Blackpool Teaching Hospitals NHS Foundation Trust

Blackpool Victoria Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Urgent and emergency services	Requires improvement
Maternity and gynaecology	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Blackpool Victoria Hospital is the largest acute hospital of the Blackpool Teaching Hospitals NHS Foundation Trust. It treats more than 80,000 daycase and inpatients and more than 200,000 outpatients from across Blackpool, Fylde and Wyre every year. The Urgent care service is one of the busiest in the country with more than 80,000 attendances every year in the emergency department. The hospital has 767 beds and employs more than 3,000 members of staff. It provides a wide range of services from Maternity to Care of the Elderly, and from Cancer Services to Heart Surgery.

The trust was one of the trusts identified for Professor Sir Bruce Keogh's review of trusts in 2013 as the trust had a significantly higher than expected mortality rate from April 2012 to March 2013. CQC inspected the trust in January 2014 and found overall the hospital required improvement. Intensive/ critical care; children and young people and end of life services were rated as Good. Accident and Emergency; Medical care; Surgery and Outpatients services required improvement and Maternity and Family planning services were rated as inadequate.

This inspection was a follow up and was conducted on 21 and 22 September 2015. We only reviewed Maternity services, to review progress against the inadequate rating, we did not review the gynaecology service. We also reviewed the Urgent care services as continued intelligence had raised concerns with regards to the department. We also looked at the governance and risk management support for the services we inspected. We did not undertake an unannounced inspection as the team were confident they had gathered sufficient evidence at the announced inspection. We will apply ratings to the maternity and urgent care services but these will not affect the hospital overall rating of requires improvement.

Our key findings were as follows:

In urgent care services we found some areas had improved since the last inspection however, the results of national CEM audits showed that there were improvements to be made in a number of areas where they were in the bottom 25% of participating trusts nationally. Plans were in place to improve and these were having an effect and were regularly monitored. However, the time to mental health assessment remained a concern with many patients waiting over four hours for assessment although the trust was working with external partners providing mental health services to address this.

We also found that systems for checking essential equipment continued to require improvement since the last inspection when this was raised. The hospital managers took mitigating action before we left the site. However, there were some basic equipment shortages which were having a minimal effect on patients but are worthy of the hospitals attention.

We also noted an induction loop system to help hearing aid users was not working at the time of our inspection. Staff did not always utilise the language support for patient whose first language was not English and were satisfied for a relative to translate.

Leadership of the service had been improved through the employment of a matron with sole responsibility for the A&E department. The new matron however, had only been in post for two months. We noted that nurse appraisal rates were below the expected and the frequency of departmental meetings was very low. Although the team meetings had been reintroduced it was too early to understand the efficacy of them or the matrons role on the culture and understanding of risk and improvement in the department. However, there was a strong multidisciplinary team in the department and staff were positive and proud of the work they did.

Summary of findings

The organisational vision and values had been cascaded but there was a lack of documented service level strategy although the direction of travel was planned with eight key actions highlighted by the A&E leadership team. A trust wide strategic review was underway at the time of the re inspection. There was a current A&E strategy, developed in December 2014, which was under review at the time of the inspection. The current work underway in developing a trust wide strategy would inform the future A&E strategy.

The lead consultant and senior managers were aware of their challenges and there were escalation processes in place for dealing with additional demand.

The layout of the department continued to hinder the flow of patients, bed management ensured capacity was monitored and managed but when the department became busy patients waited on trolleys in the walkway whilst waiting for a cubicle. The service had escalation processes in place. The 4 hour wait standard was not always met but it was better than the England average. The percentage of patients leaving the department before being seen was slightly higher than the England average however the re-admission rate and percentage of patients waiting 4 to12 hours before being admitted were similar to the England average.

The separate, newly refurbished children's department was not as busy as the adult side. Patient flow was good and it was rare for patients not to be treated within the four hour target. However, the average time each patient spent in the emergency department was above the England average between April 2013 to March 2015.

Staffing levels for both doctors and nurses had improved although bank and agency staff continued to be utilised. The emergency department was visibly clean. Patients nutrition and hydration needs had been assessed and patients had food and drinks where appropriate. Staff followed infection prevention protocols. There was a good skill mix of competent staff for both adult and paediatric patients. We saw effective collaboration and communication among all members of the multidisciplinary team and services were set up to run 7 days a week. Compliance with mandatory training did not yet meet the trust's target but was on track to meet it by year end. Risks and complaints were managed well and there was evidence of learning from them. The trust was investing in the senior staff through leadership training and coaching. Staff were positive and proud of the work they did.

Patients described a positive experience and we observed staff treating patients with compassion, respect and dignity. The department Friends and Family test scores were consistently above the national average.

In maternity services the last inspection had identified areas which were inadequate and others that required improvement and an action plan had been developed to address these which has been monitored regularly. At this inspection we found improvements had been made in the number of incidents being reported and the number of post-partum haemorrhages had reduced at the trust. Staffing levels in maternity services were being safely managed and a new midwifery staffing model had been introduced which had impacted positively on the department.

We found that women using maternity services had a high regard for staff and clinical teams, who were caring and treated patients with dignity and respect. There was a good incident reporting culture and systems were in place to ensure lessons were learned. Policies and procedures were up to date and in line with NICE guidance. The outcomes for patients were in line with the England average on most of the compared measures. Where they were worse this had been investigated and actions taken. There was a good system to triage patients who were admitted to the unit. Patients were offered choice of place for delivery and were included in the decision making for their care. There was good inclusion of the patients and systems for engagement with patients and staff were in place.

However, not all areas of the maternity unit or equipment met with infection prevention and control guidance. The systems for checking the maintenance of equipment and its readiness for use in an emergency were not robust. Training compliance in some key areas including skills and knowledge in emergency situations did not yet meet the trust's target.

We saw the following area of outstanding practice:

Summary of findings

- The trust was actively trying to support breastfeeding and there was a network of experienced breast feeding mothers called star buddies, who supported new mothers wanting to breastfeed. The star buddies were mostly volunteers and attended antenatal classes to provide information and advice, as well as meeting women on the maternity ward. There was a monthly rota in place covering seven days and five nights of the week. The women we spoke to were impressed with this service and had found it helpful.

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

Importantly, the hospital must:

- Improve the outcomes for patients through the improvements demonstrated through the national CEM audits in particular, reduce the number of patients attending urgent care services waiting for mental health assessment for over four hours.

In addition the hospital should:

- Maintain all equipment in both urgent care and maternity is checked as per the policy and kept clean within the infection prevention and control guidance for each specific item.
- Consider improving the monitoring of the impact of actions taken as a result of incident investigations in maternity services.
- Maintain training for all staff working in the maternity department with basic life support, blood transfusion and CTG training by the year end.
- Address the insufficient supply of basic equipment e.g. thermometers in A&E.
- Review the computer equipment in 'minors' area of A&E to ensure consistent recording of patients' treatment.
- Try to improve patient confidentiality at the reception.
- improve staff utilisation of translation support when dealing with patients in A&E who require communication support.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated urgent and emergency service overall as requires improvement. We rated the services as good for being safe, caring and responsive and requires improvement for being effective and well-led. At this inspection in September 2015 we found some areas had improved since the last inspection. However, the results of national CEM audits showed that there were improvements to be made in a number of areas where they were in the bottom 25% of participating trusts nationally. Plans were in place to improve and these were regularly monitored. The time to mental health assessment remained a concern with many patients waiting over four hours for assessment although the trust was working with external partners providing mental health services to address this. We also found that systems for checking essential equipment continued to require improvement since the last inspection when this was raised. The hospital managers took mitigating action before we left the site. However, there were some basic equipment shortages which were having a minimal effect on patients but are worthy of the hospitals attention. We also noted a shortage of hand sanitizers in the entrance and an induction loop system to help hearing aid users was not working at the time of our inspection. Staff did not always utilise the language support for patient whose first language was not English and were satisfied for a relative to translate. Leadership of the service through the service manager and lead consultant had been improved through the employment of a matron with sole responsibility for the A&E department. The new matron however, had only been in post for two months. We noted that nurse appraisal rates were below the expected and the frequency of departmental meetings was very low. Although the meetings had been reintroduced it was too early to understand the efficacy of them or the matrons role on the culture and understanding of risk and

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improvement in the department. However, there was a strong multidisciplinary team in the department and staff were positive and proud of the work they did.

The layout of the department continued to hinder the flow of patients, bed management ensured capacity was monitored and managed but when the department became busy patients waited on trolleys in the walkway whilst waiting for a cubicle. The service had escalation processes in place. The 4 hour wait standard was not always met but it was better than the England average. The percentage of patients leaving the department before being seen was slightly higher than the England average however the re-admission rate and percentage of patients waiting 4 to12 hours before being admitted were similar to the England average.

The separate, newly refurbished children's department was not as busy as the adult side. Patient flow was good and it was rare for patients not to be treated within the four hour target. However, the average time each patient spent in the emergency department was above the England average between April 2013 to March 2015.

Staffing levels for both doctors and nurses had improved but bank and agency staff continued to be needed to cover vacancies. The emergency department was visibly clean. Patients nutrition and hydration needs had been assessed and patients had food and drinks where appropriate. Staff followed infection prevention protocols. There was a good skill mix of competent staff for both adult and paediatric patients. We saw effective collaboration and communication among all members of the multidisciplinary team and services were set up to run 7 days a week. Compliance with mandatory training did not yet meet the trust's target but was on track to meet it by year end. Complaints were managed well and there was evidence of learning from them. The trust was investing in the senior staff through leadership training and coaching. Staff were positive and proud of the work they did.

Patients described a positive experience and we observed staff treating patients with compassion, respect and dignity. Patients were involved in their

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care and treatment being supported to make informed choices. The department Friends and Family test scores were consistently above the national average.
The organisational vision and values had been cascaded to all staff however there was a lack of documented service level strategy although the direction of travel was planned with eight key actions highlighted by the A&E leadership team. A trust wide strategic review was underway at the time of the re inspection.There was a current A&E strategy, developed in December 2014, which was under review at the time of the inspection. The current work underway in developing a trust wide strategy would inform the future A&E strategy.The lead consultant and senior managers were aware of their challenges and there were escalation processes in place for dealing with additional demand.
The department risks were monitored through the unscheduled care risk register which was up to date. These risks, incidents and performance were reviewed through the regular clinical governance meetings and appropriate actions taken.

Maternity and gynaecology — **Good**

At the last inspection areas were identified in the maternity services which were inadequate and others that required improvement and an action plan had been developed to address these which has been monitored regularly. At this inspection in September 2015 we found improvements had been made in the number of incidents being reported and the number of post-partum haemorrhages had reduced at the trust. Staffing levels in maternity services were being safely managed and a new midwifery staffing model had been introduced which had impacted positively on the department. We found that women using maternity services had a high regard for staff and clinical teams, who were caring and treated patients with dignity and respect. There was a good incident reporting culture and systems were in place to ensure lessons were learned. Policies and procedures were up to date and in line with NICE guidance. The outcomes for patients were in line with the England average on most of the compared measures. Where they were worse this had been investigated and actions

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taken. There was a good system to triage patients who were admitted to the unit. Patients were offered choice of place for delivery and were included in the decision making for their care. There was good inclusion of the patients and systems for engagement with patients and staff were in place. However, not all areas of the maternity unit or equipment met with infection prevention and control guidance. The systems for checking the maintenance of equipment and its readiness for use in an emergency were not robust. Training compliance in some key areas including skills and knowledge in emergency situations did not yet meet the trust's target.

Blackpool Victoria Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Maternity

Detailed findings

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Background to Blackpool Victoria Hospital

Blackpool Victoria Hospital is the largest acute hospital of the Blackpool Teaching Hospitals NHS Foundation Trust. It 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 is one of the busiest in the country with approximately 85,000 attendances every year. The hospital has 767 beds and employs more than 3,000 members of staff. It provides a wide 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.

The trust was one of the trusts identified for Professor Sir Bruce Keogh's review of trusts in 2013 as the trust had a significantly higher than expected mortality rate from April 2012 to March 2013. CQC inspected the trust in January 2014 and found overall the hospital required improvement. Intensive/ critical care; children and young people and end of life services were rated as Good. Accident and Emergency; Medical care; Surgery and Outpatients services required improvement and Maternity and Family planning services were rated as inadequate.

This inspection was a follow up and only covered Maternity services to review progress against the inadequate rating and the Urgent care services as continued intelligence had raised concerns with regards to its performance. We also looked at the governance and risk management support for the services we inspected.

Our inspection team

Our inspection team was led by:

Hospital Inspection Manager: Lorraine Bolam, Care Quality Commission

The team included six CQC inspectors, three who were observing as part of their induction to the organisation, and a variety of specialists including a Midwife; Consultant Midwifery Advisor, with experience as a Community Midwifery and Antenatal Clinic Matron; Consultant Obstetrician and Gynaecologist; a Nurse Manager with experience in Emergency Care, both adult and paediatric and a Director of Clinical Quality. We were also supported by two experts by experience.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG) and the local Healthwatch.

The inspection team inspected the following core services at Blackpool Victoria Hospital:

- Accident and emergency
- Maternity

We carried out an announced inspection visit of the hospital on 21 and 22 September 2015. We held focus groups with a range of staff in the hospital, including obstetricians, A&E Consultants, Midwives, Community midwives and A&E nursing staff. We also spoke with members of the executive team.

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

We did not carry out an unannounced inspection at this hospital.

Facts and data about Blackpool Victoria Hospital

Blackpool Victoria Hospital is the main site of Blackpool Teaching Hospitals NHS Foundation Trust which was established in December 2007, and serves a population of approximately 330,000 residents and 10 million visitors to the area every year. The Trust also provides services from Clifton Hospital and Fleetwood Hospital and Community services across Blackpool Fylde Coast and North Lancashire.

It is also one of four tertiary cardiac centres in the North West, providing specialist cardiac services to heart patients from Lancashire and South Cumbria.

The hospital is located in the Blackpool District which is in the 5th quintiles of the 2010 English Indices of Deprivation where the 1st quintile is the least deprived.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

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

Information about the service

Emergency and urgent services for Blackpool Teaching Hospitals NHS Trust were provided from Blackpool Victoria Hospital. The emergency department was open 24 hours a day, seven days a week.

During April 2014 and March 2015, just over 85,000 patients (adults and children) attended the emergency department. About 15,300 (18%) were children. The department had two entrances - one for ambulances and one for walk-in patients. Reception staff received patients and started their care pathway.

The emergency department had a triage and ambulatory care area, cubicle and side room areas, and a 'majors' area for more serious cases. The reception staff also signposted patients to the urgent care centre, which was on the hospital site but operated by a different provider (FCMS (NW) Ltd) and so we did not inspect this service.

