Care Quality Commission

Southport and Ormskirk Hospital NHS Trust

Ormskirk District General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Good
Medical care	Requires improvement
Surgery	Good
Maternity and gynaecology	Inadequate
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

Overall the hospital was rated as requiring improvement but the safe domain was rated requires improvement or inadequate in five of the seven services. In maternity services the well-led domain was also rated as inadequate. The concerns in this hospital were discussed with the trust at the end of the inspection.

Our key findings were as follows:

Safe

Ormskirk Hospital requires improvements in the safe domain as staffing levels were not always deemed sufficient to meet patients' needs at times when senior staff were utilised as the designated on call person for the site. The trust were made aware and have made changes since the inspection.

Patients were supported with the right equipment; however there was no approved schedule for replacing older equipment used in the theatres. The staffing levels in the theatres were not sufficient, but the theatres department had plans in place to address this. There was a potential risk of unsafe care because the arrangements for medical cover on the wards were not sufficient. There was one resident medical officer who worked 24 hours per day continuously over a two week period.

The safety of people using the maternity service was compromised due to the reduced numbers of experienced midwives employed, a lack of learning from incidents and adverse clinical data and inadequate and out of date staff training. There were risks of patients whose condition deteriorated experiencing delays in receiving blood transfusions and inadequately trained staff assisting in the obstetric theatre. Whilst the service had recognised some of these risks they had not taken sufficient actions to mitigate them.

There were a higher than average number of deliveries using forceps and of peripartum hysterectomies (Peripartum hysterectomy is a major operation and is invariably performed in the presence of life threatening haemorrhage during or immediately after abdominal or vaginal deliveries). There were no plans in place to reduce these. There was a lack of monitoring of the quality of the service with resulting plans for improvement and change.

Effective

There were insufficient medical and nursing staff with the appropriate skills and experience to provide safe and effective care to patients outside of normal working hours.

However, we found that the end of life/palliative care services at Ormskirk Hospital were generally good, and were supported by a robust training programme and adherence to national guidelines. Staff from both the general wards displayed enthusiasm to provide safe, effective and compassionate care to patients reaching the end of their life. The multidisciplinary team worked well together to achieve this. This enthusiasm and desire to maintain competencies was particularly commendable considering the small number of patients at the end of life that the staff came into contact with.

The majority of patients had a positive outcome, however, the number of patients that underwent elective trauma and orthopaedic surgery and were readmitted to hospital following discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was better than the England average across all the elective specialties at the hospital.

Summary of findings

Safeguarding measures were understood by staff and escalation processes were well managed. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

In outpatients information had been used to make improvements including improving the waiting rooms for patients and staff; the privacy and dignity for bedded patients in diagnostics department; introduction of children's activity boards and the production of a video to show young children or patients with a learning disability what it would be like when they attend the department. Additional services had been created, such as the 'dressings' clinics which had freed-up consultants time and reduced delays in fracture and orthopaedic clinics. Reviews were conducted into clinics which consistently ran late to identify blocks in patient flow.

Caring

Care was delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect. Patients spoke positively about their care and treatment. Patients and their relatives were involved in care and supported with their emotional needs and there were bereavement and counselling services in place.

Responsive

The hospital had done a significant amount of work to tackle the capacity and patient flow challenges that had affected its performance. Ormskirk Hospital met its target to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

Services provided on H ward were generally responsive to people's needs, but there was no adequate provision for patients who needed a blood transfusion without transferring them out of the hospital.

The number of cancelled elective operations was better than the England average, and there had been improvements in performance against 18 week referral to treatment standards. There were plans in place to improve theatre efficiency.

Children's services were provided in a child friendly environment by a workforce with a range of specific skills, competencies and training relating to children. All staff had relevant professional registration and were encouraged to be up to date with required training programmes.

Well-led

The organisation's vision and strategy had been cascaded and staff were proud of the work they did. The overall ethos was centred around the quality of care patients received. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.

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

However, Midwives described a culture which was not open and transparent and where the leadership was inconsistent resulting in staff feeling they could not easily raise issues or concerns. There were a high number of newly qualified midwives employed which resulted in inexperienced staff fulfilling roles for which they lacked experience and competence.

We saw several areas of outstanding practice including:

- Compassionate improvements and re-design of the outpatients departments to reduce anxiety for young children and patients with a learning disability. Child friendly activity boards are being erected. An access film showing the experience of a child attending an outpatient department is being posted on the Trust website. This will allow parents of young children or carers of patients with learning difficulties to view the film with them and explain the process and what to expect before they attend for their own appointment.

Summary of findings

- The work of the children's community nursing outreach team had been further recognised by the successful publication in the British Journal of Nursing ("Paediatric community home nursing, acute paediatric care" British Journal of Nursing 2014, vol 23, No. 4).
- Specialist paediatric nurses were employed to support children with diabetes and respiratory conditions. They held specialist multidisciplinary clinics on a regular basis. We heard of exemplary good practice such as specialist nurses visiting schools to give support and training to teaching staff.
- The trust paediatric diabetes service was peer reviewed in July 2014. Multidisciplinary team work scored 90% and hospital measures scored 100%. Some good practice was recorded, including having a support group.
- The trust and hospital proactively implemented the 'New priorities for care of those thought to be dying', before the compulsory withdrawal of all references to the Liverpool care pathway. This had been supported by a robust training programme.
- Patients at the end of life and their relatives were supported by the palliative care team to plan for their future, and a national system was in place to identify them when accessing emergency care in order to speed up admission and discharge.
- 85% of patients who had a documented preferred place of death died where they chose to, facilitated by an effective end of life rapid transfer programme.
- The mortuary team was outstanding in its responsiveness and its innovative approach to caring for the patients and relatives who used their services.

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

Importantly, the trust must:

- Ensure adequate medical and nurse staffing levels and appropriate skill mix.
- Ensure medical and senior nurse cover out of hours is safe and fit for purpose.
- Ensure consent for obstetric operations is recorded accurately.
- Ensure all staff working in obstetric theatres are appropriately trained and experienced to ensure safe care.
- Review the incident of peripartum hysterectomies and the use of forceps for delivery are appropriate and safe.
- Ensure all newly qualified midwives receive support and supervision, as per their preceptorship guidance, taking into account the number of experienced midwives working with them on any shift.
- Ensure the leadership of the maternity services encourages and enables an open and transparent culture.
- Ensure equipment used in the theatres is fit for purpose and older equipment is replaced under a planned replacement schedule.

