spacious and included a large soft play area. Families waiting for appointments told us "This is fantastic. It certainly makes the waiting time go quicker" and "I come here a lot – the play area helps with the wait." In order to meet the needs of people using the service there was a quiet room which can also be used for breastfeeding. This demonstrated that privacy and dignity issues were taken into account. A sensory room was also available for children with disabilities.

Multidisciplinary working and support

Staff within the department were supported by a range of disciplines in order to meet the needs of young people and children. Rotas demonstrated each unit was staffed using a skills mix. Staff told us team work was important in order to make sure the needs of children in their care.

By working as part of a multidisciplinary team children and young people were receiving a good quality of care.

Clinical supervision was in place for all levels of medical staff. Staff told us they were well supported and felt they could raise issues if they felt they needed to and they would be listened to.

There had been some incidents occurring on the adolescent unit which required support from Community Adolescent Mental Health Service. This service operates weekdays only. Therefore when issues occur out of hours ward staff have to manage the situation. This could be detrimental to the needs of the patients without a rapid access system available out of hours.

Are services for children & young people caring?

Good

Staff understood the importance of delivering care and treatment in a way which supported children, young people and their families or carers in a dignified way. They showed compassion in their care and treatment.

Involving children, young people, families or carers in their care planning, treatment and discharge helped to make them feel valued and part of the process.

People felt staff communicated well with them and they were trusted. This gave people confidence. Staff supported people through emotional times when support was needed.

Compassion, dignity and empathy

Parents and children were positive about the care they received. Staff told us they did all they could to make sure children felt comfortable in the unit. New facilities help staff to achieve this. For example, tracking and hoists in the children's and adolescent ward helps staff to move children with disabilities in a dignified way. Appropriate curtains and space helped staff to carry out care and treatment whilst respecting privacy and dignity.

Entrance to the day unit and ward areas had reception staff who were polite and welcoming.

Staff were seen to speak with children and families respectfully. They took account of where they were speaking with them. For example one parent wanted to speak with staff about their child's care. The staff made sure they were using a side room with the door closed before they had the discussion.

Involvement in care and decision making

Parents felt they were fully involved in their children's care planning, treatment and discharge. One parent told us the admission process had been very good. They said, "I was so pleased with the way my child went off to play whilst I was sorting out all the information. I knew they were safe as there was a member of staff around."

Trust and communication

People we spoke with felt it was important to have trust and confidence in the service delivering care and treatment to children. Examples included parents whose child had experienced treatment in the unit. They said they had been

kept informed through the whole process: "We have a lot of Trust in the staff. They have all been professional and communicated with us throughout". Another person told us, "Really pleased with the care. Nurse explained everything to us, even explaining the technical language." This gave families confidence in the service.

Emotional support

Staff working in children's services told us they had experienced occasions when families and children had required emotional support. They gave examples of how they had responded to children's distress using techniques that included distraction and reassurance. We saw staff reassuring a child. They behaved in a calm and reassuring manner and the child responded well to their approach.

There was a bereavement service for parents and carers. This meets monthly and is called Snowdrop Support Group. It creates an informal opportunity for parents and carers to discuss their grief with others.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

People we spoke to told us they were very happy with the way care and treatment was delivered. People were aware of how to access services and felt the information available to them was good.

Discharge planning systems ensured people received the information they required, including details of follow-on services.

People told us they were aware of how to raise complaints, but they did not always receive a response.

Meeting people's needs

Staff were responding to children and families in a sensitive manner throughout the visit. However,

parents were concerned that children being investigated for ear, nose or throat conditions had to attend an adult clinic. Families told us this posed problems, because there were long delays in a service that was not designed to meet children's needs. We received one example of a family waiting for two hours. There was poor communication between medical staff and the family, who didn't feel listened to.

Some children using the service had a range of complex needs which required transferring from hospital to home to hospice. The department worked with the local hospice for children and the child development centre. In order for this service to be operated to meet the needs of these children and families there was a care lead to manage transitional care.

Parents we spoke with told us they were very satisfied with the information and support they received. For example one parent said to us "Everything explained to us by a doctor, we are pleased with everything so far".

Parents thought the facilities available to them were excellent. A bedroom for parents is available and shared with neonatal unit, in addition there were lounge TV and kitchen. This gave parents some 'time out' when they were supporting their children.

The desk area was designed as a pirate ship, which children found "very interesting". Families we spoke with could not speak highly enough of the facilities with the department.