The emergency department included the observation ward. This was a short-stay nurse-led ward with two bayed areas that accommodated four patients each, two side rooms and a treatment room, making 10 beds in total. Support was provided by the enhanced discharge team of physiotherapy and occupational therapy staff, who provided prompt and focused care to support rapid discharge of patients.

The ward was intended for short-stay patients who did not require formal admission to hospital, such as those who required longer observation than could be provided in the emergency department (for example, patients with head injuries) patients awaiting transfer home or for other services to commence.

We visited the emergency department at Blackpool Victoria Hospital during our follow-up announced inspection on 21 and 22 September 2015.

We spoke with 15 patients and nine relatives or carers, and 25 staff of different grades, including doctors, nurses, consultants, senior managers, a therapist, emergency nurse practitioners, support staff and ambulance staff. We observed care and treatment and looked at care records for 10 patients. We received comments from people who contacted us to tell us about their experiences and we reviewed items from the trust's quality monitoring information and data.

Urgent and emergency services

Summary of findings

We rated urgent and emergency service overall as requires improvement. We rated the services as good for being safe, caring and responsive and requires improvement for being effective and well-led.

At this inspection in September 2015 we found some areas had improved since the last inspection. However, the results of national CEM audits showed that there were improvements to be made in a number of areas where they were in the bottom 25% of participating trusts nationally. Plans were in place to improve and these were regularly monitored. The time to mental health assessment remained a concern with many patients waiting over four hours for assessment although the trust was working with partners to address this.

We also found that systems for checking essential equipment continued to require improvement since the last inspection when this was raised. The hospital managers took mitigating action before we left the site. However, there were some basic equipment shortages which were having a minimal effect on patients but are worthy of the hospitals attention.

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Urgent and emergency services

inspection.There was a current A&E strategy, developed in December 2014, which was under review at the time of the inspection. The current work underway in developing a trust wide strategy would inform the future A&E strategy.The lead consultant and senior managers were aware of their challenges and there were escalation processes in place for dealing with additional demand.

The department risks were monitored through the unscheduled care risk register which was up to date. These risks, incidents and performance were reviewed through the formal departmental meetings held six weekly alternating between Directorate meetings and Governance meetings and appropriate actions taken.

Are urgent and emergency services safe?

Good

We rated urgent and emergency services as good for protecting people from harm.

There were good incident reporting systems and lessons were learnt. Medicines were stored and administered safely although checking of fridge temperatures were not always completed. Patient records were complete, contemporaneous and maintained securely. Systems and processes were in place to protect patients from abuse with staff trained to appropriate levels. Patients received initial assessments in a timely way and this had improved since the last inspection although there had been delays in line with the England average over the winter months.

We found the nurse staffing levels had improved since the last inspection through a positive response to a recruitment drive. The department used bank and agency staff to ensure adequate numbers. All temporary staff underwent a comprehensive induction programme. There were paediatric nurses providing care to for children.

Medical staffing had also improved, although recruitment remained a challenge. The emergency department had 2.5 full-time equivalent consultant vacancies and plans were in place to fill them. One of the newly recruited consultants was to take the lead in paediatrics. The department had a higher number of junior grade doctors to mitigate the risk of less consultants.

The cleanliness of the emergency department had also improved since the last inspection, it was visibly clean and we observed staff cleaning trolleys between patients and using the aseptic no-touch technique. Staff had received training in infection control, including hand hygiene.

Similar to the last inspection the portable appliance testing (PAT) system for monitoring and recording the testing and servicing of electrical equipment such as cardiac monitors and resuscitation equipment (defibrillators) was not robust. We also found the department did not have sufficient basic equipment to monitor patients' temperature for example and equipment that was available was not checked regularly. When we highlighted this to the trust they informed us that new defibrillators were currently being checked before being distributed. All

equipment had been checked in the department before we left the site and post the inspection the trust provided assurance that the risk had been mitigated. All defibrillators were in working order and daily checks and spot checks were being conducted.

Incidents

- Staff reported incidents of harm or risk of harm using the trust-wide electronic incident reporting system. Learning from incidents was shared with the senior team and with staff at handovers or team meetings. This was confirmed in minutes we reviewed. In addition, the trust included a summary of lessons learnt in the staff newsletter.
- The strategic executive information system data showed there were two serious untoward incidents in relation to emergency and urgent care services reported during 2015, both of which had been the subject of a full root cause analysis (a detailed investigation of the circumstances leading to the incident). These were regarding a delay in patient diagnosis and an accidental overdose of medication. Nursing and medical staff we spoke with were able to describe the two serious untoward incidents and actions taken by the department to help to minimise the risk of recurrence. Staff also told us about learning from drug errors made.
- Staff said there was an 'open culture' about raising concerns. Junior staff said they were able to share concerns directly with both medical and nursing staff.
- An action plan had been developed following the visit by the Emergency care intensive support team (ECIST) in June 2014. The trust ECIST Outcome report dated June 2015 showed the emergency department had seen a 63% reduction in minor (level 2) harms and a 27% reduction in moderate/serious (level 3) harms. In addition there had been a 16% increase in the reporting of incidents in 2014/15 falling into the near miss or low harm categories. This showed a positive reduction in harms which were not a result of a reduction in reporting.
- Staff took part in mortality and morbidity meetings where individual cases of patient deaths were presented and discussed. Staff said there was always a debrief following the death of a child or a distressing situation in paediatrics, which was good practice.
- Staff were aware of the duty of candour regulation which identifies specific action to be taken to notify the relevant person, as soon as is reasonably practicable after becoming aware that a notifiable safety incident has occurred, firstly in person and then in writing. There was a Patient Safety Including Being Open and Duty of Candour Policy in place which had been supported by training.

Cleanliness, infection control and hygiene

- The emergency department, including bed areas and commodes, was visibly clean. We observed staff cleaning trolleys between patients and using the aseptic no-touch technique. Mandatory training records showed 83 % of staff had received training in infection control, including hand hygiene.
- Staff followed hand hygiene and 'bare below the elbow' guidance and they wore personal protective equipment, such as aprons and gloves, as they delivered care.
- The infection control policy included screening all patients who were to be admitted to a ward for Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile. Staff made a note on the electronic record for any patients with infectious conditions so patients could be readily identified and treated appropriately.
- Staff handled, stored and disposed of clinical waste, including sharps bins, appropriately. Managers monitored compliance checks weekly and monthly and reported their findings as 'Knowing how we are doing'. Information shared included cost, safety, people, delivery and quality. Audits included the cleanliness of the environment and equipment and hand hygiene. The hand hygene audit for June 2015 identified that although staff adhered to the policy patients were not always supported to do so. Green 'I am clean' stickers were attached to cleaned equipment and commodes were visibly clean.

Environment and equipment

- Patients taken to the emergency department by ambulance entered through a separate entrance from other patients. The main department was separated into three areas: ambulatory care, minors (for minor injuries or illnesses) and majors (for more serious cases). Patients assessed as being at risk of deterioration or those with a high level of need were accommodated in cubicles visible from the nursing stations so staff were able to intervene rapidly if necessary. The emergency department used 10 short-stay beds on the observation ward if a patient required further monitoring. Since our

last inspection in April 2014, the service had refurbished part of the emergency department to provide a separate children's department. However, this had no separate access so children had to pass through the adult department.

- Staff had access to security alarms in each cubicle to protect them in the event of an emergency.
- The resuscitation area had three cubicles, with one designated for children. The cubicles were all well-equipped with general equipment for both adult and paediatric patients. However, The three defibrillators in the resuscitation area had stickers saying they were last serviced in 2011 and two of them had no asset number. One of the storage cabinets had the drawer missing and there was exposed chipboard at the front. There were no service dates or electrical safety stickers on either of the electrocardiograph (ECG) machines.
- We raised with the trust that the portable appliance testing (PAT) system for monitoring and recording the testing and servicing of electrical equipment such as cardiac monitors and resuscitation equipment (defibrillators) was not effective. They assured us that all equipment had been maintained correctly by the manufacturers and was tracked appropriately either by asset numbers or serial numbers. The trust sent a medical engineer to the department to test all defibrillators, label them and update the equipment register and they contacted us post the inspection to confirm this had been completed.
- The directorate manager gave us assurance that all the equipment had planned preventative maintenance checks and the medical engineering team were compiling a report of all equipment that had recently been back to manufacturers so they could be labelled correctly with service dates. This was completed by the trust after the inspection.
- Clinical staff had checked daily that defibrillators were in working order and recorded the results. The matron said the resuscitation team were doing spot checks to make sure the daily checks were taking place.
- Defibrillators were being replaced and the emergency department was due to be the first to receive new ones within a few weeks. This was expedited and the new equipment was in the department before we left the inspection.
- The department did not have enough basic equipment to monitor patients. Staff told us some equipment (for example, thermometers) was not always readily available. We saw staff having to leave the triage area to look for thermometers, which they borrowed from the children's area. This did not have a significant impact on patients.
- There were only two cardiac (ECG) machines. If both were being used in the resuscitation area, this had the potential to cause delay if one were needed elsewhere in the emergency department.
- The emergency department had a secure room that was used to assess patients with mental health needs. This met the Section 136 room guidelines (a designated place of safety) under the Mental Health Act 1983. Staff were not aware of the NHS Protect guidance on distressed patients, which could mean that patients with mental health problems would not be treated appropriately.

Medicines

- Medicines, including controlled drugs, were stored securely and in line with legal requirements.
- Staff we spoke with were familiar with policies for managing medication and there were printed copies available in the department.
- The fridges used to store medication were within the required temperature range but temperatures were not checked daily in line with trust policy. We saw that on occasional days the fridge temperature had not been checked. Keeping fridges at the right temperature is important because some drugs deteriorate if not kept cold enough.
- Pharmacy staff maintained minimum stock levels and checked medication expiry dates.
- Medicines were ordered and returned to pharmacy safely. We checked the controlled drugs in the emergency department and found the stock balances were correct and the registers had been signed by two members of staff when drugs were dispensed. The volume of any wasted drugs was recorded accurately where necessary.
- Nursing staff in the emergency department routinely administered a select range of medications using patient group directions (written instructions that allow non-prescribing healthcare professionals to supply and administer specific medications to patients who meet set criteria). The practice complied with the relevant legislation (Human Medicines Regulations 2012).

- We saw that any known allergies were clearly recorded in the patient's records.

Records

- We reviewed six sets of adult and four sets of paediatric patients' records and saw clinical assessment, diagnosis and treatment plans clearly documented.
- All nursing and medical documentation was recorded on the computer. For patient observations, paper records were used. Records included a tracker alert for risks, including safeguarding from abuse, infections and allergies.
- Two patients had been reviewed by an alcohol specialist nurse, who had filled in the associated observation charts. Another patient was allergic to penicillin, which was clearly identified and highlighted in their notes.
- We saw evidence that patients who were admitted to the emergency department after having been initially assessed and treated underwent risk assessments. Examples included, nutrition, pressure care and falls risk assessment.
- Staff said the computer equipment in 'minors' area did not always work, which led to problems recording patients' treatment.
- Records were held securely.

Safeguarding

- The department had appropriate processes for safeguarding patients from abuse.
- The emergency department had a consultant lead for vulnerable adults and there was a trust lead for vulnerable children.
- Staff knew where to find policies for safeguarding vulnerable adults and children from abuse. The policy covered issues including domestic and sexual abuse, female genital mutilation, radicalisation, forced marriage, sexual exploitation and honour-based violence.
- An emergency department nurse described how patients were checked on admission for signs of abuse or neglect, such as marks on their body or dehydration. Staff knew how to identify abuse and confirmed they were familiar with the referral process if they had concerns that an adult or child was at risk of abuse. They had good relationships with the local safeguarding teams for making referrals.
- The electronic patient record system alerted staff to any previous safeguarding issues. Safeguarding records were well completed.
- The training report provided by the trust for September 2015 showed 97% of nursing staff had completed Level 1 safeguarding children training; 87% had completed level 2 training and 88% were trained to level 3.
- Of the additional clinical services staff over 98% had completed level 1 safeguarding children training; 80% level 2 and 100% level 3 training.
- Safeguarding adults training had been completed by 98% of nursing staff and over 98% of additional clinical services staff.
- The matron reminded staff who had not yet completed this training.

Mandatory training

- Staff received mandatory training in areas such as infection prevention and control, moving and handling, equality and diversity and human rights, harassment and bullying, manual handling, consent, risk awareness, dementia awareness, and safeguarding children and vulnerable adults.
- Mandatory training was calculated in year as opposed to staff being in date with their training updates.
- Across the emergency and urgent services division less than 80% of staff had completed most mandatory training in year. This did not meet with the trust's target of 90%.
- Information provided by the trust showed only 61.4% of staff had completed training in adult basic life support but the trust did not supply data regarding the percentage of staff who had completed Paediatric life support but their nursing resource plan assured that there was always staff on duty with these skills.
- All the paediatric team were RSCN and supported to complete their Advanced Paediatric Life Support.
- In addition, all the main department band 7 nurses and band 6 nurses were supported to complete Advanced Paediatric Life Support and a number of these were on each shift which was supported by the nursing resource plan we reviewed.
- All the Emergency department qualified nurses were trained in Paediatric Life Support prior to working in the resus area, and these nurses would be used to support the paediatric nurses if required.

Assessing and responding to patient risk

- Staff followed clear processes to assess patients.
- The rapid assessment and treatment initiative (RAT) had been fully in place from December 2014. A direct comparison of time to initial assessment between 2013/14 and December 2014 toJune 2015 showed a 10 minute improvement, moving the time to initial assessment from an average of 24 minutes to 14 minutes.
- Patients arriving on foot checked in at a reception desk and their condition was assessed by a triage nurse assigned them to the minor or major injuries areas depending on their clinical need. The median time to initial assessment was in the range 5-8 minutes (Jan'13-Feb'15), and above the England average for 22 of the 25 months.
- An early warning score (EWS) was part of the patient record, with clear instructions for staff on how to escalate a patient whose condition was deteriorating. EWS is a system that scores vital signs and is used for identifying patients who are deteriorating clinically. For paediatrics, there were five different EWS forms in use to cover the different age ranges. Records we reviewed demonstrated this system was effective.
- During part of the inspection the department became busy and there were insufficient cubicles to accommodate patients. Patients waited on trolleys lined up in the department but remained in view of staff and being constantly monitored whilst awaiting cubicle space. However it was unclear if patients started any appropriate treatment before a cubicle was available, for example started antibiotics.
- Senior clinician advice was available at all times. Consultants were based in the department until at least midnight or available on call with the ability to attend within approximately 30 minutes if required.
- Paediatric patients (babies and children) were assessed by childrens nurses and waited in a separate area designated for children. A consultant to lead paediatric care had been recruited although was not in post at the time of the inspection.
- Staff in the emergency department could call security for immediate support and would also dial 999 for police assistance if required. Although there was limited presence of security staff in the emergency department, staff reported they felt safe. Six staff told us they had received conflict resolution training. Information provided by the trust showed 63% of emergency department staff had completed training in conflict resolution.
- We observed the effective management of a scenario whereby security and the police were called to support the staff with a patient whose behaviour was challenging. The patient was supported with dignity and respect by all staff involved and the outcome was favourable in meeting the needs of the patient.