In addition the trust should:

In Urgent and emergency care

- Keep a list of appropriate staff that have had the required scene safety and awareness training.
- Ensure sufficient numbers of staff are recruited.
- Ensure the department is safely staffed when staff are called away from the A&E department to assist in other duties such as covering the bed management and being the designated on call person for the site.

In Medicine

- Improve feedback and learning from incidents.
- Increase seven day working for all disciplines across the medical directorate.
- Improve the way risks are communicated to nursing staff within the medical directorate.
- Improve access to blood transfusions for medical patients.

In Surgery

- Ensure there is suitable medical staffing cover on the orthopaedic surgical ward.
- Ensure there are sufficient numbers of trained staff in the theatres department.

Summary of findings

- Improve the completion of the WHO Safer Surgery procedure.
- Improve performance relating to patients having elective trauma and orthopaedic surgery who are readmitted to hospital.

In Maternity

- The records in the maternity services should be stored securely at all times.
- Staff in the maternity services should be aware of their role within the major incident plans.
- The layout of the waiting areas for patients in the termination of pregnancy outpatients area should be separated from the ante-natal and fertility clinic.
- Ensure all staff receive information of lessons learnt following incidents.

In Outpatients

- Ensure that people are protected from the risks associated with unsafe use and management of medicines. This is something that is required as part of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, in relation to the management of medicines. However it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.
- The trust should consider the process for formalising team and multidisciplinary team meetings in order increase understanding and information flow.

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	Good	The overall rating for the urgent and emergency services at Ormskirk and District General Hospital is good however some improvements are needed in the safe domain. Processes were in place to ensure resource and capacity risks were managed. However, staffing levels were not always deemed sufficient to meet patients' needs at times when senior staff were utilised as the designated on call person for the site. The trust were made aware and have made changes since the inspection. There was a risk-aware culture and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments. Appropriate equipment was available and medicines and records were managed safely across the areas we inspected. Staff were aware of the safeguarding policy and got appropriate consent. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the care and treatment provided. There was evidence of adherence to national guidance and participation in national College of Emergency Medicine audits demonstrated this and there were clear action plans indicating what improvements needed to be made. We saw effective collaboration and communication among all members of the multidisciplinary team and services were set up to run 7 days a week. Staff treated patients with dignity, compassion and respect, even while working under pressure. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings. The hospital had done a significant amount of work to tackle the capacity and patient flow challenges

Summary of findings

that had affected its performance. Ormskirk Hospital met its target to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.
The organisation's vision and strategy had been cascaded and staff were proud of the work they did. The overall ethos was centred around the quality of care patients received. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.

Medical care

Requires improvement

Medical care services require improvement especially in the safe domain.
Care was delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect but there were insufficient medical and nursing staff with the appropriate skills and experience to provide safe and effective care to patients outside of normal working hours. Staff were confident in reporting incidents but did not always receive feedback, and lessons learned from incidents were not widely shared.
Care and treatment was delivered in line with national guidelines by a multidisciplinary care team who worked together effectively, but 7 day working was not in place. Services provided on H ward were generally responsive to people's needs, but there was no adequate provision for patients who needed a blood transfusion without transferring them out of the hospital.
H ward was well-led, although there was a disconnection between the staff providing hands-on care and the executive team. The system in place to communicate risks and changes in practice to nursing staff required improvement.

Surgery

Good

The overall rating for the surgery services at Ormskirk Hospital is good however some improvements are needed in the safe domain. Patients were supported with the right equipment; however there was no approved schedule for replacing older equipment used in the theatres. The staffing levels in the theatres were not sufficient. We

Summary of findings

found that there were 10.68 whole time equivalent vacancies in the theatres. The theatres department had plans in place to address this and had started to recruit additional staff.

There was a potential risk of unsafe care because the arrangements for medical cover on the wards were not sufficient. There was one resident medical officer who worked 24 hours per day continuously over a two week period. The trust had identified that the level of cover provided by the resident medical officer was inadequate and had prepared a draft proposal to recruit an advanced nurse practitioner and a prescribing pharmacist. However, this proposal had not been approved at the time of our inspection.

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

The surgical services provided care and treatment that followed national clinical guidelines. They participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and within the England average for applicable safety and clinical performance measures.

The majority of patients had a positive outcome, however, the number of patients that underwent elective trauma and orthopaedic surgery and were readmitted to hospital following discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was better than the England average across all the elective specialties at the hospital.

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

Patients spoke positively about their care and treatment. Patients were treated with dignity and

compassion. Patients and their relatives were involved in care and supported with their emotional needs and there were bereavement and counselling services in place.
The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. The number of cancelled elective operations was better than the England average, and there had been improvements in performance against 18 week referral to treatment standards. There were plans in place to improve theatre efficiency.
There was clearly visible leadership with the majority of staff positive about the culture and support available across the services. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and how to resolve these.

Maternity and gynaecology

Inadequate

The maternity services at Ormskirk District General Hospital were inadequate in the safety and well led domains.
The safety of people using the service was compromised due to the reduced numbers of experienced midwives employed, a lack of learning from incidents and adverse clinical data and inadequate and out of date staff training. There were risks of patients whose condition deteriorated experiencing delays in receiving blood transfusions and inadequately trained staff assisting in the obstetric theatre. Whilst the service had recognised some of these risks they had not taken sufficient actions to mitigate them.
There were a higher than average number of deliveries using forceps and of peripartum hysterectomies (Peripartum hysterectomy is a major operation and is invariably performed in the presence of life threatening haemorrhage during or immediately after abdominal or vaginal deliveries). There were no plans in place to reduce these. There was a lack of monitoring of the quality of the service with resulting plans for improvement and change. Midwives described a culture which was not open and transparent and where the leadership was

inconsistent resulting in staff feeling they could not easily raise issues or concerns. There were a high number of newly qualified midwives employed which resulted in inexperienced staff fulfilling roles for which they lacked experience and competence. The maternity services were delivered by caring staff who treated people with respect and dignity. People who had used the service spoke highly of the care they had received.

Services for children and young people

Good

We rated services for children as good in all domains.
Services were provided in a child friendly environment by a workforce with a range of specific skills, competencies and training relating to children. All staff had relevant professional registration and were encouraged to be up to date with required training programmes. The location of the paediatric services supported smooth processes and strong team work. Feedback from relatives and children using the service was positive, described caring, friendly staff that were approachable and compassionate.
The work of the children's community nursing outreach team had been further recognised by a successful publication in the British Journal of Nursing 2014. Staff on the neonatal ward proudly displayed their 2013 team award trophy.
Safeguarding measures were understood by staff and escalation processes were well managed by the lead nurse and consultant. Staff morale was high. We heard examples of motivated managers who displayed strong leadership, open door policies and encouraged staff progression. The paediatric ward sisters highlighted ongoing concerns with bed management cover and the increase in requests to hold the 'on call' bleep, when required to support other areas of the hospital as described in seven incident forms submitted since April 2014.