Children's services included six single cubicles some with en suite bathrooms. There were also two four-bed bays. One cubicle had hoist facilities for children with disabilities. The adolescent ward had seven separate cubicles, all en suite, and a tracking hoist facility in one. This meant children and adolescents with disabilities had their needs met in a dignified way

Day case surgery unit was used by the children's service one day a week. Staff took time to make sure the unit was child friendly. This included putting up posters, having a range of toys and books available in the waiting area and post-operative ward areas. Theatres were colour coded, with staff wearing the coloured sash for the theatre they were working in. This meant children and families could easily associate with staff responsible for their care and treatment. Parents we spoke with thought the system worked really well and that the design of the unit meant that children's anxiety was managed well. This was because following surgery children went to a recovery ward

away from the waiting area. Staff were communicating with families throughout the process so they knew what was going on at each stage. Parents told us this helped them get through a stressful time.

The only area that we identified in the paediatric department where family's needs were not always met was the neonatal unit. A different consultant and junior doctor covers this area every day of the week. Parents felt that the lack of continuity in this rota resulted in poor communication.

A&E Staff said they felt they responded quickly to the needs of children. A team of six permanent children's trained nurses worked on a rota in the children's A&E and were supported by support staff experienced in caring for children. Staff reported good working relations with paediatricians and the staff on the hospital children's wards. The children's A&E was separate from the main A&E department and was open from 9am to 10:30pm. Outside of these hours children were accommodated with the main department. Staff from the children's A&E told us that they would transfer the child to a ward if the child needed admission or to an agreed area in the A&E if the child required further treatment in A&E. They would formally 'hand over' the child to a nurse in the main A&E department. This means that it was clear to all staff who was responsible for the child at any given time. Clinical advice and support was available out of normal hours from the medical and nursing staff working on the children's ward. A separate waiting area was available in the children's A&E and support services such as x-ray were close by. Should a child require treatment within the major's area, there was a space specifically allocated for the care of children with appropriate equipment available.

Vulnerable patients and capacity

The staff had training in child protection procedures and reporting. The July 2013 Directors' Board Meeting minutes showed nearly all staff had received level 1 training in basic awareness. Level 2 training was being delivered however uptake appeared low. The safeguarding team were driving this forward so that all staff develop their child protection knowledge and skills.

Colour coded notes in medical records helped inform staff of key areas. There were guidelines in place to share information with partner agencies. Monthly safeguarding meetings were held by the Trust. These updated and highlighted concerns and actions taken in order to protect patients.

Access to services

Children and young people access the service in a number of ways depending on what their medical needs are. Some children and young people are admitted via accident and emergency department. Others have planned admissions. Information was available in the form of leaflets in all areas of the unit. Children or families whose first language was not English have access to an interpreting service.

Leaving hospital

People we spoke with referred to the planned discharge planning in place. This means children and their families have all the information they need before they leave the unit. One family told us they had been referred onto another service and they had the necessary information to liaise with a designated person.

Learning from experiences, concerns and complaints

Patients and children's experiences of care were used to improve the service. A Patient Experience Officer talked and worked with children and young people to gain their views on the service. Concerns and complaints were listened to, responded and actioned in order to improve the service outcomes for children and young people.

Some people's experience of raising issues was not positive. In one instance a complaint had been raised on two occasions. Whilst the first one was investigated and concluded, the second concern had not been acknowledged. The trust had recently reviewed the complaints procedure and had moved from systems of Patient Advice and Liaison Service to Patient Relationship.

However, PALS leaflets were still in evidence. If the trust wants people to access the appropriate complaints system, it should be ensuring that appropriate information is available.

Good

Services for children & young people

Are services for children & young people well-led?

Good

Vision, strategy and risks

The children's unit had recently been completed in order to provide a range of children's services. Staff had been involved in the development of the service and environment so that it meets the needs of children and young people.

There was a clear vision within the department to continue to develop the service to meet the needs of children and young people in the future.

Governance arrangements

There was a clear line of governance for children's and young people's services. There was ongoing monitoring of quality and performance of children's services. Governance leads present weekly incident meetings.

Monthly governance meetings were taking place relating to the women's and children's division. They were taking account of service specific issues including clinical issues, safeguarding, policy, risk and guidance. This ensured the services were being monitored and developed.

Leadership and culture

Children's services were being well led with clearly defined leadership roles. Senior sisters in the department reported to the Matron for Children's Services. The management team felt they were well supported and that lines of communication between staff to board level were good.