Nursing staffing

- Staffing levels were appropriate during the inspection. Nursing staff of different grades were assigned to the different patient areas. A senior staff member was in charge as the shift lead and coordinator. In addition, a senior nurse covered the resuscitation room and the assessment area. Since the last inspection managers had changed shift patterns to provide more staff at busy periods, for example 6pm-2am,11.00am-midnight and 9.30 am-7pm and to make recruitment more attractive and to help improve the service for staff and patients.
- The department did not use a specific acuity tool to determine the nursing establishment but monitoring of the emergency department over a period of time had given management sufficient information to staff it appropriately. The department used an electronic roster system which highlighted where the shortages were.
- Paediatrics was well staffed with sufficient paediatric trained staff. The shifts essentially ensured that there was a paediatric qualified nurse on duty 24 hours a day, with double cover at busy periods. Within this establishment there was a band 7 lead nurse and band 6 senior nurse that were RSCN trained.
- The main children's ward also supported the department at times of pressure and responded with appropriately trained nurses when there were seriously ill children on the department. These are automatically called upon as part of the 'crash' bleep for Paediatric Emergencies.
- The lead nurse is currently being supported to complete her advanced nurse practitioner training, in partnership with the Children's Directorate.
- In addition a number of general qualified nurses have been supported to successfully to complete the sick children's module at university.
- The expected and actual staffing levels were displayed and updated on a daily basis on notice boards in the

emergency department. Senior staff carried out checks throughout the day to monitor the flow through the department of patients and escalated staffing shortfalls due to unplanned sickness or leave.

- Cover for staff leave or sickness was provided by bank or agency staff. Duty rotas confirmed that agency staff were familiar with the emergency department or they used staff from the 'pool' or bank, which eased pressure on the permanent staff. We looked at four weeks of the nursing rota and saw there was consistency in the temporary staff used. Agency staff had a competency based induction prior to working in the emergency department. An agency nurse spoken with confirmed they had received it.
- The emergency department had two vacancies at Band 7 and five vacancies at Band 5. These posts had been subject to recruitment, two new paediatric nurses meant the department would be three band 5 nurses short.
- Nursing staff of differing grades were assigned to each patient area to ensure patients were protected from avoidable harm and received appropriate care. Staffing levels on the observation ward were good. For 10 patients there were two trained nurses and one health care assistant. Five new staff had started recently. The 'See and treat' area (a treatment area with one bed for patients who could be treated rapidly for example, X-rays, injuries and wounds) was adequately staffed. Staff would escalate issues to the duty matron if they were concerned about capacity to cope with patients.
- Recruitment had started to fill nursing vacancies. Paediatric nursing staff spoke positively about having four new recruits, who were at different stages of their induction. The paediatric service had improved now there was a paediatric nurse 24 hours a day, which had built up the team's skill set. Nursing staff spoke favourably of the input from a new consultant with a keen interest in paediatrics.
- The department had developed a specific induction pack for new nursing staff including a skills log to assess staff competencies.
- The lead nurse in paediatrics was undertaking the advanced nurse practitioner (ANP) course to learn specialist skills. Although they had two years still to complete this, management confirmed this would benefit the minor injuries side of paediatrics as there was a demand for this service.

Medical staffing

- The emergency department employed 6.5 full time equivalent consultants plus one full time locum consultant who had been in the department for over six months. The establishment was for 10 consultants. However at September 2014 they had a higher proportion of junior doctors (33%) compared to the England average (24%) which offset the lower proportion of Consultants (11% v 23%). Medical staff worked various shift patterns to cover the emergency department over a 24 hour period. Consultant hours during the week were from 9am to 10pm with 24 hour /seven days a week on-call cover.
- There was no specific paediatric consultant however one of the more recently recruited consultants was to take the lead in this specialty. A junior doctor was allocated to support the paediatric emergency department each day. Junior doctors were supported by the lead emergency department consultant and the paediatric registrar from the paediatric ward.
- The lead consultant told us the department faced challenges in recruiting middle grade doctors. Only three out of eight substantive posts were filled last year. A fourth doctor was due to start. The trust had tried recruitment overseas but struggled to fill posts to work from 1pm to 10pm seven days a week. Locum doctors were covering the vacancies.
- Staffing levels had improved with an extra registrar overnight and weekends through locum cover. Medical and nursing staff said this had improved leadership. Despite a high turnover of junior staff there were a number of established staff, particularly with the senior and middle grade doctors.

Major incident awareness and training

- There was a major incident and business continuity plan available for staff. This included the key risks that could affect the provision of care and treatment. Guidance for staff in the event of a major incident was readily available and staff were aware this had recently been updated.
- The emergency department had a lead consultant to deal with patients who may be contaminated with chemicals and other hazardous substances (HAZMAT).
- Three senior staff had attended simulation training in the last 6 weeks with involvement from fire safety. Staff

were able to tell us the actions they would take in the event of a major incident occurring. Training materials were available included a pathway manual and video to train staff in usage of equipment used in a major incident.

- The department was taking special measures for patients with symptoms of Ebola (a serious virus originating in Africa, which can be passed between people). Reception staff checked whether patients had travelled recently and knew what action to take if Ebola was suspected. Clinical isolation rooms were available in the paediatric area.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated urgent and emergency services as requires improvement for being Effective.

At the previous inspection we did not rate the service for being effective as our methodology did not support there being sufficient evidence to make a judgement at that time. It has since been developed.

The department participated in national College of Emergency Medicine audits however, the results showed that there were improvements to be made in a number of areas where they were in the bottom 25% of participating trusts nationally. These were being monitored through the Clinical Governance monthly meetings.They had not participated in the CEM Severe sepsis and septic shock since 2013-14 but instead were engaged with the NCEPOD audit.

However, we saw that there were up to date policies and procedures. Clinical pathways were in place which staff used effectively and supported appropriate and timely care. Patients were assessed for pain relief following triage and patient records demonstrated timely assessment and administration of pain relief. Patients nutrition and hydration needs had been assessed using a MUST risk assessment and we saw patients had food and drinks where appropriate. There was a good skill mix of competent staff for both adult and paediatric patients attending the service. Staff had the skills and knowledge regarding consent, MCA and DoLS. We saw effective collaboration and communication among all members of the multidisciplinary team and services were set up to run 7 days a week. Nursing staff told us they received supervision but less than half had received annual appraisals.

Evidence-based care and treatment

- Policies, procedure and guidelines in the emergency department were based on nationally recognised best practice guidance from the National Institute for Health and Care Excellence (NICE) and the Clinical Standards for Emergency Departments.
- Nursing and medical staff we spoke with confirmed policies and procedures reflected current guidelines. We looked at four policies and procedures and these had been updated and reflected national guidelines.
- A range of care pathways were followed in the emergency department, in line with national guidance, examples included trauma, sepsis, fractured neck of femur, stroke, asthma, alcohol dependency and pneumonia. We saw some of the protocols for the clinical pathways were displayed for the most frequent conditions that patients presented with at the emergency department.
- Pathways are interlinked clinical questions arranged into 'pathways'. These pathways provided safe and effective clinical decision support to trained users who provide assessment for patients visiting emergency departments. Reception staff could then direct patients to the correct area for treatment.

Pain relief

- A screening process was in place to identify any patients requiring pain relief. Patients were assessed for pain and provided with analgesia after contact with nurse prescribers during triage when they attended the emergency department.
- There was evidence in patients records that pain relief had been prescribed appropriately and was administered when pain relief was required.
- The majority of patients we spoke with told us they were asked about pain levels and were given analgesia when required.
- Within the paediatric area, we noted a behavioural pain scoring tool for younger children.
- A behavioural pain scoring tool was used for patients with a learning disability.

Nutrition and hydration

- Patients nutrition and hydration needs had been assessed and a MUST risk assessment was recorded on the nursing record for those patients who had been in the department for four hours or more. Healthcare assistants were responsible for ensuring food and drinks were provided for patients with diabetes as necessary.
- We observed staff providing drinks or snacks to patients. A vending machine was available to patients, relatives and other visitors. Prior to offering food or drinks staff checked patients were allowed this due to the reason for their admission or condition.
- On the observation ward patients were offered a choice of food and drink. Referrals were made to dieticians if required. We saw staff followed care plans if patients' specific needs were identified, for example, if a patient required assistance at mealtimes.

Patient outcomes

- The emergency department participated in the College for Emergency Medicine (CEM) national audits including Assessing for cognitive impairment in older people; Paracetamol overdose; Mental health in the ED; Initial management of the fitting child and Asthma in Children over the last two years.
- The results for the CEM Paracetamol Overdose 2013/14 audit showed 82% of patients received treatment in line with MHRA guidelines however, there was one form of treatment where they did not meet the standard to administer within one hour.
- The results for the CEM, Asthma in Children 2013/14 audit showed they fell within the lower quartile (worse than other trusts, bottom 25 %) for two of the seven observations expected to be recorded and in the administration of steroids in the department and prescribing them on discharge.
- The results of the CEM, Assessing for cognitive impairment in older people 2014/15 audit showed they were in the lower quartile (worse than other trusts, bottom 25 %) for early warning score documentation and undertaking a cognitive assessment.
- The results of the CEM, Mental health in the ED audit 2014-15 showed they fell within the lower quartile (worse than other trusts, bottom 25 %) for risk assessment taken and reported in the patients clinical record; provisional diagnosis being recorded; patient assessed by a mental health practitioner (MHP) from organisation's specified acute psychiatric service and details of any referral or follow-up arrangements documented. It was also noted that there was no dedicated assessment room for mental health patients which has now been addressed.
- The results of the CEM, Initial management of the fitting child 2014/15 audit showed they were about the same as other trusts in the areas where there was a significant sample size.
- The trust had participated in the national Severe sepsis and septic shock audit in 2013-14 but had made a decision not to participate in the 2014/15 audit as the trust was committed to the NCEPOD sepsis study and trust wide implementation of the sepsis pathway with monthly performance monitoring. All NICE, NCEPOD Sepsis 6 and CEM recommendations were implemented within the pathway.
- The findings from audits were reviewed, action plans developed to improve the areas where shortfalls were identified and progress monitored. For example regarding care of the fitting child documentation was improved to make GCS / AVPU easier to record and regarding care of patients with mental health needs the development of a proforma for mental health assessment and review of the recommendations of the Psychiatric Liaison Accreditation Network regarding the assessment room features and layout by January 2016.
- The directorate manager told us staff would be encouraged to undertake additional clinical audits to assess how well NICE and other guidelines were adhered to. This was with a view to increasing staff education and changes in practice to improve patient care.
- In July 2015, the re-attendance rate was 7.9% compared to the England average of 7.7%.
- The clinical quality indicator for July 2015 showed 95% of patients waited under 12 minutes from arrival to initial assessment.
- The trust ranked 'about the same' as other trusts for the three questions on effectiveness in the 2014 A&E survey.

Competent staff

- Staff we spoke with in the emergency department reported they had received an appraisal within the last

year. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Data the trust supplied showed only 45% of trained nurses had received an annual appraisal.

- A band 5 nurse told us their objectives had been set and they had an assigned mentor. Although their mentor was pressured when at work, they felt able to access support and guidance when needed from other staff.
- The junior and middle grade doctors we spoke with told us they felt well supported by the consultants, they received medical supervision, regular teaching sessions and they were able to discuss any issues or concerns as required.
- Nursing and medical staff spoke positively about the learning and development opportunities they were able to undertake.
- Newly appointed staff completed an induction and had their competencies assessed before working unsupervised.
- Staff confirmed that managers provided clinical supervision of their work performance.

Multidisciplinary working

- We saw effective communication between members of the multidisciplinary team to support the planning and delivery of patient-centred care. Daily multidisciplinary team meetings, involving the medical staff, nursing staff, therapists as well as social workers, child health visitors, hospital discharge team and safeguarding leads, where required, ensured patients' needs were fully explored.
- We observed handovers between shifts and found them to be comprehensive and confidential.
- The mental health and alcohol liaison teams reviewed practices and provided interventions with patients whose admission to hospital was alcohol related.
- There was a daily consultant led multidisciplinary ward round on the observation ward, which involved nurses, physiotherapists and occupational therapists.

Seven-day services

- Sufficient out-of-hours medical cover was provided to patients in the emergency department by junior and middle grade doctors, including on-site and on call consultant cover.
- Since the last inspection there was now a separate paediatrics unit within the emergency department, staffed 24 hours a day. Staff felt they could now give better care to children due to this increased provision of the service.
- The mental health and alcohol liaison teams had processes to manage referrals out of hours.
- Staff rotas showed that medical and nursing staff levels were sufficiently maintained out of hours and at weekends.
- The diagnostic services, for example X-rays were available 24 hours a day, seven days a week specifically to support the emergency department.
- A community mental health crisis team was accessible for patients with mental ill health through a single point of access referral 24 hours a day, 7 days a week.
- Pharmacy services were not available 7 days a week however a pharmacist was available on call out of hours.

Access to information

- The emergency department used an electronic information system to track when patients were admitted to the department. Staff showed us how readily they were able to access patient information.
- Patient information such as test results, x-rays or medical information gathered during the booking in process, triage or in the emergency department was available on the receiving wards so staff were able to prepare for their patient.
- Safety performance information, audit results and some pathways were displayed in the emergency department for staff to access readily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to ask patients for consent to treatment and were able to explain how they sought consent. The training records demonstrated that 91% of staff in the emergency department had completed training on consent and mental capacity.
- Staff understood the legal requirements of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and consent arrangements. Staff we spoke with had a reasonable understanding of the trust's policy and of the legislation. Staff told us they would consult with a senior member of the team for

advice and would seek the advice of appropriate professionals to ensure decisions were made in the best interests of patients and that carers and family were involved.