End of life care

Good

We found that the end of life/palliative care services at Ormskirk Hospital were generally good, and were supported by a robust training programme and adherence to national guidelines.
Staff from both the general wards displayed enthusiasm to provide safe, effective and compassionate care to patients reaching the end of their life. The multidisciplinary team worked well

together to achieve this. This enthusiasm and desire to maintain competencies was particularly commendable considering the small number of patients at the end of life that the staff came into contact with.
The mortuary and bereavement service was focused on making its environment and interaction with patients and relatives as minimally distressing as possible, and displayed excellent, innovative care.

Outpatients and diagnostic imaging

Good

Overall the outpatient and diagnostic services was found to be good but required improvement in the safety domain.
This was because we could not be sure that all matters of concern were properly recorded or that the service had clear oversight of the issues. This was demonstrated by the monthly 'discrepancies' meeting in which there had been no involvement of the trust risk team. Issues were discussed and learning was shared but only within the group. At Ormskirk we found that there were no formal meetings between radiologists and radiographers which prevented learning.
A small quantity of eye ointment was found to be out of date and a number of small electrical appliances and equipment checked in the Ophthalmology clinic were found to have expired portable appliance tests (PAT). We found four items had not been safety tested which represented a third of all the equipment available in the room.
National targets for referral to appointment times were exceeded in all area but one, reports following chest x-rays at Ormskirk had a target of 5 days and on occasions had taken up to twelve days to complete. We were told this was due to current demand on the service.
Staff were well trained and encouraged to take additional training. Outpatient staff of band 5 and below were rotated between departments and sites to increase their skill base.
Multidisciplinary working was evident both at a local level and within the wider health community. Specialist consultants from neighbouring trusts ran clinics which were staffed by Ormskirk staff, enabling patients to receive a first appointment nearer to home.

Summary of findings

We observed staff interacting in a friendly and helpful way.Patients could not speak highly enough of nursing staff. Doctor's, nurses and receptionists had all taken time to explain things to patients in terms which they understood.
Audits were completed and services reviewed. We saw how information was used to make improvements including improving the waiting rooms for patients and staff; the privacy and dignity for bedded patients in diagnostics department; introduction of children's activity boards and the production of a video to show young children or patients with a learning disability what it would be like when they attend the department.
Additional services had been created, such as the 'dressings' clinics which had freed-up consultants time and reduced delays in fracture and orthopaedic clinics.Reviews were conducted into clinics which consistently ran late to identify blocks in patient flow.
We found that staff respected their local managers who had a good understanding of their teams and recognised where improvements could be made and led on the issues on behalf of the teams.

Ormskirk District General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Contents

Detailed findings

Background to Ormskirk District General Hospital

Ormskirk District General Hospital is one of two hospitals within the Southport and Ormskirk NHS Trust. The trust is not a foundation trust. The hospital provides the maternity services for the Southport and Ormskirk area as well as services for children including a specialist children's emergency department. They also provide some medical and surgical services and an outpatients facility. The hospital was inspected as part of a new approach comprehensive inspection.

Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspectors and a variety of specialists including consultants in paediatrics, acute medicine, trauma and orthopaedics, gastroenterology, obstetrics and gynaecology and a consultant anaesthetist. There was also a chief nurse, deputy director of nursing, consultant nurse in orthopaedics, McMillan nurse specialist, advanced nurse practitioner in paediatrics, midwife and specialist nurses in accident and emergency and medicine. The team also had a risk manager, senior manager in paediatrics, physiotherapist and speech and language specialist. The team was also supported by four experts by experience who are lay members of the team.

How we carried out this inspection

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

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

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

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

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

- Accident and emergency (A&E)
- Services for children and young people
- Medical care
- Surgery
- Maternity including the maternity HDU
- Palliative and end of life care
- Outpatients

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational

therapists, pharmacists, domestic staff and porters. We also spoke with staff individually, as requested. We also trialled a focus group for BME staff which was well attended

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

Facts and data about Ormskirk District General Hospital

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

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

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

There are 138 beds at Ormskirk District General Hospital of which 128 are for inpatient and 10 for daycases. 54 were maternity beds (including 12 Neonatal beds).

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

The trust is currently in financial surplus.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites in the Southport and Ormskirk Hospital NHS Trust. The emergency department at Ormskirk District General Hospital was open 24 hours a day, 7 days a week, providing emergency care and treatment for children under the age of 16. The department treated children with serious and life threatening emergencies, as well as those with illnesses or injuries that were not life threatening but still needed prompt treatment, such as minor head injuries or suspected broken bones. People over the age of 16 were assessed and if the condition was not life threatening they were referred to the accident and emergency department at Southport District General Hospital.

The urgent & emergency services saw approximately 105,000 patients between April 2013 and March 2014 across both sites with 11,834 patients being seen at Ormskirk Hospital between April 2014 and September 2014. There were six bays in the minor injuries area and two bays designated for resuscitation. There were six beds in the paediatric assessment area for patients who required diagnosis or observation.

We carried out an announced inspection during 12–14 November and an unannounced inspection on 20 November between 10pm and 1am. We spoke with eight patients and relatives, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the clinical director for emergency medicine, matrons, senior sisters, nurse practitioners, consultants, the practice development lead for paediatrics, the play specialist, healthcare assistants and the receptionist staff. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

The overall rating for the urgent and emergency services at Ormskirk District General Hospital is good with some improvements needed in the safe domain.

Staffing levels were not always deemed sufficient to meet patients' needs especially when nursing staff were called away from the A&E department to assist in other duties such as covering the bed management duties and being the designated on call person for the site. A number of incidents had also been raised in relation to this issue.

There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments with appropriate equipment. Medicines and records were managed effectively and safely across the areas we inspected. Staff were aware of the safeguarding policy and obtained appropriate consent. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the care and treatment provided.

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

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

A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings. The trust had done a significant amount of work to tackle the capacity and patient flow challenges that had affected its performance. Performance was improving trust wide and as an individual location, Ormskirk District General Hospital met its target to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

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

The organisation's vision and strategy had been cascaded to all staff, who were proud of the work they did. The overall ethos was centred around the quality of care patients received, and meeting targets was secondary. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We found that services in this domain required improvement. Staffing levels were not always deemed sufficient to meet patients' needs especially when nursing staff were called away from the A&E department to assist in other duties such as covering the bed management duties and being the designated on call person for the site. A number of incidents had also been raised in relation to this issue.