Staff were supported in their role at all levels. Supervision systems were in place to ensure all staff had the opportunity to develop professionally. Staff told us they were encouraged by managers to develop their skills practically and academically. The trust has close links with UCLAN (University of Central Lancashire), Manchester and Liverpool Universities; these educational and training links help continue to develop the skills across the clinical and support staff workforce.

Patient experiences, staff involvement and engagement

We looked at how the department was involving and engaging children and young people in the service. The most recent patient involvement child health document showed the Patient Experience Officer reported on what was happening. An ongoing project will give young people a chance to build their knowledge and skills to allow them to take part in the recruitment process for child health. This has received quite a bit of media coverage. There are now 'Top Tip' cards with all paediatric doctors for top tips on communication. Feedback has been positive.

The children services day case surgery review in September 2012 informed the directorate and trust board that the level of care and clinical management for children were appropriate. Information for this review came from 22 members of a multidisciplinary team. Patients and carers were invited to give their views by advertising through 'my experience' posters

Learning, improvement, innovation and sustainability

The unit's day case surgery received a highly commended award from the 'Nursing Times' in recognition of its innovative approach to care and treatment for children using the service. Other hospitals have visited to view the facilities and gain advice about the good practice.

Good

End of life care

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

Information about the service

The Blackpool Teaching Hospitals NHS Foundation Trust has a dedicated palliative care team which is a multi-professional team. Palliative care is the holistic care of patients towards the end of their lives whose illness is incurable. It also recognises the care of relatives immediately post death. The palliative care team offers advice on pain and symptom control, supports families and provides practical advice to other healthcare professionals. The service is provided seven days a week and 53% of 680 of people who were diagnosed with a terminal disease in 2013 choose to use the Liverpool Care Pathway (LCP) and were provided with end of life care at the Blackpool Hospital and Trinity Hospice Service. The other 47% of patients chose to have the end of life care provided to them in their own homes. There is a network of 260 nurses across both sites that have been given extra training in palliative care who help to ensure that patients receive appropriate care when they are near death.

There is a team of Macmillan staff based at the trust who support patients and their families for end of life care at the hospital and in the community.

The trust has a dedicated bereavement team which provides care and support to relatives following the death of their loved ones. There is also a large and well organised chaplaincy service, which is able to provide a multi-faith spiritual support network 24 hours a day, seven days a week.

Summary of findings

The trust has a multi-professional approach to end of life care, working in partnership with Trinity Hospice and the trust's palliative care services. This means that good practice was shared across both the trust and Trinity Hospice. The trust have reviewed their pathway for end of life care and are using the Liverpool Care Pathway for people in the last few days of their lives. Staff we spoke to within all areas visited were aware of the procedure to follow in end of life care, ensuring a good experience for patients and a safe approach to care.

The palliative care team focused on ensuring the provision of high quality services that meet the needs of the patients and their families who used their service. It underpinned its practices with the belief that care for the dying is part of the core business of the organisation. If care was necessary within the hospital environment, the palliative care team provided support and information to the patient, their families and the care team working on the ward.

People told us that they were satisfied with the care they received from the palliative care team. For patients who remained in hospital, plans were put in place to ensure that their wishes were respected.

The evidence we found indicated that the 'care of the dying' pathway was being followed from diagnosis until after death and that patients were receiving appropriate support and compassionate care.

Good

End of life care

Are end of life care services safe?

Good

Safety and performance

We spoke to senior managers who confirmed the trust was using the Liverpool Care Pathway (LCP). The trust is using the 'Amber Care Bundle' for advanced care planning. This is to ensure that a patient who has been diagnosed with a terminal disease has all the relevant records completed. The records include their consent to treatment, their wishes and any religious beliefs they wish to have followed at the end of their life.

Learning and improvement

There has been high impact transformation training (aimed to improve awareness of processes) on end of life care for staff in three wards at the trust (wards 12, 25 and 26). We were told this training is to be disseminated throughout the trust. Staff spoken with on the six wards visited were aware of the procedure to follow.

Systems, processes and practices

There is a consultant pharmacist in the palliative care and end of life teams at the trust. The end of life care team has specific procedures for medication, including 'Just in Case 4 Core Drugs'. This initiative has been implemented for patients at the end of their life who can no longer swallow oral pain-relieving medication. It allows doctors to safely prescribe injectable drugs in advance and authorise appropriately trained staff to administer the drugs.

Monitoring safety and responding to risk

We spent time on all six wards talking to all levels of staff. We asked all staff about incident reporting, and all staff informed us of the process they would follow, including completing the record on the trust's IT system. One member of staff discussed how they had completed an incident record and how the sister had followed it up and informed them of the outcome. All staff also said that they would verbally inform a senior member of staff of any incident.