- Paediatric staff were aware of Fraser guidelines (whether doctors should give contraceptive advice or treatment to under 16-year-olds without parental consent) and Gillick competence (a term used in medical law to decide whether a child [for these purposes a person under 16 years of age] is able to consent to his or her own medical treatment, without the need for parental permission or knowledge) was used for children where suitable.
- There was on line mandatory training in consent MCA and DoLS. Some staff told us additional training may be of value to help them understand this better.
- We observed nursing and medical staff gaining consent from patients prior to any care or procedure being carried out.

Are urgent and emergency services caring?

Good

We rated urgent and emergency services as good for being caring.

Patients described a positive experience attending the emergency department and receiving treatment. During this inspection we observed staff treating patients with compassion, respect and dignity. Patients were involved in their care and treatment, and staff spent time explaining treatment options to allow patients and relatives to make an informed choice. The department was working hard to increase the Friends and Family test response rate and its scores were consistently above the national average.

Compassionate care

- We observed good interaction and communication between doctors, nurses and medical crews. Nursing staff showed care and compassion towards patients. Staff dealt with a distressed and agitated patient in a supportive way. We saw staff providing reassurance to relatives while caring for a patient whose condition had deteriorated. Relatives told us how assured they felt as their loved ones' condition was clearly explained to them. Clerical and clinical staff were observed to be caring.
- Parents and children told us the staff were attentive to their needs. One parent and their child told us the staff had explained clearly exactly what treatment they needed.
- The trust performed consistently better than the England average for the Friends and Family Test. The patient experience dashboard showed the percentage of people who would recommend the service to their friends and family had gone up from 88% in April 2014 to between 94 and 96% from November 2014 to February 2015. The service's results were consistently above the England average. In August 2015 93.7% of people were likely to recommend the services of the emergency department. Staff aimed to achieve 10 patients per day to complete the survey.
- The trust ranked about the same as other trusts for the 24 questions about caring in the 2014 A&E survey.
- Despite the layout of the reception making some patients feel uncomfortable answering questions on arrival at the emergency department reception staff were able to and tried to offer patients an opportunity to move to another area for privacy.

Understanding and involvement of patients and those close to them

- Staff involved patients in their care. We saw consultants and nursing staff keeping family members up to date with information about patients where appropriate. Patients' families reported good communication about care. Patients and relatives we spoke with knew about their family members' diagnosis, treatment and investigations.
- Adult and paediatric patients and relatives spoke favourably about the information they received from staff both verbally and written, such as information leaflets which were specific to their condition.

Emotional support

- We observed many episodes of patient and staff interactions, during which staff demonstrated caring attitudes towards patients.
- Chaplaincy, bereavement or counselling services.were available to support patients and their relatives.

Urgent and emergency services

- A family room was available to accommodate the relatives of patients who had been involved in traumatic incidents or the death of a family member/friend which meant that emotional support could be delivered in privacy.
- Staff were able to access support from colleagues, managers or from counselling services. Medical and nursing staff confirmed they were able to access debriefing sessions after traumatic events.

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

Good

We rated urgent and emergency services as good for being responsive.

The department had guidance for staff when dealing with surges in activity. Bed management meetings and meetings to discuss patient flow and staffing ensured capacity was monitored and managed effectively. The 4 hour wait standard was not met although it was better than the England average. The percentage of patients leaving the department before being seen was slightly higher than the England average however the re-admission rate and percentage of patients waiting 4 to12 hours before being admitted was similar to the England average.

Handovers from ambulance arrival to emergency department that take longer than 60 minutes are also referred to as 'black breaches'. The trust was not meeting this target between July 2014 and July 2015. Trust data showed there were 66 black breaches during this period but the majority were over the winter months. The trust had an ambulance liaison officer in post who was working to improve these targets.

The rapid assessment and treatment initiative (RAT) and having a second senior trainee doctor overnight had reduced the time patients waited before initial assessment. The median time to treatment was 63 minutes.

The paediatrics side of the emergency department was not as busy as the adult side. Patient flow was good and it was rare for patients not to be treated within the four hour target. However, the average time each patient spent in the emergency department was above the England average (130 to 140 minutes) for each month April 2013 to March 2015 by an average of 36 minutes.

Staff demonstrated an understanding of the need to recognise the cultural, social and religious needs of individual patients. Complaints were managed well and trends and themes were monitored and there was evidence of learning from the complaints.

However, the trust ECIST outcomes report, following a visit in June 2014, highlighted the time to mental health assessment remained a concern with 63% of patients waiting over four hours for assessment in April 2015 when the report was compiled. The trust was working with external partners providing mental health services to address this.

We also noted that the induction loop system to help hearing aid users was not working at the time of our inspection.

Service planning and delivery to meet the needs of local people

- The service provided care and treatment for patients across Blackpool and the Fylde coast. Trust data showed that during 2014/15, approximately 85,000 patients attended the emergency department.
- The Unscheduled Care Division, (the division the emergency department falls within) had an escalation policy that provided guidance for staff when dealing with surges in activity, whether planned or unplanned. Twice-daily bed management meetings and meetings to discuss patient flow and staffing took place to ensure capacity was monitored so the flow of patients to and from the emergency department could be managed effectively.
- The trust is one of the four tertiary cardiac centres in the North West, providing specialist cardiac services to heart patients from Lancashire and south Cumbria.
- Patients who required a stay in the hospital but not full admission were accommodated on the observation ward. The observation ward was led by a nursing sister and in-reach support was provided by the enhanced discharge team of physiotherapy and occupational therapy staff who provided prompt and focused care to support rapid discharge.

Meeting people's individual needs

Urgent and emergency services

- Staff demonstrated an understanding of the need to recognise the cultural, social and religious needs of individual patients. We observed a relative of a patient whose first language was not English being asked by the staff if they were satisfied for a relative to translate. Staff confirmed language skill and appropriate translation was assessed by clinical need. Staff said they had used the Language Line telephone translation service and the trust staff with language skills to help them communicate with patients.
- Staff tried to assigned children with a learning disability to a cubicle straight away as the waiting room was not an appropriate environment. Staff had a list of children who were seen regularly by the paediatrics team so they could usually transfer them quickly to a ward where their medical history and needs were known.
- An induction loop system to help hearing aid users was installed in the emergency department reception area but it was not working at the time of our inspection.
- Staff used the 'butterfly scheme' to help identify patients living with dementia or otherwise in need of memory support.
- The waiting areas were busy but were appropriate to meet the needs of the patients during this inspection as people were not left standing. We were told of plans to improve the department.
- Patients' privacy and confidentiality was compromised at times. We observed how some patients felt uncomfortable answering questions on arrival at the emergency department because staff were behind a window and other people behind them could hear what they were saying. In addition when the department became busy, the environment did not support dignified care as there were not sufficient cubicles for patients. Reception staff were able to offer patients an opportunity to move to another area for privacy.
- Information posters were displayed in the children's emergency area to help keep children safe. For example, posters gave recommendations regarding treatment for dog bites and keeping bleach out of reach.
- The Information screen in the Emergency Department was constantly updated so that patients and relatives were kept informed. It identified the staff and what their roles were, along with the waiting times.

Access and flow

- The national standard for emergency departments is to admit, transfer or discharge at least 95% of all patients within four hours of arrival. In Q2 2015/16 the 4 hour wait standard was not met at 91.8% although it was in line with the England average of 91.4%.
- Patients seen within four hours were met for the majority of weeks from April 2014 to March 2015; however, performance declined between December 2014 and March 2015. Performance was above the England average for 42 of the 52 weeks (April 2014 to March 2015).
- From June 2014 to December 2014 there were consistent breaches. From February 2015 to the time of the inspection there had been a reduction in 4 hour breaches. Senior nursing staff were aware of the reasons for the breaches, examples included unavailability of a medical bed and delays in access to the acute medical beds as discharges were happening too late in the day. Other reasons included patients waiting for mental health assessments.
- The emergency department had created a detailed action plan to improve their performance against the 4 hour standard in response to an external review. Improvements included better access to intermediate care, early supported discharges, enhancing mental health services and improving the patient flow had resulted.
- The latest figure available (July 2015) gave a Median time to treatment of 63 minutes.
- The percentage of patients leaving the department before being seen was above the England average for each month from April 2013 to February 2015. The latest HSCIC published data figure available (July 2015) showed 3.8% of attendees left before being seen compared to an England average of 2.7%.
- The latest HSCIC published data figure available (July 2015) gave a re-admission rate of 7.9% compared to an England average of 7.7%.
- In Q2 July to September 2015 the percentage of patients waiting 4 to12 hours before being admitted was around 4.3% compared to the England average of 4.5%
- The total time spent in the emergency department (average per patient) was above the England average for each month April 2013 to March 2015 by an average of 36 minutes. The England average during this period was 130 to 140 minutes.
- The department saw a high number of patients with mental health problems and it could take a lengthy time

for them to be seen by external partners however the trust was working to improve this. Patients were moved to the observation ward, where caring for them created challenges for the staff and other patients, many of whom were often older people. Some patients with mental health problems had become aggressive if kept waiting for long periods.

- The trust ECIST outcomes report following the visit in June 2014 highlighted the time to mental health assessment remained a concern with 63% of patients waiting over four hours for assessment in April 2015. The concerns have been raised with partner organisation and monthly meetings had been scheduled to help drive improvements forward. The extended waits were recorded on the risk register. The matron confirmed staff had a named contact for out of hours in the last month to escalate concerns to which things had improved.
- The paediatrics side of the emergency department was not as busy as the adult side. Patient flow was good and it was rare for patients not to be treated within the four hour target. When the target was exceeded it was usually because of delays in admission to medical wards.
- The directorate manager told us they had a specialist person to provide advice regarding the flow of patients across medicine. The discharge lounge was a permanent arrangement. The trust had created ward 19 as a short-stay ward.
- If the department was unusually busy a medical doctor would come from a ward to help assess patients.
- The DH target for handovers between ambulance and emergency department is that they must take place within 15 minutes with no patients waiting more than 30 minutes. The median time to initial assessment was worse than the national average. However, no handovers were taking longer than 30 minutes.
- Those arriving by ambulance as a priority were transferred to the resuscitation area and were assessed by a nurse. The department had consistently been around 5 minutes for their Median time to initial assessment for ambulance arrivals.
- The trust was ranked in the middle of the range of all trusts for delayed ambulance hand-overs in the 2014/15 winter period.
- We observed five ambulance handovers, one took 17 minutes and another took 34 minutes but the other three took under 15 minutes.
- Handovers from ambulance arrival to emergency department that take longer than 60 minutes are also referred to as 'black breaches'. The trust was not meeting this target between July 2014 and July 2015. Trust data showed there were 66 black breaches but 45 of them occurred between January and March 2015, the winter months.
- These 'black breaches' were mainly (39%) caused by no beds being available, with a further 19% due to no clinical assessment capacity in the department.
- The rapid assessment and treatment initiative (RAT) and having a second senior trainee doctor overnight had reduced the time patients waited before initial assessment. From December 2014 to June 2015 a 14-minute improvement had been achieved, taking the average time to treatment from 79 minutes to 65 minutes.
- Staff expressed frustration around the delays encountered when there were no bed available to move patients to and how this affected their ability to meet the targets for the department.
- Medical and nursing staff felt the difficulties moving patients through the department could be improved if care pathways were better embedded in the rest of trust.
- We saw three ambulances arrive in emergency department at the same time. The triage area was very busy but the staff appeared to manage and process the patients in a timely manner.
- We observed patients in the department that self-presented or arrived via ambulance. We saw patients were seen in a timely manner and the flow of patients was controlled and well managed by staff. There was sufficient capacity and bed space to treat the number of patients arriving in the emergency department.
- The triage area where staff made initial assessments of patients' needs had room for only two patients. Staff told us that more cubicles would help them deal with patients more effectively .
- We reviewed four records and saw that the patients were triaged by a nurse within 15 minutes of arrival but none of these patients were seen within an hour of arrival by a doctor or practitioner.

Learning from complaints and concerns

- Information was available for patients and their representatives on how to make a complaint and how to

access the patient advice and liaison service (PALS). This included contact details for an independent advocacy service. Patients we spoke with were aware of how to raise concerns with the trust.

- The trust's policy stated that once investigations were complete complainants would receive a written response, normally within 25 working days but that might be extended to 35 days if it was a complex complaint.
- An action plan was developed following the visit by the Emergency care intensive support team (ECIST). The emergency department had seen a significant reduction in complaints by 35%, comparing 2013/14 with 2014/15 data.
- There were 56 complaints relating to the emergency department between July 2014 and July 2015. We looked at five in detail. All had been responded to within the expected timeframe. The reports included information regarding lessons to be learnt. One example included the implementation of a new flowchart for patients discharged with lower limb injuries. Information showed this had been discussed at governance meetings and had been validated and ratified, which was good practice.
- Learning from complaints was shared during staff handovers or recorded on file. Complaints were an agenda item at clinical governance meetings to promote learning and improve the patient experience.
- The complaints manager for unscheduled care told us that informal and formal complaints were monitored for trends and themes. Since April 2015 themes had included communication, premises/facilities, staff attitude, and treatment issues and they had shared these results and actions being taken with staff in the department.

Are urgent and emergency services well-led?

Requires improvement

We rated urgent and emergency services as requires improvement for being well led.

The organisational vision and values had been cascaded to all staff however there was a lack of documented service level strategy although the direction of travel was planned with eight key actions highlighted by the A&E leadership team. Development of the service was apparent with the development of the paediatric area and the employment of a consultant to lead the paediatric work and development. The lead consultant and senior managers were aware of their challenges and there were escalation processes in place for dealing with additional demand including additional medical support from the wards, improved short stay arrangements to prevent lengthy admissions and investment in community care beds in winter. The department risks were monitored through the unscheduled care risk register which was up to date. These risks, incidents and performance were reviewed through the regular clinical governance meetings and appropriate actions taken.

However, the equipment concerns raised at the previous inspection had not been robustly addressed although the hospital managers took mitigating action before we left the site. There were some basic equipment shortages which were having a minimal effect on patients but are worthy of the hospitals attention.

Leadership of the service through the service manager and lead consultant had been improved through the employment of a matron with sole responsibility for the A&E department. The new matron however, had only been in post for two months. We noted that nurse appraisal rates were below the expected and the frequency of departmental meetings was very low. Although the meetings had been reintroduced it was too early to understand the efficacy of them or the Matrons role on the culture and understanding of risk and improvement in the department. However, there was a strong multidisciplinary team in the department and staff were positive and proud of the work they did.

Vision and strategy for this service

- Urgent and emergency care staff were aware of the trust's core values to engage with staff, to promote a culture that supported staff to be the best they could be and to achieve better care together for the benefit of their patients.
- The trust's priorities, outlined in their 2014/15 strategy included specific strategic objectives applicable to the urgent and emergency care services such as a focus on a community centred, proactive, continuous approach,

to minimise the demand for true urgent and emergency services across the local health economy. However there was no specific strategy for the service based on the trusts priorities.