There was a risk-aware culture in the department and a willingness to learn from mistakes. Patients received care in safe, clean and suitably maintained environments with appropriate equipment. Medicines and records were managed effectively and safely across the areas we inspected. Staff were aware of the safeguarding policy and obtained appropriate consent. There were efficient and well managed processes in place for handovers. There was an up to date trust major incident plan, which listed key risks that could affect the care and treatment provided.

Incidents

- Staff were confident about reporting incidents, near misses and poor practice via the electronic incident reporting system for issues such as abuse from patients, patients who had absconded and medication errors.
- Trust data showed there were 52 incidents reported in the accident and emergency (A&E) department from 1 May 2014 to 12 November 2014. The majority of these were rated as being low risk.
- We reviewed a number of these incidents and found, where appropriate, action had been taken to prevent reoccurrence. In one instance, a child had a significant fracture and an urgent request to have the x-rays reviewed was put in place but this did not occur. We saw this incident was discussed at the senior team meeting and a draft procedure for clinical administration workload was written.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of investigations of incidents to prevent reoccurrence. We saw that all members of the multidisciplinary team were involved in these investigations.
- When the risk from an incident was rated as high, it had been added to the divisional risk register that was being routinely reviewed. We looked at one incident rated as severe risk where confidential information about an x-ray was sent to the wrong fax number. The investigation was thorough and a new system was put in place to stop this from reoccurring.
- Learning from incidents was shared across the department via noticeboards, newsletters and safety huddles at handovers.

Cleanliness, infection control and hygiene

- The emergency department was clean, well maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as:
  - Staff following hand hygiene and 'bare below the elbow' guidance.
  - Staff wearing personal protective equipment, such as gloves and aprons, while delivering care.
  - Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.
  - Cleaning schedules in place and displayed throughout the ward areas.
  - Clearly defined roles and responsibilities for cleaning the environment, and cleaning and decontaminating equipment.
  - Hand washing facilities and hand gel available throughout the department.
  - Specific policies in place for the cleaning and decontamination of the toys in the A&E area. The toys appeared to be clean and well looked after.
- Data showed that rates of the healthcare-associated infections MRSA and Clostridium difficile (C. difficile) for the trust were within expected limits. There were no cases of C. difficile attributed to the department from October 2013 to September 2014.
- The A&E dashboard showed the department met the trust compliance criteria for the 'Matrons checklist for the environment and infection control' as well as for the hand hygiene and commode cleanliness audits.

Environment and equipment

- The emergency department was set up so patients who were deemed to need more care were visible from the nursing stations for continual observation and quick intervention if required.
- The x-ray service was situated close to the department for easy accessibility.

- Staff were aware of alerts that had been issues by the National Patient Safety Agency and warnings had been shared with staff, such as potential equipment sabotage.
- The resuscitation room was well equipped with equipment for paediatrics. Equipment was in place for specific procedures that may only be carried out several times a year. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Equipment was checked and decontaminated regularly in accordance with checklists for daily, weekly and monthly monitoring. We saw the equipment such as the resuscitation trolleys were checked daily. There were clear and visible records of servicing and maintenance that had been carried out.
- Staff told us having onsite security, especially during the night shifts, was vital to ensure staff safety, as the police did not always respond in a timely manner.

Medicines

- Policies were available for the management of medication and posters were displayed reminding staff to check protocols if changes were made to regular medication.
- Medication was safely stored with an audit trail of who had accessed it. When issuing medication, staff adjusted stock levels and the pharmacy department was responsible for maintaining minimum stock levels.
- Medicines throughout the emergency department were stored correctly and safely in locked cupboards or fridges and temperatures were recorded where necessary.
- We checked the storage and balance of controlled drugs and saw that, where appropriate, the register had been signed by two staff members when drugs were dispensed and the amount wasted was recorded.

Records

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

Safeguarding

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

Mandatory training

- Staff received mandatory training in areas such as infection prevention and control, moving and handling, safeguarding children and vulnerable adults, and investigating incidents.
- Staff within urgent and emergency care also received training in areas applicable to their role such as medicines management, resuscitation training such as advanced paediatric life support (APLS), trauma nursing core course (TNCC), advanced and immediate and paediatric life support (ALS, ILS and PILS).
- There was a practice development lead for paediatrics who told us training was carried out mostly from January to October, because November to December were busy months. She acted as a clinical trainer and mentor, and maintained the departmental training register and timetable. The training was based on what was recommended by the Royal College of Nursing (RCN) and the National Institute for Health and Care Excellence (NICE), and what was required by the trust. This role was part time and only covering Paediatrics at Ormskirk Hospital. All nurses had portfolios and competency booklets alongside their personal development plans.
- The practice development lead had arranged training at university to further develop staff nurses to become specialists, and seven healthcare assistants had become nurses through secondments into training.
- The trust target was to have 90% of staff having received mandatory training. Trust data, as of October 2014,

showed that compliance with the target was met in the majority of areas such as training in infection control, moving and handling practices and health and safety in the urgent and emergency care areas.
- There was 100% compliance with the safeguarding of adults and children training, and with specific training such as APLS.
- The performance dashboards showed that compliance with mandatory targets had been poor over the previous 12 months, but the practice development lead confirmed the main trust records were not accurate.

Assessing and responding to patient risk

- Patients either presented to the emergency department themselves or were brought by an ambulance. All patients were booked in by staff who asked routine questions to determine the nature of the ailment, and a triage was performed.
- All minor injuries (self-referral) patients were streamed and assessed immediately to check the severity of their ailment.
- A qualified senior sister or an experienced band 5 nurse performed screening and triage of patients depending on the severity of their ailment.
- The nurses in triage would carry out initial observations, and request initial blood tests and x-rays so patients were not delayed and results were available when they were reviewed by a consultant for a more efficient diagnosis.
- Upon admission, patients at high risk were placed on care pathways to ensure they received the right level of care. An early warning tool was included in the patient record with clear directions for escalation printed on the back of the observation charts.
- Staff were aware of the appropriate actions to take if patients deteriorated acutely.
- We reviewed completed charts and saw that staff had escalated correctly, and repeated observations within the necessary periods.
- Staff knew how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was an escalation and bed management policy in place with daily involvement by matrons and senior staff to address these risks.