We looked at the care planning records for four people who were on end of life care at the trust. There were no dedicated LCP records (which we expected to see), and staff had recorded end of life information on the regular note documentation, which was difficult to follow in the files. Three of the four records looked at were difficult to track, it was hard to identify what care was being provided, and the Amber Care Bundle was only evident in one patient record.

We spoke to around 30 people including patients, family members and volunteers working at the trust. All were unclear about the Patient Relation Services

Anticipation and planning

The wards we visited were extremely busy. In discussion with all levels of staff we were told that end of life care would be supported by palliative care staff. We were unable to discuss this procedure on the wards as there were no palliative care staff on them at the times we visited. We did talk to a palliative care staff nurse on the oncology day unit, and they informed us that once a patient had been diagnosed with a terminal disease the procedure was to follow the Amber Care Bundle record.

End of life care would be initiated soon after the prognosis was given to a patient. However when we looked at four patient records, in two patient records it was difficult to ascertain when they had implemented the LCP. Accurate records are important to properly manage patients care.

The lead pharmacist and a senior member described how patients' medication is prescribed on the ward and then prepared at the pharmacy to go to the ward. There are strict guidelines and auditing of controlled drugs. We were sent the last two safety checks from the trust. They showed how the trust safely monitors controlled drugs and is compliant with its own procedures. End of life medication can be mixed at the pharmacy in preparation when required or by the staff on the ward. There are emergency medication storage units available on wards for patients at short notice or for four-hour discharge when a patient wishes to go home to end their life. However, a serious incident occurred in August 2103 when a patient on end of life care was discharged to a care home where she wanted to spend her last days. The patient was sent home without the relevant pain relief medication and consequently suffered pain and had to be readmitted into hospital.

Are end of life care services effective?

(for example, treatment is effective)

Good

Good

End of life care

Using evidence-based guidance

The trust's end of life care procedure is the LCP in both the hospital and in the community services. The trust works closely with Trinity Hospice Services to ensure it is sharing information and good practice. Patients and family members spoken with told us they were happy with the palliative care and support provided at the trust.

Performance, monitoring and improvement of outcomes

End of life care was monitored throughout the trust. Statistics showed that where patients were diagnosed as an inpatient, 54% choose to follow the end of life care pathway at home or in the Trinity Hospice, with support from the palliative care team.

The trust monitors end of life data on a monthly basis as part of its quality performance report. The data was therefore included in the trust's mainstream reporting and mitigating action planning process. This allows the trust to plan and allocate resources effectively.

There are weekly meetings called 'Transforming End of Life Care at Blackpool Teaching Hospitals', which staff are required to attend. They cover all staff disciplines across the trust. These meetings are to discuss and share information to ensure excellence in end of life care.

Staff, equipment and facilities

The lead consultant spoken with was dedicated to ensuring that staff were trained and competent in their roles and was positive about the dissemination of the high impact transformation training. Eight staff spoken with told us they were aware of the pathway for end of life care, and they informed us they would liaise with the palliative care team to initiate end of life care. On the six wards visited, all staff were responsible for following the end of life care pathway for a patient. Staffing levels on all wards were seen to be adequate. However, staff were observed to be extremely busy.

The chaplaincy team was very involved and told us they would be contacted when a patient is diagnosed with a terminal disease and was going to be placed on end of life care in the hospital. The chaplaincy team were seen around the hospital over the two days of our inspection, offering support to patients and visitors.

Multidisciplinary working and support

There was a multi-professional approach to end of life care that consisted of palliative care nurses, and an end of life care team with a team leader to coordinate care. A lead consultant with support from a consultant pharmacist, complementary therapists, medics and volunteers are all part of the team. The trust worked in partnership with Trinity Hospice Services. There is a Macmillan support team based at the trust, and staff, patients and their families can go to it for advice and support.

The trust works closely with Trinity Hospice Services and can refer patients directly to the hospice if that is their chosen place to go. The trust also has a quick response service for patients if they choose to go home, and it has process for ensuring the appropriate support mechanisms are implemented. We were told that the multi-professional team works responsively, ensuring safe, caring and effective end of life care is provided by the palliative care team and other professionals.

We looked at four patients' records and only one contained any information regarding the patient's last wishes.

Are end of life care services caring?

Good

Compassion, dignity and empathy

We were told by one person that staff were wonderful and had treated her with compassion. They had spent time talking through the support mechanisms and constantly enquired whether she was in any pain and whether she was comfortable. The family members we spoke to told us that staff treated their relative with compassion and dignity.