- A trust wide strategic review was underway at the time of the re inspection.There was a current A&E strategy, developed in December 2014, which was under review at the time of the inspection. The current work underway in developing a trust wide strategy would inform the future A&E strategy.
- To ensure delivery of the shared vision, the trust had five strategic objectives: to provide a holistic model of care, to prevent unnecessary emergency admissions to hospital, to provide safe, high quality and patient-centred care , to manage services within available resources and to support and develop a skilled, motivated and flexible workforce.
- The key objectives were driven by local and national priorities and were promoted internally so that all staff were aware of the trust's focus for the future. Managers confirmed they were asked to use these key objectives when setting annual objectives for individuals and teams.
- Staff were provided with a corporate induction that included the trust's and the service's core values and objectives. The trust's vision, objectives and improvement priorities were clearly displayed throughout the department and staff could tell us what the vision and values meant for their practice.

Governance, risk management and quality measurement

- The service held regular six weekly clinical governance meetings, the agenda included the review of key risks, incidents and monitoring of the departments performance and national audit reviews
- The manager with lead responsibility for the emergency department reviewed incident reports and identified trends and themes to look for ways to improve the service.
- The unscheduled care risk register (covering the division of which the emergency department is part), included risks identified for the emergency department. Progress and improvements were monitored through a committee, and then fed back at divisional, department and clinical leaders' meetings.
- The lead consultant and senior managers were aware of their challenges; the flow of patients out of the emergency department and the changing needs of the local population, such as an ageing population; increasing numbers of people living with complex, long-term health and social care needs; rising expectations about quality of life and the range of services that are provided and increasing costs of providing care for patients.

Leadership of service

- There was a manager with lead responsibility for the emergency department. A new matron, in post for only two months, had made changes that had been of benefit to both staff and patients. There had previously been a lack of department meetings, with only two in the last 18 months.
- Band 7 staff were being sent on leadership courses and encouraged with personal development. An external company was providing some coaching.
- A directorate managers met weekly to discuss recruitment and workforce planning.
- The numbers of patients that waited longer than 4 hours to be seen, treated, transferred or discharged in the department ('breaches') was analysed daily.

Culture within the service

- Staff we spoke with told us that they enjoyed working in the emergency department despite the pressures of the workload.
- There was a strong multidisciplinary team.
- There was an open culture where staff could share concerns and participate in the solutions.

Public engagement

- The friends and family test results were monitored through the Clinical Governance meetings. The department had achieved the 20% return rate for March 2015 and as such had achieved the CQUIN target for the year.
- We observed suggestion boxes for people to complete in the waiting areas.

Staff engagement

- Staff received communications via emails, newsletters and briefing documents and senior nurses shared information with the staff teams.

- We observed information displayed on notice boards which included audit results and performance indicators to keep staff informed. In addition staff reported they could access the intranet for updates to policies and procedures and learning from incidents.
- The senior team now met fortnightly but there had been a lack of departmental meetings, with only two in the 18 months prior to our inspection.

Innovation, improvement and sustainability

- Work was being done to improve patient flow utilising flexible beds, improving discharge support and the commissioning of care beds in winter.
- The trust was working with external partners to improve referral times to mental health liaison services and to ensure community beds were used appropriately. There had been some delays related to the partner trust moving to new facilities which was improving.
- In addition work in the hospital included raising awareness around discharge by ensuring discharges did not happen too late in the day and a daily discharge review meeting had been introduced to improve planning and awareness. In addition the discharge lounge had become a permanent arrangement.
- The emergency department had had difficulties in recruiting medics and nurses. Two national recruitment campaigns held during 2014 had led to substantive appointments. Recently, an initiative had been introduced to expand posts and to develop staff, for example trainee nurse practitioners, physicians' associates and development of the pharmacists' role.

Maternity and gynaecology

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

Information about the service

The trust offered pregnant women and their families antenatal, delivery and postnatal care at Blackpool Victoria Hospital. The department delivered approximately 3,000 babies every year. A range of gynaecology services was also provided.

There was a consultant led delivery suite with 12 rooms on two parallel corridors and a dedicated operating theatre. The delivery suite was interconnected to the midwifery led Fylde Coast birth centre which had four rooms, two with pools for water births.

Ward D was a 22 bedded maternity ward with antenatal and postnatal admissions. There were six single side rooms and four bays, each with four beds. There was a transitional care unit with six en-suite rooms offering midwifery led care for mothers who were well enough to be discharged home and look after their babies but needed to stay for a short time due to the baby needing some extra care.

There was a maternity day unit, interconnected with the gynaecology unit. The antenatal unit had three single rooms. There was also an early pregnancy foetal assessment unit which provided medical and surgical management for patients experiencing miscarriages or ectopic pregnancies.

There were eight teams of community midwives, in three geographical areas. Blackpool had North, South and Central teams, Wyre had teams in Poulton, Fleetwood and Thornton and Fylde had teams in St Ann's and Kirkham.

We visited the maternity department during the announced inspection on the 21st and 22nd September 2015. During our visit we spoke with 61 staff, 18 patients and two family members. We spoke with 19 of the staff at three focus groups. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 23 patients. We also looked at 15 medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

At the last inspection areas were identified in the maternity services which were inadequate and others that required improvement and an action plan had been developed to address these which has been monitored regularly. At this inspection in September 2015 we found improvements had been made in the number of incidents being reported and the number of post-partum haemorrhages had reduced at the trust. Staffing levels in maternity services were being safely managed and a new midwifery staffing model had been introduced which had impacted positively on the department.

We found that women using maternity services had a high regard for staff and clinical teams, who were caring and treated patients with dignity and respect. There was a good incident reporting culture and systems were in place to ensure lessons were learned. Policies and procedures were up to date and in line with NICE guidance. The outcomes for patients were in line with the England average on most of the compared measures. Where they were worse this had been investigated and actions taken. There was a good system to triage patients who were admitted to the unit. Patients were offered choice of place for delivery and were included in the decision making for their care. There was good inclusion of the patients and systems for engagement with patients and staff were in place.

However, not all areas of the maternity unit or equipment met with infection prevention and control guidance. The systems for checking the maintenance of equipment and its readiness for use in an emergency were not robust. Training compliance in some key areas including skills and knowledge in emergency situations did not yet meet the trust's target.

Are maternity and gynaecology services safe?

Requires improvement

Maternity services at Blackpool Victoria hospital required improvement in terms of protecting people from harm.

There had been serious incidents but they had been fully investigated and actions taken to mitigate future risk. There was a good incident reporting culture and incidents were discussed at a weekly multidisciplinary meeting where any necessary follow-up actions were identified. However, these actions were not audited which meant the effectiveness of changes to practice was not being measured.

Safety information was used at departmental level to raise the awareness of staff to current risks. Systems for cleaning were in place and audit results suggested good compliance however we found examples of poor cleanliness where some equipment was not visibly clean and did not meet with infection prevention and control guidance. The systems for checking and servicing equipment did not provide assurance that all of the equipment was in full working order. Some emergency equipment had not been checked as frequently as expected. The trust was aware of this and were taking steps to address the compliance with checks of equipment. Training compliance rates were below the trust's targets in three key areas however they were on track to meet the target by the year end.

A new staffing model had been introduced and this had improved the number and consistency of staff available for each area of the maternity unit. Staff had good knowledge of safeguarding and a multi-disciplinary approach was established. Medicines were well managed. Records were legible and up to date, however best practice guidance for record keeping was not always adhered to. There was a good understanding of duty of candour and there was an open culture around errors.

Incidents

- There were six serious incidents during the period May 2014 and April 2015, of which three were unexpected neonatal deaths.
- We reviewed reports for the two most recent of these incidents which had been thoroughly investigated with

recommendations actioned and changes to practice put in place. However, there were no plans for follow-up audits to measure the impact of these changes, which would identify their effectiveness.

- Following the last inspection there had been a compliance action for the trust to improve incident reporting. The trust had put processes in place to address this and increase incident reporting.
- Staff knew how to report incidents on the electronic system and gave examples of changes to practice following incident investigations, for example the introduction of postnatal cards providing delivery suite contact details for women who had recently given birth. These were introduced following a complication experienced by one new mother who attended accident and emergency.
- There was a trigger list which identified when to report an incident. Staff were aware of this and used it to identify incidents to report.
- Staff received individual feedback, by e-mail from incidents they had reported. These were also discussed at local monthly team meetings when learning and changes in practice were discussed.
- Incidents were discussed at an open forum every Thursday and attendance records between April 2015 and July 2015 showed good representation by different grades of staff from various disciplines. Staff were also invited to attend when an incident they had submitted, or an incident involving their patient was due to be discussed.
- Outcome actions from the incidents were discussed and documented at the Thursday meetings, however specific, measurable, achievable, realistic and timely (smart) principles were not always followed, for example where a staff error had occurred some outcome actions were that "staff were reminded to follow the policy" or the "correct process was reiterated to staff". Where these actions had been taken there was no evidence that follow-up reviews or audits were planned to ensure the reminders had been effective and the same errors were not recurring.
- A scoring system of one to five was used to identify the level of risk for incidents, with 'one' classified as an insignificant risk, and 'five' being catastrophic. Incidents with a score of three (moderate risk) or above were allocated to a case review team for investigation and completion of a route cause analysis where appropriate. Senior staff described an open door policy with the director of nursing and they could go and discuss more serious incidents with a score of four or five when they needed to.
- The Supervisors of Midwives followed up incidents with individual midwives and held quarterly meetings attended by the clinical governance and quality manager who advised on the correct processes to be followed.
- There were monthly community midwife meetings where any new policies were discussed, along with other governance matters including incidents and actions. We saw the minutes from the September 2015 meeting. Minutes were circulated by email.
- Staff at different grades were aware of Duty of Candour and there was a Patient Safety Including Being Open and Duty of Candour Policy in place.

Safety thermometer

- The Maternity Safety Thermometer measures harm from Perineal and/or Abdominal Trauma, Post-Partum Haemorrhage, Infection, Separation from Baby and Psychological Safety. In addition, those babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a Neonatal Unit are identified. This is a point of care survey that is carried out on one day per month in each maternity service on all postnatal mothers and babies who consent to take part. Data provides a 'temperature check' on harm that can be used alongside other measures of harm to measure progress in providing a care environment free of harm for patients.

- Between February 2015 and October 2015 the proportion of women who had a maternal infection ranged between 12 and three per cent. Data showing the proportion of women who had a 3rd/4th degree perineal trauma was available between November 2014 and August 2015 and ranged between two and six per cent. The proportion of women who had a PPH of more than 1000mls was 17 per cent in January 2015 but has been consistently lower since then, dropping to four per cent in June 2015.

- There was little data available for the proportion of term babies with an Apgar score less than seven at five minutes but the four data points showed a range between 3 and 9% since February 2015. The proportion of women who were left alone at a time that worried

them was usually around 5% but reached 12% in May 2015. There were only two months data for the proportion of women with concerns about safety during labour and birth not taken seriously, with the most recent result showing zero proportion.

- Midwives collected maternity safety thermometer data on the last Wednesday of every month.
- Community midwives had not seen the results of their submissions for the last few months. This meant the information collected was not being used to inform midwives about their performance in delivering harm free care.
- The manager on Ward D had a comprehensive understanding of the safety thermometer programme and the results. There were plans to display the results on their 'knowing how we are doing' board in the future, however this was not yet in place.
- A safety cross is a visual data collection tool in the form of a one-month colour-coded calendar that notes daily safety incidents. The 'knowing how we are doing' information board on Ward D displayed safety crosses for medication errors, incidents, hand hygiene and information governance audit results so it was easy to see on which days of the month these had occurred. There were certificates which showed compliance with the annual health check and data protection requirements. There was no explanation of this information for patients or visitors.

Cleanliness, infection control and hygiene

- A cleaning regime was in place on the wards and in theatres and monthly results for May 2015 through to August 2015 showed a compliance rate of between 99.2% and 100% for all areas.
- However, some blood spots were seen on the foetal blood sampling machine and in the top drawer of the instrument trolley on delivery suite and in one of the bathrooms on Ward D. This meant these areas had not been adequately cleaned. When we informed staff they were cleaned immediately.
- There were patches of mould in several of the bathrooms on Ward D which staff had reported to estates. These had also been noted by three of the women we spoke to. One of the women said she had not been able to use the bathroom in her room as there was a drain smell which she had reported to staff but she was told it could not be fixed. Refurbishment of these bathrooms was planned for 2016/17 with some immediate work for improvement completed following the inspection.
- The drugs trolley in the office on Ward D was dusty, as was the foetal blood sampling machine in the delivery suite. This showed these areas had not been adequately cleaned.
- Three of the four sharps bins in the clean utility room on Ward D had not been signed and dated when they were set up. One had a pair of scissors sticking out of it due to it being overfilled. This presented a risk of harm to staff, patients and visitors and meant the guidelines for safe use of sharps boxes were not being followed.
- Hand gel was available in all the areas we visited. We saw staff using the gel.
- There was a hand hygiene champion on Ward D who carried out monthly covert audits on staff following the five moment's technique for hand hygiene at the point of care. The results of this audit were displayed on the 'knowing how we are doing' board. When the score dropped below green for full compliance follow-up actions were taken with the relevant staff group to address any identified issues, for example the healthcare assistants had scored amber in the current audit so this was discussed at the team meeting.
- There were four single rooms on Ward D, one with an en-suite bathroom and one next to a toilet. When isolation facilities were required one of these two rooms were used and other patients would use separate toilet facilities to avoid cross-contamination.

Environment and equipment

- The emergency trolley on the delivery suite had a checklist attached. This had not been signed daily to indicate the contents had been checked which could mean all of the equipment required in an obstetric emergency, such as eclampsia, may not be readily available. Staff told us the checklist was not completed on days when then trolley was sealed, however the trust policy requires daily checks of the intact coded seal with a name and signature recorded.
- The resuscitation trolleys on Ward D were checked daily against a checklist and signatures were recorded to indicate these checks had been fully completed daily. However, in one trolley we found out of date equipment and an infusion set with damaged packaging. This meant the system for checking equipment was not

robust and the equipment was not adequately checked to ensure it was safe for use. This was brought to the attention of the ward manager and immediately rectified during the inspection.