Nursing staffing

- Paediatric nursing staff of differing grades were assigned to each of the patient areas in the department.
- The numbers of nursing staff during the inspection were adequate for the flow of patients we observed.
- The nursing establishment was based on a recognised staffing assessment tool based on the RCN recommendations.
- The shift patterns showed there were always two nurses and one healthcare assistant assigned to the department on night duty shifts. On all other shifts there is always 3 trained nurses and 1 HCA as minimum. This is evidenced by the e-rostering system. However, staff told us they were routinely moved to assist other areas when demand increased, which could leave them short staffed. The trust told us staff were moved to assist in other areas depending on activity and acuity of patients on the Unit as a whole. No areas were left short staffed.
- Staff felt the morale was low and there was low staff retention due to the pressures in the department at peak times. A large number of staff told us they were struggling to take time out for refreshments and routinely missing breaks.
- Before the inspection, we contacted the RCN, who identified concerns about the high use of agency staff, high rates of staff vacancies and the skill mix, in particular the high use of band 5 nurses.
- Cover for staff sickness was provided by bank staff made up of the existing nursing team or own staff doing extra shifts, or by agency nurses to provide cover at short notice. Where agency staff were used, the organisation carried out checks to ensure they had the right level of training in delivering emergency care.
- Issues also arose around the night shift when the nursing staff were called away from the A&E department to assist in other duties such as covering the bed management duties and being the designated on call person for the site.
- We saw a number of incidents relating to inadequate staffing within the A&E department due to trained staff being the designated on call person for the site where no additional cover was available.
- One incident stated that a band 6 nurse was taken off the floor to cover the bed manager's duty when there were no additional nurses on the shift and the A&E department was extremely busy, with two sick children in the resuscitation bay, one of which needed high level nursing care for 5 hours. The band 6 nurse from the early shift stayed behind and worked a long day, which was

tiring. Although this had not resulted in any known patient harm, staff stated they felt the staffing was unsafe and it had caused a build-up of patients in the waiting areas.

Medical staffing

- All staff worked various shifts over a 24-hour period to cover rotas and to be on call out of hours and during weekends. The department had funding for six consultants but only four were in full time posts.
- The permanent staffing comprised four middle grade doctors and two senior house officers with various shifts from 8am to midnight. Locum staff were being used as required but mostly for the 4pm until midnight shifts.
- There was no on site senior medic in the A&E department at night (midnight to 8am) the A&E consultant and Paediatric consultant were both on call for A&E, and both received calls depending on the issue. This was in additional to the paediatric Registrar and SHO on night duty.
- It was proving difficult to recruit medical staff, so existing vacancies were covered by locum, bank or agency staff. he department had utilised different staffing models and the agency usage had decreased due to the employment of Emergency Nurse Practitioner's.
- Staff told us that there were generally enough medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.

Handovers

- We observed handovers of patients from the ambulance staff to the hospital staff. These were discreet, dignified and efficient.
- Professionals such as nursing and medical staff attended and the liaison paediatric nurse would attend if required. Topics discussed included issues such as clinical acuity (the intensity of care needed by patients), medication needs, staffing levels, complaints and incidents.
- Senior and junior staff attended to ensure they could all be aware of any risks and tasks that were allocated such as blood samples to be taken from patients.
- All the information was then logged in a communication file to ensure those staff not present could also be made aware.
- A system was in use for tracking patients before handover to the ward areas based on clinical prioritisation by the national early warning scores.

Major incident awareness and training

- There was a documented business continuity plan within the Southport and Ormskirk NHS Trust that listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available within the trust's major incident plan, which contained key action cards for the A&E department with specific roles each person would take. However, on the unannounced inspection it was found not to have been completed with contact information. This was raised with the trust and we were assured this would be rectified immediately.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated or at risk from chemical, biological, radiological, nuclear defence and explosive matter. Equipment to deal with such scenarios was situated outside the A&E department, which meant it could take some time to set it up when needed.
- The clinical director told us staff did not receive specific major incident safety and scene awareness training. However, all Paediatric nursing staff had major incident awareness training delivered as part of the Paediatric study days attended by all staff annually.
- There were no onsite security arrangements for staff in the A&E department. Staff told us they had all received conflict resolution training and would dial 999 for police assistance if required.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

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

Urgent and emergency services

Evidence-based care and treatment

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

Pain relief

- Patients were assessed as they entered the emergency department. A streaming process identified any patients who may need pain relief, which was given immediately via patient group direction (medication provided on an individual basis, where this offers an advantage without compromising safety).
- Patient records and patients we spoke with reported that they had been offered appropriate pain relief.

Nutrition and hydration

- The healthcare assistant was the designated staff member on each shift responsible for offering drinks and small snacks on a 2 hourly basis, such as yoghurts and fruits, to patients waiting in the department.
- We saw patients being offered refreshments during our visit. The healthcare assistant asked nursing staff if patients could have refreshments before offering them due to the nature of their medical conditions.
- Snack boxes were available for patients who were admitted out of meal times.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national College of Emergency Medicine audits so it could benchmark its practice and performance against best practice and other A&E departments.
- The last College of Emergency Medicine audit for pain in children was conducted in 2012. The trust performed below the college standards. There were clear action plans, indicating what improvements needed to be made as a result, which included adding information to be collected in the patient clinical assessment record.
- Unplanned re-admittance rates to A&E within 7 days from January 2013 to May 2014 were above the 5% target set by the Department of Health but were below the England average for the same timeframe.

Competent staff

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

Multidisciplinary working

- We saw effective collaboration and communication among all members of the multidisciplinary team to support the planning and delivery of patient-centred care. Daily multidisciplinary team meetings, involving the medical staff, nursing staff, therapists as well as social workers, child health visitors and safeguarding leads, where required, ensured patients' needs were fully explored.
- Issues discussed included identification of patients' existing care needs, relevant social/family issues, mental capacity, and any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.

Urgent and emergency services

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

Seven-day services

- Staff rotas showed that medical and nursing staff levels were sufficiently maintained out of hours and at weekends.
- The x-ray department was open 24 hours a day, 7 days a week. However, there was limited access to specialist investigations such as MRI and CT scans and to a radiologist to interpret scans between midnight and 8am.
- Pharmacy services were not available 7 days a week but a pharmacist was available on call out of hours. During working hours, patients attending A&E who needed medication were directed to the hospital pharmacy. The departments held a stock of frequently used medicines such as antibiotics and painkillers, which staff could access out of hours. Stock levels were appropriate and were regularly checked to ensure the supply was adequate for peak times such as weekends and public holidays.