We spoke to one patient and two families of patients who were using palliative care services at the hospital. They told us they were satisfied with the care being provided. One patient told us they were happy with all of the care and support provided by staff. They said, "It's a wonderful place." Family members were happy with the way that the staff treated their relatives; one relative told us "staff have explained everything to us". Staff had provided relatives with vouchers for meals and car parking.

Staff were observed to treat patients with empathy when providing care. We saw staff talking to a patient who was unconscious, telling them what they were doing to make them comfortable.

Good

End of life care

Involvement in care and decision making

One person told us that they were fully involved in the decisions regarding their end of life care. The relatives of two patients were informed by staff what the Liverpool care Pathway was and how their relative was on the pathway. Relatives were not clear, however, if their relative had made decisions about where they wished to end their last days. We were unable to discuss this with the patients as they were sleeping.

We looked at the LCP records for four people. However, in two patient records it was difficult to find the relevant records.

Emotional support

The palliative care team had trained staff who were available for patients and family members to talk to. We spent time with the Chaplain and a team member who informed us that they provide emotional support and follow the patient journey with the family. We observed the Chaplain on wards spending time with patients and family members who were on end of life care. There was a large group of the travelling community at the chapel, as one of their relatives was on end of life care. The Chaplain spent time talking to them and organising a priest to join them at the chapel. They were very grateful to the Chaplain, thanking him profusely for his help in enabling their relative to have their religious wishes adhered to.

There is a directory available at the trust that contains contact information with contacts for many of the religious faiths that can be contacted 24 hours a day.

We spent time with the mortuary service and bereavement staff. They explained that there were processes in place to support relatives once their loved one had died. This included help with all of the paperwork, including the death certificate. The mortuary had comfortable office space, where staff could take relatives so that they could grieve in private and talk confidentially. Staff had created a pleasant environment for people to visit their relative in the viewing room. Staff liaised directly with the person's religious contacts to ensure their religious beliefs and traditions were observed after death. There were counselling staff and psychological support staff available as part of the bereavement support teams.

One relative had spent the last two days sitting in a chair by the patient's bed. The individual told us that they were fine.

Are end of life care services responsive to people's needs?

(for example, to feedback?)

Outstanding ☆

The palliative care team operates seven days a week and aims to see patients within 24 hours of being referred. There were support and communication mechanisms in place, including contact details for patients and staff to contact end of life professionals at the trust.

Meeting people's needs

The evidence we found indicated that the LCP was being followed from prognosis to the end of a patient's life. Relatives had the support of the bereavement team in dealing with their grief at losing someone and ensuring their relative's last rites and wishes were followed.

Staff training was being disseminated with 260 staff already trained in the high impact transformation training. All staff working at the trust have to complete mandatory training on end of life care. Training information we looked at informed us that the staff complete the training as part of their induction and annually as part of the e-learning programme. Staff spoken with on the six wards we visited were aware of the LCP and how to respond to a patient when they were diagnosed with a terminal disease.

The four records we looked at had information in place regarding end of life care. However, it was difficult in two patients' files to ascertain what specific care actions were being provided by staff.

Vulnerable patients and capacity

The LCP included information on a patients' capacity to understand their prognosis. A palliative care team member of staff told us they would talk to the patient and where appropriate any relatives. A mental capacity assessment would be completed if required.

Leaving hospital

The trust had a four-hour discharge plan for patients if they decided they wanted to go home to die. This included the 'Just in Case 4 Core Drugs', which enabled patients to be

Good

End of life care

prepared and signed off by the doctor to ensure they had a pain free death and that they died with dignity and compassion. We were unable to talk to anyone about this procedure at the trust at the time of our inspection.

Learning from experiences, concerns and complaints

The trust monitored end of life data on a monthly basis as part of its quality performance report. This data was therefore included in the trust's mainstream reporting and mitigating action planning process.

The end of life care team gave feedback directly to the Director of Operations and to the Chief Executive.

There are weekly meetings called 'Transforming End of Life Care at Blackpool Teaching Hospitals', which staff are required to attend. These cover all staff disciplines across the trust. These meetings are to discuss and share information to ensure excellence in end of life care.

We spent time talking to the lead consultant regarding any significant incidents reported. We were told that significant events are taken very seriously and are taken to the quality board, where action plans are implemented to show how staff learn by them. We were told by the lead consultant that she became involved in a patient's end of life care who had dementia and complex needs. The consultant had herself initiated the incident report, as she was unhappy with the confusion from three wards as to where this patient should be cared for. The learning from this incident was that staff across the trust report to the palliative care team when any patient is diagnosed with end of life care needs.