- In one room on the delivery suite the resuscitaire had a "Daily room check" record present. This had not been signed or dated for two of the previous seven days. This meant the system in place for checking equipment was not being used in practice.
- The rooms on delivery suite were not all fully equipped. We were unable to look in occupied rooms however in the room we looked in there was no hand-held Doppler (Sonicaid) or Pinard stethoscope used for listening to a baby's heartbeat and no Cardiotocography (CTG) which measures a baby's heart rate. Staff had to fetch equipment from the store room when they needed it, including the foetal scalp electrode (FSE) used to monitor foetal heart rate. This may cause a delay in the assessment of foetal wellbeing.
- The fridge and steriliser on Ward D had a daily checking sheet but had not been checked between 10th September and 13th September 2015. This meant the system for checking this equipment was in good working order was not robust.
- The blood gas machine was in the sluice room on the delivery suite. This meant blood samples were being handled in an unclean environment.
- Portable appliance testing (PAT) is the examination of electrical appliances and equipment to ensure they are safe to use. There were no clear systems in place to ensure that electrical equipment such as monitors and Resuscitaires were regularly tested and serviced. We raised this with the trust who reported that all equipment had been maintained correctly by the manufacturers but that paper labels with this information on had been removed or worn off over time. We were told that the medical engineering team were compiling a report of all pieces of equipment that had recently been back to manufacturers so they could be labelled correctly with service dates, this was supported by a confirmation of completion post inspection from the trust.
- There was a system in place with an external company to calibrate the weighing scales in the maternity department and in community clinics. The calibration certificates were registered on an online system rather than with labels on the equipment. The trust reported that these were up to date.
- Although the required equipment was available to evacuate a patient from the birthing pool in an emergency this was not stored so as to be immediately accessible. Staff were not aware exactly where it was located.
- There was a clean goods store where equipment was kept. This was visibly clean, tidy and well stocked.

Medicines

- On Ward D there was a clean utility room where drugs were stored. Controlled drugs were stored appropriately and the keys for the controlled drugs cabinet were held by the shift leader who was supernumerary where possible.
- On Ward D and on the delivery suite drugs were stored in refrigerators where appropriate, and these were visibly clean.
- 15 drugs charts we reviewed on Ward D all were appropriately completed.
- Staff were able to articulate the correct controlled drugs administration procedures and what action to take when an error was discovered.
- On Ward D there was a 'hypo box' stocked with equipment to treat hypoglycaemia including lucozade, biscuits and dextrogel. The glucagon pack and IV glucose were stored in a locked fridge which could cause a time delay if it was needed for an unconscious patient although we had no evidence of such an incident.
- The transitional care unit had introduced new lockable medication boxes in the rooms to allow the women to manage their own medication in preparation for going home.

Records

- We reviewed a total of 18 care records, including antenatal, postnatal and surgical records.
- In 10 patient records reviewed there were two in which the foetal monitoring records had not been signed or dated. This meant good practice guidance for record keeping was not met on these occasions.
- Antenatal patient information was recorded electronically and women also had some handheld notes which contained information such as recent blood test results and scan information which would be required if they attended another hospital.

- Antenatal test results were in the notes in specific places, with specialised information such as diabetic blood sugar tests easily identifiable.
- We looked at eight sets of records on Ward D and found them to be legible with comprehensive risk assessments and clear plans around birth and postnatal care.
- Five venous thromboembolism (VTE) forms were reviewed and all were correctly completed.
- We looked at a number of other patient records and found them to be clear and appropriate but not always filed in chronological order which meant that it could take some time to find the most up to date information.
- We looked at a record for the wound care pathway where good practice had been followed, with input from the tissue viability nurse.
- When care was transferred between consultants it was not always clear from the notes who was the lead consultant for the patient. Staff said that if they needed advice for a patient they would contact the consultant on call and they received a timely response.
- Handover documentation included situation, background, assessment, recommendation (SBAR) charts which were all completed in the notes. This meant appropriate information was transferred with the patient.
- Personalised birth plans were present in the records where appropriate.

Safeguarding

- The training report provided by the trust for September 2015 showed 76% of midwives were up to date with safeguarding training to level 3. The projection was that 100% would be trained in the current year. We did not have data regarding the number of doctors trained to level 3.
- Staff had good knowledge of potential safeguarding concerns and were experienced with dealing with vulnerable families, for example babies who were being placed in foster care. They were able to give examples of recent cases and how these were managed such as multi-disciplinary, discharge planning meetings.
- Next to the delivery suite was the Victoria Centre, a multi-agency safeguarding unit with input from different services including the police. Maternity staff had close links with this unit.
- There was a safeguarding midwife on call and the option to refer to the complex cases team where appropriate.
- We reviewed safeguarding paperwork and found management plans were well documented.
- Staff were aware of female genital mutilation and of how to identify and report any concerns they may have.
- Community midwives had lone worker devices which were electronic buttons on their badges. When they arrived on a visit they pressed a small button which would pinpoint their location for the security team monitoring their whereabouts. Should an incident or threat occur, staff pressed a large button on their ID badge which triggered an alarm with the security company. The alarm was also triggered if the badge was pulled off.
- Babies did not wear security tags, however there were locked doors on the delivery suite and maternity unit, with cameras in situ at points of entry. There had been no incidents reported or complaints made to suggest this placed babies at risk.

Mandatory training

- Across the families division there was over 80% compliance with most mandatory training. This did not yet meet with the trust's target of 90% however they were on track to meet the target by the year end.
- 73.2% of nursing and midwifery staff were up to date with basic life support training. This meant some staff may not have the knowledge and skills required to assist patients in an emergency situation.
- 61% of nursing and midwifery staff had completed up to date training in the safe administration of blood transfusions. Staff told us that there was a practical competence element to this training which could only be completed when they administered a blood transfusion which was the reason compliance with this training was low. However this meant staff may not be competent to safely administer a blood transfusion.
- CTG training compliance was flagging as 'red' (high risk) on the projection, with 61% compliance for midwives and 64% for doctors. This had been identified by the trust however the action plan stated there would be "more robust encouragement of CTG updates." This did not present a clear plan of how the target of 80% would be reached.

Assessing and responding to patient risk

- In the records we saw on Ward D, Modified Early Obstetric Warning Scores (MEOWS) were completed and appropriate action was taken when this indicated a patient was at high risk.
- Up to date risk assessments, for example safeguarding and diabetes care, were completed antenatally in the records that we checked and were discussed at handover and safety huddles.
- The World Health Organisation (WHO) checklist was completed and documented on a board in theatre. We saw these records were kept in the notes of patients who had a Caesarean section.
- Spot checks of the WHO checklists had taken place in May and August 2015. This showed 100% compliance in three of the four areas audited with 87.5% compliance for the sign in completion. Actions resulting from this consisted of identification of "focus areas" rather than a measurable action plan.
- Situation, background, assessment, recommendation (SBAR) is a structured method for communicating important information. An SBAR handover was completed in theatre which meant the transfer of care for a patient between the ward and theatre areas was recorded and discussed.
- We observed a safety huddle at 8.45 am. The anaesthetic consultant and registrar reviewed the patient status with the obstetric team before proceeding with the theatre list.
- Clinical observations for women who had had Caesarean sections were recorded on a portable electronic data pack which could be taken from the monitor in theatre and inserted into the monitor in delivery suite, allowing different staff access to the information and enhancing continuity of care.
- Women who needed high dependency care, for example ventilation, were transferred to the intensive therapy unit.
- Cell salvage was used in theatre. This is a medical procedure involving recovering blood lost during surgery and re-infusing it into the patient. This reduced the need for blood transfusions.
- When babies were transferred from delivery suite to the neonatal unit a public lift was used. This meant there could be a delay in transferring a new-born to the unit in an emergency.

Midwifery staffing

- Since the last inspection there had been a review of midwifery staffing across the different teams. This had resulted in the introduction of a new midwifery staffing model in July 2015. Within this model staff were allocated to either the inpatient or community teams. This meant the delivery suite and birthing centre was staffed by a dedicated team of midwives (intrapartum team) and the community midwives were no longer responsible to attend births in the birthing centre. Staff felt this was a positive change which had resulted in improved continuity of care for patients.
- Establishment figures had been assessed using birth rate plus and were always set at 3 midwives and two support workers for the early and late shifts on Ward D, with two midwives and two support workers for night shifts. The maximum number of patients on this ward was 22 which meant this met the safer staffing in childbirth standards.
- Additional health care assistants and midwifery support workers had been employed. Their roles had been clarified and two development days to offer support and guidance had taken place. This meant some of the tasks previously undertaken by qualified midwives were now completed by these support workers, releasing more time for clinical care by the midwives.
- The ratio of all midwifery staff to births was in the range 1:28 to 1:30 between October 2013 and May 2015. This was slightly worse than the England average which had reduced from 1:30 to 1:27 over the same period. The midwifery staffing changes to improve this ratio had taken place after this date and these were due to be reviewed after three months.
- There were seven midwives on duty as the intrapartum team from 10.00am to midnight on weekdays and 11.00am to 7.00pm at weekends in the delivery suite. There was always one supernumerary band 7 on duty in the delivery suite and an extra senior midwife (band 6) between 4pm and midnight allocated to triage.
- The intrapartum team included a mix of experienced and newer midwives. It was managed by the intrapartum manager who was both a senior midwife and a nurse.
- Staff from the intrapartum team worked in the birth centre and the delivery suite, and helped on Ward D if the delivery suite was not busy. At morning handover the status of the patients was discussed and staff were allocated to either the birth centre or the delivery suite dependant on patients' needs at that time.

- Shift handovers took place at 7.30am, 1.00pm and 8.45pm. At this time staff discussed the management needs for the patients and any potential admissions to the unit.
- There was a safety huddle at 8.30am and 3.30pm every day where patient status was discussed. An extra huddle took place at 12.00pm when necessary. As a result of this staff would move between the areas to ensure staffing levels were kept adequate.
- There was a white board on Ward D with a traffic light system indicating which patients were due to be discharged home. The ward manager and the team leader reviewed the board every morning and planning for bed management took place.
- The electronic system was used to monitor staffing levels in the maternity unit. There were criteria to measure the level of need for each patient and staff numbers were entered at the end of each shift. Every 24 hours a work flow activity was completed which monitored admissions, discharges, transfers and ward attenders. Other ward activity was also monitored, including time spent escorting patients and on safeguarding. This information was analysed and the red flag system was used which identified when the needs of patients meant staff levels were not adequate. This meant they were following the recommendations of the National Institute for Clinical Excellence (NICE) guidance "Safe midwifery staffing for maternity settings".
- If there was a shortage of midwives in the hospital, the escalation policy meant that community midwives were called in to help out. The on call community midwives were asked first. The intrapartum team at the hospital ensured the community midwives worked in an area appropriate to their competencies and if necessary would move people around to accommodate this.
- Midwives said they did their best to deliver one to one care during labour and would always stay with a patient during birth.
- Staff felt that pressures on midwife numbers had eased with the introduction of the new model. Five new band five midwives had been recruited and were starting in September. Recruitment was underway for a further 2.4 whole time equivalent midwifery support workers.
- There was a discharge planning facilitator Monday to Friday 9.00am to 5.00pm. This staff member had been in post since August 2015 and carried out the administration duties for safe discharge many of which had been completed by midwives previously. This was seen as a positive development by the staff.
- Registered nurses assisted in obstetric surgical procedures and an extra midwife was on duty between 10.00am and 6.00pm to deliver care to the babies.
- Operating department practitioners were available at night to help with recovery but out of hours the midwives had to undertake the role of nurses assisting in theatre. When this occurred this midwife was no longer available to work on the delivery suite.
- The e-rostering systems automatically identified if there was a shortage of maternity support assistants on any shift. These were then filled by internal bank (bench) staff which meant there was continuity of staff to fill these gaps.
- Community midwives had the option of joining the intrapartum team for a period of time. This was intended to enable the teams to work together, rather than in isolation, and would enable the community midwives to increase their skill level for less straightforward births occurring in the hospital rather than at home. At the time of our inspection this option had not yet been taken up by any of the staff we spoke to; however a focus group for community midwives to discuss their involvement with the intrapartum team was in the planning stage.
- There were no vacancies in the community teams.
- Full time community midwives had caseloads of 90-100 defined by geographical areas of the patients' GPs. Previously, community midwives were responsible for staffing the birth centre at the hospital but the introduction of the new midwifery model meant this was now undertaken by the intrapartum team, allowing community midwives more time with their patients. It had improved continuity of care and clinics were covered by the named midwife, rather than whoever was available. All midwifery staff we spoke with at the hospital and in the community were positive about the new model and felt that it had eased pressure on their workload and increased staff morale.

Medical staffing

- There were 60 hours per week consultant cover for the maternity services which met national guidance for the number of births at the unit.

Maternity and gynaecology

- There were seven obstetric and gynaecology consultants employed by the trust and one locum consultant. There were plans to increase the numbers to eight full time consultants employed by the trust.
- There were 7.6 whole time equivalent middle grade doctors which was equivalent to the England average. One of these doctors was a locum, however they worked for the trust on a long term basis which meant the locum cover was consistent.
- There was a consultant who was allocated to be on call for the week and they were in the hospital from 8.00am to 6.00pm Monday to Friday and for five hours on Saturdays and Sundays. They were available to attend if required the rest of the time. 24 cover was provided by a middle grade doctor who had access to the consultant on call should they be required. The doctors we spoke with said the current system worked well and all felt supported by their colleagues.
- The anaesthetist on call out of hours could also be required as a second anaesthetist for the cardiac unit. There was a standard operating procedure in place for this which included the obstetric and gynaecology department always taking priority. This use of the anaesthetist was monitored and it had occurred once or twice per month on average and had never caused a delay for the delivery suite. A third anaesthetist was on call and would attend to relieve the obstetric anaesthetist as soon as possible should they be required.
- Doctors had handover with the shift lead at 8.00am, 1.00pm and 9.00pm. At 8.00am handover on the delivery suite they reviewed the operating list for the day to make sure they had all necessary equipment available.
- There was a consultant ward round seven days per week on both the delivery suite and Ward D between 9.30am and 10.00am where discharges were agreed.
- An electronic handover was updated at 8.00am, 1.00pm, 5.00pm and 9.00pm for gynaecology patients. This was password protected and saved so that it could be referred to again when necessary, for example junior doctors could look back to see what had happened with their patients. Management of patients was discussed with both consultants present and we saw the management plan for one patient being changed by the consultant with a full explanation of why, and some teaching provided as to the reasons for the change.
- A consultant paediatrician reviewed babies on the transitional care unit every day.

Major incident awareness and training

- There was limited staff awareness of major incident or business continuity plans. The staff we spoke with were not able to provide examples of actions to take should a major incident occur.
- In practice, however, there had recently been an incident where local drinking water could not be used without boiling due to contamination. As well as impacting on the availability of drinking water this also affected use of the birthing pools. The situation had been managed well, with very little disruption for patients.