Access to information

- Patients confirmed they had received information about their care and treatment in a manner they understood.
- Information about patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents.
- Staff could access information such as audit results, lessons learned from incidents, performance indicators and updates to policies via the staff room and clinical pathways, and policies and procedures were accessible on the intranet site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives.
- Gillick competence (a term used in medical law to decide whether a child [16 years or younger] 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.
- Staff were clear on how they mostly sought verbal and implied informed consent due to the nature of the patients attending the departments. Written consent was mostly sought before providing care or treatment such as anaesthetics.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults and children, the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead.
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient. Patient records showed that verbal or written consent had been obtained from patients or their representatives.

Are urgent and emergency services caring?

Good

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

Compassionate care

- All the patients, relatives and representatives we spoke to during the inspection were positive about the care and treatment provided.
- We observed many occasions of compassionate care being provided. A child who was in the spinal injuries unit at Southport Hospital had recently been provided with a play schedule by the play specialist based at Ormskirk Hospital to ensure the child wasn't bored.
- A review of the data from our adult inpatient survey 2013 showed that 79% of patients felt they were given information about their condition and 89% felt they were given sufficient privacy and dignity.

Urgent and emergency services

Understanding and involvement of patients and those close to them

- We saw ambulance staff work with the hospital staff to ensure continuity of care by making sure all information about patients was handed over to the staff at triage.
- Upon admission, patients were allocated a named nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent.
- Patients confirmed their consent had been sought before care and treatment was given.

Emotional support

- We observed staff providing patients with emotional support, with many positive interactions such as reassuring and comforting children who were anxious or worried. We observed healthcare assistants performing distraction therapy to ensure children didn't feel anxious.
- A relative's room was available for people who had witnessed trauma such as road traffic accidents. There was a viewing room for deceased patients that allowed family to spend extra time with their loved ones.
- A link nurse was assigned to A&E from the end-of-life team. This nurse had provided training in dealing with patients who were deteriorating and families of those who had passed away. Bereavement packs were also available in the department.
- Staff confirmed that debriefs were held after all traumatic events and that they could access counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as fatal road traffic accidents, or if they had a negative experience.
- Staff told us a senior manager was available for emotional support if required, and that they could take some downtime after very traumatic experiences.

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

Good

A departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances, and capacity was being constantly monitored via daily bed management and safe staffing meetings. The trust had done a significant amount of work to tackle the capacity and patient flow challenges that had affected its performance. Performance was improving trust wide and as an individual location, Ormskirk Hospital met its target to admit or discharge 95% of patients within 4 hours of arrival at A&E between April 2014 and September 2014.

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

Service planning and delivery to meet the needs of local people

- The departmental escalation policy described how the department would deal with a range of foreseen and unforeseen circumstances where there was significant demand for services.
- There was a responsive coordination of senior staff who arranged beds, investigations and scans to ensure the service could better manage patients at busy times.
- Capacity was being constantly monitored via daily bed management and safe staffing meetings.
- The hospital was part of the North West and North Wales Transport Service (NWTS) that is a collaboration between Royal Manchester Children's Hospital and Alder Hey Children's Hospital. It was commissioned to transfer critically ill children from district general hospitals to one of the two paediatric intensive care units within the North West and North Wales area. Clinicians could get clinical advice on the management of a critically ill child, a paediatric intensive care unit bed and a transport team as needed with one phone call, by means of teleconferencing with relevant specialist teams such as cardiology and neurosurgery.

Access and flow

- During routine operating hours, the department could cope with the patient flow, and staff felt there was sufficient capacity. However, when paediatric trained nursing staff from the department were called away to assist in other duties, such as covering the bed management duties and being the designated on call person for the site, the department was put under pressure.

Urgent and emergency services

- The hospital had a clear escalation policy that described the steps staff would take when demand caused pressure on capacity. Staff were familiar with this policy and were clear about the importance of the whole hospital, and other agencies working together.
- Overall, the trust met the national Department of Health target for emergency services to admit or discharge 95% of patients within 4 hours of arrival at A&E by achieving 97% from April 2014 to September 2014.
- Total time in A&E (average per patient) from January 2013 to May 2014 was below the England average.
- Data were collated about patients leaving the department without being seen, and showed that the rate of this was below the England average from January 2013 to May 2014 and always below the upper target of 5% set by the Department of Health.
- The Department of Health data are a combination of Southport Hospital and Ormskirk Hospital. Data for the Ormskirk Hospital children's A&E showed that the department met the targets comfortably between April 2014 and September 2014, where the lowest compliance was in October at 99.84%.
- Data provided by the trust showed there were only nine breaches to admit or discharge 95% of patients within 4 hours from April 2014 to October 2014. All individual breaches were investigated and categorised by why they occurred.
- The number of attendances to the emergency department also varied, with the department seeing 2031 patients in April, 2150 patients in May, 2172 patients in June, 2180 patients in July, 1430 patients in August and 1871 patients in September.
- The target to achieve 85% of ambulance handovers within 15 minutes was achieved by the department at Ormskirk Hospital.
- The clinical director for the emergency department told us should any ambulance wait for over 60 minutes this was automatically raised as an incident and a root-cause analysis investigation was undertaken. There had been no ambulance waits of this time.
- The percentage of emergency admissions via A&E for which the time between the decision to admit and being admitted was between 4 and 12 hours .(sometimes termed the conversion rate) was better than the England average. The department has a low conversion rate because high numbers of lower acuity patients are seen compared to an average A&E department.
- Referral to treatment times were below the England average for similar trusts.

Meeting people's individual needs

- A variety of information leaflets were available in all areas of the emergency department and via the trust internet site. Some leaflets had been translated into Polish for the large local Polish community. The leaflets had references to recognised guidance such as the National Institute for Health and Care Excellence (NICE).
- Staff told us they would use interpretation services via telephone or face-to-face, if English was not a patient's first language. Staff would only use relatives or family members to assist patients when it did not involve consenting to procedures.
- A noticeboard and information leaflets outlined the chaplaincy services available with timings for specific prayers and services.
- If a patient was identified with learning disabilities, staff could contact specific link nurses for advice and support.
- Staff had access to a passport document for patients admitted to the hospital with learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's medical history and likes and dislikes, which made it easier for staff to meet patient's individual needs.
- Care plans were in place in the A&E department for children and people aged 16 to 19 with learning disabilities who regularly accessed the emergency department for reoccurring and on-going conditions.
- We saw that patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- Play specialists provided distraction to children who were having treatment. They worked from 8am to 4pm Monday to Friday in areas such as the x-ray department and in the theatres, to make children feel at ease. They had also provided training to all the healthcare assistants in distraction therapies.
- The emergency department was well maintained, secure and was designed to ensure children remained safe. It had been decorated in bright colours.