In all six wards we visited, we spent time talking to staff about the Patient Relation Services (PRS), which was previously called the Patient Advice and Liaison Service. Most of the staff were unclear about the service and were not aware of the trust's procedure on informing patients, their families and representatives that they could use the PRS team to discuss any complaints, compliments or issues.

We spoke to patients and relatives who told us that they did not know how to make a complaint at the trust. We spent time talking to patients and staff in all six wards we visited. There was little knowledge of the Patient Relation Service (PRS), which was previously known as Patient Advice and Liaison Services.

We discussed this with the PRS team, who informed us that they had received over 4,000 informal complaints and over 700 formal complaints from across the trust in the last 12 months. We were informed that the team had gone through a lot of changes and its staffing levels had diminished by 50%, which had had a huge impact on the workload of the four staff who were left. There were leaflets and posters around the hospital informing people how they could use the service; we were told that there was some confusion as it had recently changed its name. The staff told us they were relocating to the new main Hospital entrance and were going to hold information briefing sessions for the public and staff.

Are end of life care services well-led?

Good

Vision, strategy and risks

A new training initiative has started to be disseminated across the trust to ensure all staff are responsive to patients on end of life care.

The lead consultant told us that end of life care was a priority at the trust. They had a multi-professional team in place for end of life care which was well supported and the reporting structures and processes were in place.

Governance arrangements

There is a clear line of responsibility for end of life care that includes all multi-professional teams.

There are weekly meetings where a core team of staff from the different disciplines discuss issues and end of life care. There is a clear line of reporting to the trust's Chief Executive and board members.

Leadership and culture

The leadership team spoken with were committed to improving end of life care at the trust. It worked closely with the palliative care teams, including the Trinity Care Services and the Macmillan staff, to learn and provide a training programme to meet patients' end of life care needs.

Good

End of life care

Patient experiences, staff involvement and engagement

We spoke to approximately 30 people on all six wards visited. Many were unsure of how to make a complaint at the trust.

Requires improvement

Outpatients

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

Information about the service

Blackpool Victoria Hospital has a large outpatients department with separate outpatients' locations for breast care and cardiology. There were 296,917 patients who used the outpatients departments across the trust in 2013.

Summary of findings

On the whole, patients received effective, safe and appropriate care. The outpatient areas were clean and well maintained. However, we observed staff taking patients in sluice rooms to be weighed, which is not clinically appropriate. In addition, in one sluice area, this was not only used for weighing patients but also for patient examinations about twice a week for example chest physiotherapy or ultrasounds.

We found that there were issues around the patient experience within outpatient services. Patients told us that waiting times were at times unacceptably long, up to 40 minutes in some departments. However, the 18 patients we spoke with told us that they were generally satisfied with the service they received.

We found that all of the outpatient areas respected patients' privacy and dignity, as people were seen in consultation rooms.

We also noted that if English was not a patient's first language an interpreter could be booked in advance of their appointment. However, we were unable to meet with any interpreters at the time of our inspection.

We spoke to all levels of staff during our inspection. All were aware of how to report an incident and the procedure for completing the report.

We saw there were clear leadership structures in place and staff were very supportive of their colleagues. All outpatient staff said that they were well supported in their roles.

Requires improvement

Outpatients

Are outpatients services safe?

Requires improvement

We spoke to patients in all areas of the outpatients departments. Overall the response was that the service was provided in a safe way by staff at the trust.

Safety and performance

We discussed staffing levels with the sister of outpatients. We were told that staff work as a team and cover for any absence. No agency or bank staff are used. Staff spoken with told us they were busy, but they felt supported by their colleagues and senior staff.

Learning and improvement

Staff told us about their training and the majority were up to date in mandatory training, including safeguarding vulnerable adults and child protection training. We were sent the details of staff training, and they informed us that staff were up to date with training. All staff told us that they had annual appraisals.

Systems, processes and practices

We checked the resuscitation equipment in all of the outpatients areas visited; all had been checked regularly by a designated nurse. The equipment was in working order and staff were aware of where the resuscitation trolleys were.

We looked at 12 patient records in the outpatient departments. It was difficult to find the relevant documentation for their appointment. Files appeared to be in no order and had a lot of records to go through.