Are maternity and gynaecology services effective?

Good

Maternity services at Blackpool Victoria hospital were good in terms of being effective, an improvement from the inadequate rating in April 2014.

The outcomes for patients were in line with the England average on most of the compared measures. Where they were worse this had been investigated and actions taken, for example with post-partum haemorrhage. The policies and procedures reflected national guidance, were up to date and available for staff. Support to encourage and assist breast feeding included the use of star buddies who were well regarded by patients and staff alike.

There were good examples of multi-disciplinary working between all professionals. There were some services available at the weekends including scanning on Sunday mornings in the early pregnancy unit. There was sufficient medical cover including out of hours. Doctors and midwives had access to the information they required and all staff had an understanding of the Mental Capacity Act and how it may affect their work.

However, pain scores were not always recorded. Appraisal rates were lower than expected across the families division although the data could not be disaggregated to midwives it suggested that uptake by midwives was lower than expected. There was an audit programme in place; however the summary report provided by the trust was unclear, with some key dates and actions incomplete and follow up review was not clearly demonstrated.

Maternity and gynaecology

Evidence-based care and treatment

- The antenatal, Caesarean section and postnatal care policies and practices were in line with the relevant NICE guidance.
- Policies and procedures for the management of post-partum haemorrhage were in line with national guidance. The antenatal guideline was updated following the Royal College of Obstetrics and Gynaecology (RCOG) review in April 2014.
- It was documented in the risk governance group minutes of July 2015 that policies were to be reviewed to ensure they were in line with updated antenatal care guidance and NICE pre-term labour guidance. Information provided by the trust showed that this was on-going.
- Proformas for specific emergency procedures such as post-partum haemorrhage, pre-eclampsia and shoulder dystocia were available for staff reference in the patient treatment rooms. Those we saw were up to date with the latest guidance.
- Policies were stored electronically.
- The assessment of CTG met with best practice guidance from the Royal College of Midwives in that they were assessed hourly using 'fresh eyes' stickers. 'Fresh eyes' means another midwife views the heart-rate trace of the unborn baby on an hourly basis which means that any potential changes are more likely to be identified.
- The antenatal pathway had been revised to formalise the identification of vulnerable women and provide clarity on when to refer to the complex social needs team. The new pathway was taken through maternity services liaison for women to check that they were happy with the content. It was cascaded to staff through the weekly brief.
- There was a new stillbirth policy which was part of the new integrated pathway adopted across the North West. There was a separate pathway for the loss of a baby at less than 24 week gestation, and for 16 weeks and under there was a pathway which nurses and midwives could use to navigate bereavement management if the bereavement nurse was not available.

Pain relief

- Of the ten sets of records we reviewed, pain scores were not recorded in five. This meant patients were not consistently having their level of pain documented and the effectiveness of pain relief was not monitored.
- One patient we spoke to was given effective analgesia when in pain and was given an epidural when she requested it without delay.
- Staff reported administration of epidural pain relief began within 30 minutes of request. This was confirmed via audit results which showed 89% of women received pain relief within 30 minutes, from 1 June 2014 to 8 July 2015.This exceeded the Royal College of Anaesthetists. Raising the standard 3rd edition 2012 standard that at least 80% of women attended by anaesthetist within 30 minutes of requesting labour regional analgesia.
- Entonox (pain relieving medical gas) was available in the delivery rooms.
- There was a consultant who specialised in pain relief and provided weekly clinics and support for patients with complex pain management needs.

Nutrition and hydration

- The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. Blackpool community services were accredited as baby friendly through this initiative.
- The trust had achieved Baby Friendly status level three. Stage three was the final stage of assessing the implementation of the baby friendly standards. This was part of the United Nations International Children's Emergency Fund of the United Kingdom (UNICEF UK) baby friendly initiative and the assessment was carried out in May 2014. The initiative worked to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.
- Information provided by the trust showed the target they had set for initiating breast feeding within 48 hours of birth had only been met twice in the previous 15 months. Staff were aware of this and an action plan was in place which included infant feeding workshops for mothers and training for midwives. .
- There was a network of experienced breast feeding mothers called star buddies, who provided support to new mothers wanting to breastfeed. The star buddies were mostly volunteers and attended antenatal classes to provide information and advice, as well as meeting women on the maternity ward. They worked on a rota system and covered seven days and five nights of the week.

- Information with details of breast feeding groups held across the community was provided to patients on discharge.
- Patients we spoke with had received support on the ward and were aware of how to express and store breast milk safely.
- Bottled milk for babies was stored in a designated milk kitchen, with several varieties available. All were in date.
- There was information on display for women who were supplementing breastfeeding with formula milk.
- Sterilisers and breast pump kits were available for women to use.
- Patients had access to food and drink. Mothers in labour had their fluid balance monitored and this was recorded on the Partogram documentation.

Patient outcomes

- At the time of the last inspection there were concerns that the post-partum haemorrhage rate was higher than expected. Following that inspection in April 2014 RCOG undertook a review of 31 sets of case notes. The review concluded there were no serious problems within the unit however some recommendations to changes in practice were made. At the time of this inspection those recommendations had been actioned and the post-partum haemorrhage (PPH) rates had remained within the trust's target in the past 15 months.
- In September 2014 the trust had completed a review of 23 PPH cases and an audit of a further 43 cases was completed in March 2015. An action plan was in place with plans to re-audit cases of PPH above 1000mls annually and review PPH cases of above 2000mls on an on-going basis.
- Audits had been completed to measure compliance against a range of trust policies and national guidelines including for Induction of labour, Consultant involvement in the intrapartum care of women, Caesarean sections and Operative vaginal births. Action plans were in place and set out with re-auditing plans on the Monitoring and Performance Dashboard – Quality Improvement Action Plan 14/15 (updated August 2015).
- There was a wider audit programme in place however the summary report provided by the trust was unclear, with some key dates and information about actions incomplete.
- The most recent NHS Maternity Statistics published by the Health and Social Care Information Centre (HSCIC) showed that 25% of women who gave birth in England underwent induction of labour between April 2013 and March 2014. Information provided by the trust showed induction rates had been above this national average and the trust's target of less than 25% of total births in 11 of the last 15 months. It rated as high risk of over 30% in six of these months. An audit showed a multifactorial related rise in the incidence of induction of labour without significant rise in other maternity process indicators (e.g. Caesarean section rate, PPH). Outcomes for the women who had been induced were good.
- The trust was in line with the England average for incidences of puerperal sepsis.
- There had been no stillbirths for six of the eight months from April to November 2015. In the remaining two months one had been within the trusts' target of two and one had been above.
- The modes of delivery including elective and emergency Caesarean sections had been in line with the trust's own targets for nine of the past 15 months.
- The incidence of 3rd and 4th degree tears was below the trusts' target of 4% of births in 10 of the past 12 months. Where it had not been met it was slightly above the target at 4.3%.
- The trust confirmed that it achieved four of the five standards in the National Neonatal Audit Programme 2014 due to be published in October 2015, the exception being that 100% of eligible babies should receive 1st retinopathy of prematurity screening in accordance with guideline recommendations.

Competent staff

- New midwives joined the trust on a preceptorship programme. They attended trust induction, received an induction pack and attended an introductory meeting with a Supervisor of Midwives within their first week.
- Community midwives received community based training including a 'normal births' study day.
- Skills and drills training for midwives included competency assessments for breech births, shoulder dystocia and growth surveillance. Study days provided by the trust included suturing and water birth courses.
- Changes had been made to the programme for junior doctors to hold the drills sessions during their induction period which had significantly increased compliance with training. Areas covered included sepsis, obstetric haemorrhage and pre-eclampsia.

Maternity and gynaecology

- In September 2015 the training projection for the year showed there would be 100% compliance with the five multi-disciplinary drills days for midwives, health care assistants, maternity support workers and doctors. Safeguarding level 3 training was also on course to reach 100% compliance.
- Neonatal updates were projected at 86% compliance for midwives and below target for health care workers and maternity support workers at 74%.
- Information provided by the trust showed 51% of nursing and midwifery registered staff in the families division were up to date with their annual appraisals. The trust could not disaggregate this information to midwives so we were unable to ascertain how many midwives had not had their performance, knowledge and skills assessed and discussed with their line managers.
- Midwives received annual supervision from their supervisor of midwives but had 24 hour access to a supervisor via a bleep holder at the hospital should they required it. The role of the supervisor is to protect the public through monitoring the practices of midwives to ensure the mothers and babies receive good quality safe care. The ratio of supervisor to midwife ratio was 1:11 which was better than the recommendation of 1:15The bereavement nurse received external supervision from Cruse bereavement care to ensure her wellbeing was monitored
- Supervisor training was available to midwives, as well as continuing professional development (CPD) courses at the University of Central Lancashire.
- Following their induction training, junior doctors had an induction appraisal with their educational supervisor and their competency was assessed against a training matrix which was recorded individually online.
- All junior doctors had an annual record of clinical progression. Consultants monitored competencies and discussed trainee progression at monthly meetings.
- A 'vulnerability' study day was delivered to all midwives by the complex social needs team. This was also open to obstetricians.
- Ad hoc training drills were facilitated by the trust, with no prior warning for staff. A recent example of this was an emergency buzzer had sounded during a quiet time on the delivery suite, and staff took part in a drill to rescue someone from the birthing pool using a net.
- Four midwives had attended external training on emergency procedures which may occur in the community and had shared what they learned with team members.
- Midwives had the opportunity to undergo 'examination of the new-born' training by enrolling on a module at the University of Central Lancashire. This examination is usually completed by a paediatrician so having midwives available who could undertake this meant some women were able to be discharged from the ward earlier, without having to wait for a paediatrician.
- There was a trust bereavement nurse who liaised with the Coroner to ensure the appropriate language was used when dealing with bereaved parents. She coordinated meetings between the different staff involved when a baby died, including pathology, obstetrics and paediatrics. Bereaved parents were offered a meeting to discuss their baby's death, at a time chosen by them.
- Training for midwives who may need to assist in theatre was on-going as part of the progression from a band 5 to a band 6. This included undertaking training in the main theatres for one week and a comprehensive competence assessment if not carrying this out for some time.
- The trust has developed a socially complex pregnancy team, led by a consultant obstetrician. Specialist midwives in this team included substance misuse, perinatal mental health, homelessness, non-English speaking, teenage pregnancy, travellers and Safeguarding. There was a pathway in place for referral to this team when appropriate

Multidisciplinary working

- The maternity and gynaecology services at Blackpool Victoria hospital were part of the families division. This promoted close links with the other teams involved in women and children's health including health visitors, school nurses and the paediatric and adolescent inpatient wards.
- We observed excellent multi-disciplinary working which included the development of clear plans of care for patients with complex health needs. We saw the lead midwife for diabetes explain clearly to several other midwives about a new plan of care for one patient with gestational diabetes.
- Midwives and doctors reported excellent working relationships between the two disciplines. Doctors

particularly praised the way the head of midwifery communicated between the two teams. Both said they were confident to raise concerns about care or procedures within the service and worked together to achieve positive changes in practice, such as those resulting from the RCOG report.

- The bereavement nurse had close links with SANDS (stillbirth and neonatal death society) and offered help with funeral arrangements, remembrance services and worked closely with the mortuary and three local councils who offered free cremation services.
- If patients required interventional radiology they would be referred to St Mary's in Manchester as this was not available on site at Blackpool. This policy was developed as part of the action plan following the RCOG review into the care of patients at high risk of post-partum haemorrhage however we had no examples of this in practice.

Seven-day services

- The obstetric consultant on call was present in the hospital for at least five hours on Saturdays and Sundays.
- At weekends there were four midwives on call in the community but no clinics. The birth centre at the hospital was where discharges were reviewed and home visits were scheduled at weekends.
- On Ward D there was no discharge facilitator at weekends and no elective Caesarean sections.
- Pharmacy services were available seven days a week.
- New-born blood spot screening tests were carried out by community midwives at weekends to ensure they were completed within the required timescale of within five days of birth.
- The early pregnancy unit offered scanning between 9.00am and 4.00pm Monday to Friday for patients suffering potential miscarriages, and on Sunday mornings when it was also available for emergency gynaecology patients. No scanning was available in the unit on Saturdays. Should these be required they would be arranged through the emergency department.
- A community mental health crisis team which could be accessed by all patients with mental health problems was based in accident and emergency and was available through a single point of access referral 24 hours a day, 7 days a week.

Access to information

- There were paper based and electronic systems in place for patient care records. Patients had their own hand held paper records and electronic ante-natal records. Paper records were kept for details of treatment and care during admission.
- Information was accessible to staff and there were systems in place to make particular sections of the paper notes easily identifiable, for example purple coloured notes signified to staff that there was a safeguarding concern.
- Copies of safeguarding plans were kept on the ward to ensure that midwives had access to them and were familiar with them.
- Staff told us they had to rely on the hand held notes for patients who were visiting Blackpool on holiday and presented at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Five sets of notes were reviewed for patients who had undergone a Caesarean section. Consent documentation was correctly completed, with risks explained, and the forms were signed and dated.
- There was a trust mental capacity act implementation lead who facilitated assessments around mental capacity.
- 96.58% of nursing and midwifery staff in the families division had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are maternity and gynaecology services caring?

Good

The maternity services were good in terms of caring.

The feedback from patients and their families was positive in terms of the caring, patient and supportive attitude of the maternity services staff. Privacy and dignity of the patients was respected by staff. Patients and their families told us how they had been involved in making decisions about their own care and given clear information throughout their pregnancy and following delivery.

The Friends and Family Test (FFT) survey in August 2015 showed 100% of patients' responses recommended the antenatal services in the hospital and in the community to

friends and family. Results received for the labour ward and birthing unit were 97% positive and the inpatient ward was recommended by 87% of patients who completed the test. Community postnatal care received 100% positive responses.

Healthwatch Blackpool published a Maternity Consumer Review in July 2015 in which 84% of respondents reported a very good or good overall experience and there were no major concerns highlighted.

There was good support for bereaved parents with access to a specialist bereavement nurse when required. There were other specialist midwives who offered additional emotional support to patients and guidance to staff.