Learning from complaints and concerns

- Information was displayed in the department about how patients and their representatives could complain.

Urgent and emergency services

- Complaints were recorded on a centralised trust-wide system. The centralised customer services team managed formal complaints. A complaints review panel was held to discuss more serious complaints.
- Staff understood the process for receiving and handling complaints and told us that information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.
- Noticeboards included information such as the number of complaints and compliments received. For September 2014, one complaint was received in relation to staff referring parents for safeguarding due to unexplained fractures in a child. We investigated this and found appropriate action had been taken.

Are urgent and emergency services well-led?

Good

The organisation's vision and strategy had been cascaded to all staff, who were proud of the work they did. The overall ethos was centred around the quality of care patients received, and meeting targets was secondary. Key risks and performance data were monitored. There was clearly defined and visible leadership, and staff felt free to challenge any staff members who were seen to be unsupportive or inappropriate in carrying out their duties.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Senior staff were aware of the risk register, performance activity, recent serious untoward incidents and other quality indicators.
- The divisional risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and executive levels.
- Risks were rated from low to high with the lower risks being managed at ward level and the higher risks being escalated corporately.
- The clinical director told us the department's biggest risk was not being able to recruit medical staff, which impacted on the skill mix. The second risk was patient flow during busy times. The matron expressed that taking trained staff away for bed management was a big risk.
- We looked at the divisional risk register and saw these and other key risks had been identified and assessed.
- Day-to-day issues, information about complaints, incidents and audit results were shared on notice boards around the department and via meetings and safety huddles.
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles within department. The departments were well-led locally by the senior staff on the wards, the clinical leads and the matrons.
- Senior staff in the department provided visible leadership, particularly at times when the department was stretched.
- The teams were motivated and worked well together with good communication between all grades of staff. There were rotations between staff from the A&E and staff from the paediatric wards to enhance working relationships and so they could appreciate each other's services.
- Staff felt their efforts were acknowledged and felt managers listened and reacted to their needs.
- Staff we spoke with felt free to challenge any staff members who were seen to be unsupportive or inappropriate in supporting the effective running of the service.

Urgent and emergency services

Culture within the service

- The matron, the senior sister, and staff in the emergency department told us the overall focus of the work was the "child" and that "children were at the centre of everything they did". The quality of care patients received came before meeting targets and cost of care.
- We observed that staff from all specialties worked well together and had mutual respect for each other's specialties.
- Staff told us they were encouraged to report any issues in relation to patient care or any adverse incidents that occurred.
- Overall staff spoke of an open culture where they could raise concerns that would be acted upon. They were dedicated and compassionate and felt proud to work at the hospital.
- Staff told us the morale within the department was mostly good and the teams worked well together. However, at times, when the department reached high patient capacity, staff felt that the morale dropped.

Public and staff engagement

- Information on how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also available on the internet site.
- Staff told us they routinely asked patients and relatives for their feedback..
- Information was displayed on notice boards on the number of compliments and complaints received in the department.
- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and departmental meetings. Staff told us they were made aware when new policies were issued.
- The autumn/winter 2014 newsletter included feedback from the public and staff, and relayed information about events and strategies taking place. Positive feedback about the latest A&E target for spring being met was also included.
- The department included 'What are you saying' information on notice boards, which listed improvements made by the trust in response to queries raised by patients.

Innovation, improvement and sustainability

- The matron and the senior sister told us the main challenge was staffing, and in particular senior nurses with intermediate and advanced life support training covering the bed management rota, which left them short staffed.
- The A&E department had made a 'safety thermometer' (measures targets in the department for a quick overview of how safe the department is) using their own initiative, as they felt the information being collected wasn't appropriate for a children's A&E. The thermometer gave information such as training targets met, sickness in the department and early warning score compliance data. Staff felt this was a positive initiative.

Medical care (including older people's care)

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

Information about the service

The only medical service provided at Ormskirk District General Hospital was a small rehabilitation service provided on H ward. H ward has 14 beds and provides longer term rehabilitation care and treatment predominantly for patients with neurological conditions.

Summary of findings

There were insufficient medical and nursing staff with the appropriate skills and experience to provide safe and effective care to patients on H ward outside of normal working hours.

Staff were confident in reporting incident but did not always receive feedback and lessons learned from incidents were not widely shared.

National guidelines were used to treat patients. Care and treatment was delivered by a multi-disciplinary care team who worked together effectively, but seven day working was not in place. Services provided on H ward were generally responsive to people's needs, however there was no adequate provision for patients who needed a blood transfusion without transferring them out of the hospital.

Medical care services were delivered by a hardworking, caring and compassionate staff who treated patients with dignity and respect.

H ward was well-led, although there was a disconnect between the staff providing hands on care and the executive team. The system in place to communicate risks and changes in practice to nursing staff required improvement.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We found Medical Care Services to require improvement. The RMO (resident medical officer) provided medical cover around the clock for two week periods of time without a break.

There were insufficient nursing staff with the appropriate skills and experience to provide safe and effective care to patients outside of normal working hours.

Staff were confident in reporting incidents but did not always receive feedback, and lessons learned from incidents were not widely shared.

Incidents

- There were robust systems for reporting incidents and' near misses across the medical directorate, including H ward. Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so.
- Staff on H ward received feedback from incidents they were involved in but received very little feedback from other incidents throughout the medical directorate which could have had informed and improved their own practice.

Safety thermometer

- Staff managed patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. This is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month. Information was displayed on the ward performance board.

Cleanliness, infection control and hygiene

- Performance related to infection prevention and control was monitored monthly across the medical directorate.
- Specific infection control issues were discussed during the ward safety huddles and at handover meetings. Staff on H ward could describe actions taken to improve infection control performance.
- There was an ample supply of hand washing facilities and liquid soap and hand towel dispensers were adequately stocked. Alcohol hand gel was available throughout H ward and good hand hygiene was observed throughout our visits.
- Staff observed 'bare below the elbow' guidance and wore personal protective equipment, such as gloves and aprons while delivering care.

Environment and equipment

- Nursing and allied health professional staff we spoke with told us they had all the equipment they needed to provide safe and effective care for patients.
- Emergency equipment was checked daily and was ready for use if required.

Medicines

- Medicines were stored correctly, including the safe storage of controlled drugs.
- The temperature of the drugs fridge was checked and recorded daily.
- During our inspection we reviewed three medicine charts and found them to be well completed.

Records

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

Safeguarding

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

Mandatory training

- Compliance with mandatory training for nurses and allied health professionals on H ward was very good, showing compliance rates well above the trust target of 90%.