Staff were using a sluice room that was divided into storage and cleaning to take patients to weigh them before their appointment with the consultant. Staff told us this procedure had been happening for a long time. In addition, in one sluice area, this was not only used for weighing patients but also for patient examinations about twice a week, for example chest physiotherapy or ultrasounds.

We spent time talking to the Deputy Director of Operations and Scheduled Care Division who was responsible for managing the outpatients departments at the trust. We spent time discussing notifiable incidents that were reported through the breast clinic outpatients department. There was a report compiled called the Jubb report (an external review initiated by the trust in response to concerns in the service) that stated the investigations and remedial actions the trust was taking in relation to lessons to be learnt from the notifications. This is a positive action by the trust in recognising processes that have the potential for improvement.

Monitoring safety and responding to risk

We spoke to staff at all levels and asked them to tell us the procedure for reporting any incidents. All staff were aware of how to respond to an incident and told us they would complete the report on the trust's IT reporting system. All staff spoken with told us they would also liaise with a senior member of staff and report the incident verbally.

We spent time talking to numerous patients in all outpatients departments in the Blackpool Victoria hospital. The majority of patients were unaware of how to make a complaint and what The Patient Relations Service (PRS) was (it used to be called Patient Advice and Liaison Services (PALS). We did see leaflets in the outpatient departments. However there were new leaflets advertising the PRS and old leaflets for PALS.

Patients were satisfied with the care given. The Outpatients Survey for 2012 showed that the trust had been in the top 20 of all NHS trusts for 11 out of 39 questions.

Anticipation and planning

Four patients spoken with told us that their appointments had been cancelled numerous times; one patient told us they had six appointments cancelled and their GP had intervened to request the appointment they were attending for on the day of this inspection. Other patients told us that they were waiting a long time, up to forty minutes in some areas, for their appointments. In two outpatient areas there was signage showing how far delayed appointments were. In others we saw staff informing patients of the delay. When we followed this up with staff they told us the biggest area of complaints in the outpatient departments was waiting times.

Requires improvement

Outpatients

Are outpatients services effective?
(for example, treatment is effective)
Not sufficient evidence to rate

Performance, monitoring and improvement of outcomes
Outpatients services often have a high rate of people who did not attend for their appointments (DNAs). This is not only a poor use of hospital resources, but more importantly means that people do not access the medical care they were referred for and there is then a potential that their condition could worsen if untreated. Patients for some clinics were sent a text message to remind them of their appointment in order try to reduce the number of people who did not attend for their appointments. This is recognised as good practice.

Staff, equipment and facilities
Staffing rotas were looked at for the outpatients departments across the hospital. Levels of staff were adequate. The sister responsible for ensuring staffing levels told us that they allocated staff with the relevant skill mix and knowledge to the different outpatient departments. They did not use bank or agency staff in outpatients; they would use staff on duty to support staff in areas that were under-resourced. All staff spoken with told us they worked as a team and supported each other. Staff were observed in all outpatient areas to be extremely busy.

Are outpatients services caring?

Good

We spent time in all of areas of the outpatients departments talking to patients. Patients were all very positive about the care provided by staff. They told us "staff are really friendly" and "even though I sometimes have to wait the nurses are informative and really friendly".

Compassion, dignity and empathy
We went to all areas of the outpatients departments, and staff in all areas were observed to be respectful to patients. All patients were seen in private in a consultation room. The only issue with dignity for patients we recognised was the sluice room being used to weigh patients.

Involvement in care and decision making
We spoke to 18 patients regarding the information they received in relation to their treatments. The majority of patients were aware of why they were seeing a consultant or nurse. We were told that the consultant and nurses would explain the reason for their appointments.

Emotional support
We were told by patients that staff were always supportive. There were volunteers throughout the outpatient departments assisting people with directions and offering support. Patients in the breast care clinic were very positive about the staff support they had received, saying "fantastic support from staff" and "lovely staff, always friendly".

All outpatients' services we visited were very busy. However, staff were heard to be respectful and friendly to patients.

Are outpatients services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Meeting people's needs
The staffing levels in all outpatients departments were adequate, although staff were observed to be extremely busy. Staff told us they were well supported in their roles.

We spent time with the Chaplain and a team member who informed us that they provide emotional support and follow the patient journey with the family. We observed the Chaplain walking through outpatients', spending time with patients and family members. There is a directory available at the trust that has contacts for all of the religious faiths who can be contacted 24 hours a day.