Compassionate care

- Patients we spoke with said staff were kind, patient and caring.
- Women told us they were not left alone during labour and that continuity of care by midwives in hospital was good, with "great support" offered.
- The Friends and Family Test (FFT) is a survey which gives patients an opportunity to give feedback on the quality of the care they receive. In August 2015, 100% of patients' responses recommended the antenatal services in the hospital and in the community to friends and family if they needed similar care or treatment. Results received for the labour ward and birthing unit were 97% positive and the inpatient ward was recommended by 87% of patients who completed the test. Community postnatal care received 100% positive responses.
- The percentage recommended for the Postnatal Ward element of the Maternity FFT fell over time (March 2014 to February 2015), and was below the England average for ten consecutive months to February 2015. It has since improved each month to June 2015, when the percentage recommended was 96% (above the England average).
- Healthwatch Blackpool published a Maternity Consumer Review in July 2015 in which 84% of respondents reported a very good or good overall experience and there were no major concerns highlighted. 90% felt that having a named midwife was important, yet only 44% reported seeing their named midwife consistently throughout their pregnancy. The new midwifery model has been introduced since this report to improve continuity of care in the community. 73% did not know there was a choice of where their antenatal appointment could be held. 27% of new Mums felt they were in hospital too long.

Understanding and involvement of patients and those close to them

- The patients we spoke to were positive about the service and felt well informed and involved in their care. Staff introduced themselves the majority of the time and any concerns were listened to and taken seriously.
- Partners of women in labour were able stay on the delivery suite for the duration of the labour. In the birth centre women tended to go straight home rather than being admitted to the maternity ward and partners were welcome to be present.
- Patients told us they were given choices and were involved in planning their births.
- Where a patient wanted a home birth but had risk factors such as high BMI or a previous Caesarean Section delivery she would be referred to the consultant to discuss options.
- The women we spoke to had talked with doctors about their experiences, what had happened and why, were given the opportunity to ask questions and felt supported to ask further questions later if required.

Emotional support

- Good practice was observed when a patient who requested personal information was taken into a side room by a member of staff, ensuring privacy.
- There was a birth 'afterthoughts' service where women who had given birth could submit feedback about their experiences.
- There was a bereavement nurse with mental health experience who took referrals from maternity services when there was a stillbirth or unexpected death. She offered bereavement support across the trust.
- Children in a bereaved family where a baby had died could be referred to paediatric services.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

The maternity services were good in terms of being responsive.

Bed occupancy was low. Patients were encouraged to use the birth centre when possible and this was next door to the delivery suite should a transfer be necessary. There was a new system for triaging patients which was working well. The new team for socially complex patients was taking referrals for vulnerable women and provided good support for patients with complex physical and mental health needs. There were tertiary unit agreements with other hospitals including Royal Preston and St Mary's for women with complex conditions, for example interventional radiology.

The trust had developed a socially complex pregnancy team, led by a consultant obstetrician. Specialist midwives included: substance misuse, perinatal mental health, homelessness, non-English speaking, teenage pregnancy, travellers and Safeguarding. There was a pathway in place for referral to this team when appropriate. Their aim was to facilitate a normal birth and use the birth centre where possible. In 2014 there were 319 babies born in the birth centre. This year the number was between 350 and 400 at the time of our inspection in September, which represented 12% of births under the care of the trust.

Clinics were planned to engage vulnerable patients including a clinic next to a school to facilitate antenatal checks for pregnant teenagers and a clinic alongside the community drugs team clinic so that women needed to attend for only one appointment.

There was a dedicated patient experience midwife in the intrapartum team who was available for patients to raise their concerns with. Bereaved parents had access to a comfortable, non-clinical environment in the Victoria centre next door to the maternity services. They were able to spend time in this area away from the general maternity environment. There was a strategy for the development of services to meet the better births campaign of the Royal College of Midwives. Complaints and staffing issues had eased since the introduction of the new maternity model but it was in its infancy so this had not yet been evidenced. There was a 'birth afterthoughts' service where women who had given birth could submit feedback.

Service planning and delivery to meet the needs of local people

- There was a midwifery led unit which meant low risk patients had the choice of this option for delivery of their baby. This met NICE guidance CG 190 'Intrapartum care: care of healthy women and their babies during childbirth.'
- There were two birthing pools in the birthing unit and another on the delivery suite. Midwives told us they encouraged use of the birthing pools, especially in the midwifery led unit.
- Between April and June 2015 around 10% of births were either birth centre deliveries or planned home births.
- We observed that patients were offered a real choice of where to give birth.
- The labour ward had a soundproofed room with a separate entrance for use by women who had delivered a stillborn baby. This protected them from hearing activity on the delivery suite and allowed access to the room without passing through the delivery suite. The television and stereo in this room had been donated by parents, and there were memory boxes which had been donated by the stillbirth and neonatal death charity, Sands.
- There was a strategy for the development of services to meet the normality in childbirth vision of the Royal College of Midwives through the better births campaign. This was reflected in the compassionate care strategy and the clinical strategy.

Access and flow

- Ward D had 22 beds with no set allocation for antenatal and postnatal patients. This flexibility meant patients could be accommodated on this ward regardless of the stage of their pregnancy care.
- Following the last inspection work was undertaken to reduce bed occupancy at high risk times. An audit of ward occupancy completed by the trust showed at 07:30am on Ward D from January to August 2015 it was 73%. NHS England data reported 48% bed occupancy.
- Triage for the delivery suite was based in the antenatal day unit between 8.30am and 6.00pm. There was a specific senior midwife (band 6) from the intrapartum

team allocated to a triage shift between 4.00pm and midnight. This meant midwives were not interrupted from their work on the delivery suite to assist patients who arrived in the unit.
- In the birth centre there were two rooms used for triage with a third available if required.
- Community midwives saw their patients throughout their antenatal care and for ten to 14 days postnatally. Discharge forms identified any risks and support was for longer if required.
- There was no set length of stay on Ward D and staff were guided by the new mother, but a 6-12 hour transfer was considered ideal. Patients who had an elective Caesarean section generally stayed for around 24 hours and women who had had an emergency Caesarean or had complications stayed longer. Discharge times were sometimes challenged where involvement was required from other agencies, such as social work or legal teams.
- Discharge from the transitional care unit was agreed when the paediatrician was happy for the baby to go home. The mothers in those beds were already fit for discharge.
- There was an appointment system on the maternity day unit and if no appointments were available, women could attend the delivery suite.
- There were tertiary unit agreements with other hospitals including Royal Preston and St Mary's for women with complex conditions, for example interventional radiology. This had been developed as part of the action plan for the management of post-partum haemorrhage and complex surgical cases which resulted from the RCOG report.

Meeting people's individual needs

- The trust had developed a socially complex pregnancy team, led by a consultant obstetrician. Specialist midwives included: substance misuse, perinatal mental health, homelessness, non-English speaking, teenage pregnancy, travellers and Safeguarding. There was a pathway in place for referral to this team when appropriate.
- The head of department took the lead on antenatal planning for patients with complex social needs. The aim was to facilitate a normal birth and use the birth centre where possible. In 2014 there were 319 babies born in the birth centre. This year the number was between 350 and 400 at the time of our inspection in September, which represented 12% of births under the care of the trust.
- Midwives had some awareness of female genital mutilation (FGM) and there was a routine question included on the antenatal booking system.
- Where women had surgery, the gowns were put on in such a way to allow skin to skin contact between mother and baby after delivery.
- Six clinics were held across the local area for glucose tolerance and there were two satellite consultant clinics with at least two midwives.
- The transitional care unit had six beds for women whose babies needed to stay in hospital a little longer, for example they were on intravenous antibiotics, were slightly jaundiced or needed phototherapy. These rooms had an extra bed allowing the mother's partner to stay if required.
- Mothers who had given birth to twins pre-term and needed extra support with breastfeeding stayed on the transitional care unit. This unit was also used to accommodate parents who had a very poorly baby on the neonatal unit which was adjoined to the transitional care unit.
- Clinics were planned to engage vulnerable patients including a clinic next to a school to facilitate antenatal checks for pregnant teenagers and a clinic alongside the community drugs team clinic so that women needed to attend for only one appointment.
- Similarly, flu and MMR vaccines were offered at baby clinics to reduce the number of appointments people needed to attend.
- Patients with known mental health problems were referred to the complex social needs team. There was a pathway for the care of patients with mental health needs.
- Bereaved parents had access to a comfortable, non-clinical environment in the Victoria centre next door to the maternity services. They were able to spend time in this area away from the general maternity environment.
- Community midwives assessed women's mental health during visits using observations and continuity of care. They used assessment charts for postnatal anxiety and

depression and there was a mental health pathway which could be used if required, which defined referral options to GPs, the crisis team and the complex social needs team.

Learning from complaints and concerns

- There was a complaint review panel which looked at the number of complaints per quarter. Upheld complaints were reviewed at this meeting and actions identified for learning and changes to practice.
- Community midwives felt that complaints and staffing issues had eased since the introduction of the new maternity model but it was in its infancy so this had not yet been evidenced.
- The intrapartum team included a patient experience midwife who dealt with local complaints and incidents and was available for patients to speak to with concerns.
- There was a 'birth afterthoughts' service where women who had given birth could submit feedback. The local strategy for statutory supervision of midwives was updated in June 2015 and included a commitment from supervisors to monitor performance of patient experience through reviewing the responses to the friends and family test, birth afterthoughts, complaints and case reviews.

Are maternity and gynaecology services well-led?

Good

Maternity services were good in terms of being well-led.

Staff were familiar with the trust values however there was no documented strategy for the maternity service despite much work in response to the last CQC inspection and the RCOG review. Staff were however aware of the changes to the service and their role in the new model of care.

Governance systems were in place to monitor the quality of the service and escalation processes were in place. The maternity service fed in to the families division risk register which was regularly reviewed and updated.

Very senior managers were visible and staff knew who they were. Staff enjoyed being part of the families division and staff engagement and morale were good. Senior managers were approachable and there was an 'open door' policy.

There was a system in place to include patients and engage with them to develop the service.

Vision and strategy for this service

- Midwives at the hospital and in the community were aware of the trust values and felt that they were part of the 'together we care' culture.
- The service did not have a documented strategy but changes to the service had been based on the RCOG review and staff were aware of the requirements and the changes that had been implemented as part of the response to the review and the new model of care.

Governance, risk management and quality measurement

- The families division had a performance dashboard which demonstrated safety, quality and activity information.
- There was a monthly performance 'review' meeting, chaired by exec directors, with senior managers from the Division in attendance. A team from the families division presented three key items from their dashboard.
- There was a monthly trust management team meeting attended by the head of midwifery who cascaded to her team any useful information she gathered there.
- There was one risk register for the family division service and this had been updated following review by external auditors. There was a '5 T's system in place to manage the register so each item was identified with a decision to tolerate, treat, transfer, terminate or take the risk. Senior staff had a clear vision of working to keep the register focused and strategic and there was input from the director of nursing for escalated risks.
- Every two months the top three risks were presented at the Corporate Quality Committee where they would be addressed and reviewed. Every quarter the risks would be taken to the Health Care Governance meeting where each division presented their risk register and divisional action plan.
- The top three risks were related to the outcomes for patients and babies in relation to reduced breast feeding, smoking in pregnancy and lack of mental health provision. The measures in place to manage these included new initiatives such as recruitment and joint working and strengthening additional measures such as increased training.

- At a local level the risk register was regularly reviewed and updated. It was also discussed at the directorate meeting and the directorate governance meeting.
- There was a programme of audits in place to measure compliance against a range of trust policies and national guidelines. Action plans including timescales to re-audit were in place where appropriate.

Leadership of service

- The head of department was the lead obstetrician. They worked alongside their colleagues, understood the challenges in the service and offered support and leadership which was commended by the medical team.
- Staff felt listened to in terms of what their service required, for example 12 new beds had recently been acquired for the delivery suite which reduced patient safety risks and allowed different positions for optimal delivery.
- Doctors said the medical director was visible on the ward.
- Senior managers had an open door policy and were approachable.

Culture within the service

- Staff felt that the director of nursing was very approachable. The chief executive had recently spent time on the delivery suite and there was also support from the chairman.
- The directorate had a human relations business partner who facilitates 'one family' work with the different teams.
- Maternity services were part of the families division. Staff enjoyed the close links with the other teams involved in women and children's health including health visitors, school nurses and the paediatric and adolescent inpatient wards.
- Communication was good between nursing staff and senior midwives and there was an 'open door policy' to discuss any issues. Staff felt able to report any concerns they had and felt they would be listened to.
- The culture encouraged candour, openness and honesty.

Public engagement

- There was an active group of patients who met monthly to discuss the maternity services at the hospital. They had representation on the monthly maternity ward forum meetings and told us they could present ideas and suggestions which were listened to and acted upon.
- The representation from this group included involvement in guideline development as well as peer support for the patients in the unit.

Staff engagement

- There were 'good ideas' boards where staff were able to make suggestions, for example the acquisition of a mobile phone for the delivery suite which enabled women to speak to language line from their rooms when English was not their first language.
- Morale was good among the community midwives who felt that the new midwifery model was allowing them better continuity of care with their patients.

Innovation, improvement and sustainability

- The new midwifery model introduced in July 2015 was working well and was due to be reviewed after three months, in October 2015. Staff felt pressures on staff numbers had reduced since its introduction, and that continuity of care for patients had improved.
- Patients were offered a choice of facilities within the maternity unit and this was reflected in their comments to us.

Outstanding practice and areas for improvement

Outstanding practice

The trust was actively trying to support breastfeeding and there was a network of experienced breast feeding mothers called star buddies, who supported new mothers wanting to breastfeed. The star buddies were mostly volunteers and attended antenatal classes to provide information and advice, as well as meeting women on the maternity ward. There was a monthly rota in place covering seven days and five nights of the week. The women we spoke to were impressed with this service and had found it helpful.

Areas for improvement

Action the hospital MUST take to improve

- Improve the outcomes for patients through the improvements demonstrated through the national CEM audits in particular, reduce the number of patients attending urgent care services waiting for mental health assessment for over four hours

Action the hospital SHOULD take to improve

- Maintain all equipment in both urgent care and maternity is checked as per the policy and kept clean within the infection prevention and control guidance for each specific item.
- Consider improving the monitoring of the impact of actions taken as a result of incident investigations in maternity services.
- Maintain training for all staff working in the maternity department with basic life support, blood transfusion and CTG training by the year end.
- Address the insufficient supply of basic equipment e.g. thermometers in A&E.
- Address the shortage of hand sanitizers and signs to encourage visitors to use the alcohol gel in the entrance to the emergency department.
- Review the computer equipment in 'minors' area of A&E to ensure consistent recording of patients' treatment.
- Try to improve patient confidentiality at the reception.
- improve staff utilisation of translation support when dealing with patients in A&Ewho require communication support.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Performance regarding the number of patients waiting for mental health assessment for over four hours did not always meet the needs of the patient. Regulation 9(2)