Four patients spoken with told us that their appointments had been cancelled numerous times; one patient told us they had six appointments cancelled and their GP had intervened to request the appointment they were attending for on the day of this inspection. Other patients told us that they were waiting a long time, up to forty minutes in some areas, for their appointments. In two outpatient areas there was signage showing how long

delayed appointments were. In others we saw staff informing patients of the delay. When we followed this up with staff they told us the biggest area of complaints in the outpatient departments was waiting times.

Vulnerable patients and capacity

We were told by staff that they would monitor patients' health and if they deemed them to be ill they would fast track them through their appointments. The outpatient department had access to chaperones, social workers and staff trained in working with vulnerable patients. We observed patients being supported by different staff in the outpatients departments. The majority of patients were accompanied by another person.

We looked at 12 patient records in the outpatient departments. It was difficult to find the relevant documentation to inform us if patients had the capacity to understand their appointment details. Files were in no order and had a lot of records to go through.

Access to services

We were informed by a patient who used the car park while visiting outpatients that it had no communication access to the outpatients department to organise a wheelchair to get from car park to the department. The patient spent 40 minutes trying to get from the car park to outpatients. On the day of this inspection the lifts were not working in the car park.

We discussed transport with a patient who told us that they were happy with the transport and had used it numerous times. A member of the transport staff told us that outpatient staff will book transport for patients and give the relevant pick up and drop off times. The member of staff had worked in transport for 40 years and was happy doing so.

Learning from experiences, concerns and complaints

We spoke to patients and relatives who told us that they did not know how to make a complaint at the trust. We spent time talking to patients and staff in all six wards we visited. There was little knowledge of the Patient Relation Service (PRS), which was previously known as Patient Advice and Liaison Services.

We discussed this with the PRS team, who informed us that they had received over 4,000 informal complaints and over 700 formal complaints from across the trust in the last 12 months.

We were informed that the team had gone through a lot of changes and a change in skills mix had been implemented, which had had a huge impact on the workload of the four staff in the team. There were leaflets and posters around the hospital informing people how they could use the service; we were told that there was some confusion as it had recently changed its name. The staff told us they were relocating to the new entrance and were going to hold information briefing sessions for the public and staff.

Are outpatients services well-led?

Good

Leadership and culture

Frontline staff were not aware of the managerial leadership for the Outpatients' departments. However, they were very positive about the sisters in charge in Outpatients, saying they were supportive. We were told by the Deputy Director of Operations and Scheduled Care Division that he did not spend as much time as he would like walking around and talking to staff and patients in the Outpatient departments.

Staff told us they were supported in their roles by senior staff. All staff spoken with talked us through their training, and the majority were up to date in mandatory training, including safeguarding vulnerable adults and child protection training. All staff told us that they had had their annual appraisals. This helps to ensure that staff maintain their skills and competency.

Learning, improvement, innovation and sustainability

We spoke to the Deputy Director of Operations and Scheduled Care Division who was responsible for managing the outpatients departments at the trust. We were informed about how they were monitoring the outpatient departments and improving the services provided, for example initiating the Jubb Report, looking at actions required in response to notifiable incidents. The Jubb report contained a series of recommendations from an external review into breast services. Some of these recommendations impacted on outpatient clinics.

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
Treatment of disease, disorder or injury	Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against the risks associated with outcomes from their pregnancy. There is a high rate of Primary Postpartum Haemorrhage and associated Hysterectomy. Action has been taken to begin assessing this, but this requires urgent resolution.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against the risks associated with outcomes from their pregnancy. There is a high rate of Primary Postpartum Haemorrhage and associated Hysterectomy. Action has been taken to begin assessing this, but this requires urgent resolution.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against the risks associated with outcomes from their pregnancy. There is a high rate of Primary Postpartum Haemorrhage and associated Hysterectomy. Action has been taken to begin assessing this, but this requires urgent resolution.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against the risks associated with defective equipment because the systems for checking essential equipment were ineffective. In A&E, there were not effective procedures to check key items of clinical equipment such as defibrillators. Clear procedures are required that are audited regularly.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against the risks associated with defective equipment because the systems for checking essential equipment were ineffective. In A&E, there were not effective procedures to check key items of clinical equipment such as defibrillators. Clear procedures are required that are audited regularly.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision. People were not protected against risks associated with failure to carry out timely and appropriate pre-operative assessments by a specialist. Where appropriate, patients should have a preoperative assessment by an orthopaedic geriatrician.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Surgical procedures

Regulation 10 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.

People were not protected against risks associated with failure to carry out timely and appropriate pre-operative assessments by a specialist. Where appropriate, patients should have a preoperative assessment by an orthopaedic geriatrician.