Assessing and responding to patient risk

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

Medical care (including older people's care)

- Staff we spoke with told us how they accessed medical advice and assistance both within and outside of normal working hours. Within working hours access to medical assistance was satisfactory.
- Outside of normal working hours emergency medical care was provided by resident medical officer, who was a junior doctor. The ward manager on H ward had escalated this as a risk as they had concerns regarding the competency of the resident medical officer in recognising and taking appropriate action with regard to deteriorating patients.
- The resident medical officer was on duty, day and night for 2 week periods. Nursing staff were aware of this and had been instructed not to call the resident medical officer during the night unless absolutely necessary. Any calls by nursing staff to the resident medical officer were triaged by the clinical bed manager to ensure they were not disturbed unnecessarily. This risked nursing staff being less likely to call early for medical assistance if a patient's condition was deteriorating.

Nursing staffing

- There were insufficient nursing staff to provide care and treatment for patients on H ward at night.
- Copies of nursing off duty and actual staffing numbers displayed at the entrance to H ward demonstrated that it was usual for the ward to be staffed by one trained nurse and one healthcare assistant at night. Almost all the patients were heavily dependent and required care to be delivered by two people. This meant the trained nurse was unable to administer the medicines and deliver care as both were required at the same time. This was usually managed by a clinical nurse manager assisting with patient care while the medicines were administered, when they were available to do so. Night staff during our unannounced inspection confirmed this was normal practice.
- Nursing handovers took place at the start of each shift. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were detailed and staff on duty were familiar with the needs of patients under their care.

Medical staffing

- The resident medical officer was employed by an agency to provide emergency cover only. Despite this they undertook all medical tasks at weekends and out of hours, including routine prescription of medicines for patients being discharged, which left them feeling overworked and exhausted.This had been highlighted as a risk by the surgical team. Further information can be found within the surgical report for this hospital.

Major incident awareness and training

- Plans were in place to deal with the additional pressures on beds and staffing within the trust during the winter, which included H ward. The effectiveness of these plans was reviewed regularly in line with changing demands on the service provided"

Are medical care services effective?

Requires improvement

National guidelines were used to treat patients. Care and treatment was delivered by a multidisciplinary care team who worked together effectively, but 7 day working was not in place. There was no routine medical presence on H ward at weekends. Patients who were not acutely ill and did not require a daily review of their condition were not routinely seen by a doctor at weekends.The trust told us there is no doctor presence at weekend due to patients being medically optimised for discharge and undergoing rehab, therefore no requirement for ward rounds at the weekend.

Evidence-based care and treatment

- Staff on H ward used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and had been updated periodically.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care bundles were used in the treatment of sepsis.

Pain relief

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

Nutrition and hydration

- Appropriate nutritional assessments had been done and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.

Medical care (including older people's care)

- Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We saw that volunteers were used very effectively at mealtimes which enabled more patients to receive assistance with meals in a timely manner.

Patient outcomes

- The average length of stay for patients on H ward was significantly worse than the England average. However, it should be recognised that the patients admitted to this ward required considerable rehabilitation in order for them to be discharged. It is not unusual for patients who need this level of rehabilitation to have a longer than average length of stay.

Competent staff

- 74% of staff across the trust had an appraisal in the last year. All staff we spoke with on H ward told us they had received an appraisal in the last year and that they had found the process valuable.
- The General Medical Council's decisions about revalidation of doctors at this trust is in line with other trusts throughout England.

Multidisciplinary working

- Goal setting was an important part of the recovery process for patients on H ward. Patients were involved at each stage of the goal setting process.
- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multidisciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.

Seven-day services

- There was no routine medical presence on H ward at weekends. Patients who were not acutely ill and did not require a daily review of their condition were not routinely seen by a doctor at weekends.
- There was no routine service provided by allied health professionals outside of normal working hours.
- Limited diagnostic services, such as x-rays and ultrasound, were available out of hours.
- Some services, such as laboratory services were provided from Southport District General hospital out of hours. Provision of point of care testing machines, meant that some samples needed to be transported to SDGH. This resulted in delays as specimens were transported to the neighbouring hospital.

Access to information

- Access to information was good for patients and their families. We saw examples of comprehensive information for patients about the management of their health conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are medical care services caring?

Good

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

Compassionate care

- We found that care and treatment throughout the medical directorate was delivered by hardworking, caring and compassionate staff.
- We spoke with five patients and everyone spoke very positively about the care they had received. Some comments made were, "They look after me really well here " and "All the staff on this ward are brilliant".
- We saw examples of ways in which people were encouraged to share their impression of the hospital and ways in which improvements could be made.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Of those patients who responded to the test within the medical directorate, including H ward, over the last 6 months, the majority of patients would recommend the trust for care, with between 80% and 92% reporting they would be likely or extremely likely to recommend the trust. Between April 2014 and September 2014 an average of 70% of patients said they would be extremely likely to recommend the service.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

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

Emotional support

- Staff built up trusting relationships with patients through their interactions and patients told us that they received considerable emotional support. Staff we spoke with were conscious that at times reduced staffing affected their ability to consistently offer emotional support to patients and families.

Are medical care services responsive?

Requires improvement 

Services provided on H ward were generally responsive to people's needs, however it was noted that at certain times there were insufficient members of staff to meet the needs of patients for example when there was only two members of staff and medicines were being administered it left only one member of staff available to support patients other needs and when the majority of patients required two staff to support them they had to wait for basic care. There was also no adequate provision for patients who needed a blood transfusion without transferring them out of the hospital.

Service planning and delivery to meet the needs of local people

- The rehabilitation facilities within H ward were good. The nursing and allied health professionals were next to each other on the ward, which enabled good communication and effective multidisciplinary working. There was a bright, roomy and well equipped therapies room attached to the ward.
- There was good communication and co-operation between the hospital staff and local community teams from both the NHS and local authority, which enabled safe, timely and effective discharge of patients.

Access and flow

- Patients were assessed before admission to H ward and were not moved within the hospital, once admitted to the ward, unless there was a clinical need to do so.
- We saw that the multidisciplinary team met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. Multidisciplinary team decisions were recorded, and care and treatment plans amended to include changes.

Meeting people's individual needs

- When the ward was staffed with two members of staff with a ratio of 1:7 this met the safer nurse staffing guidance but left patients waiting for basic care whilst one member of staff administered medicines. The trust had taken temporary mitigation utilising the bed manager to support at this time but this support was not always available and therefore did not fully mitigate the risks associated with the low staffing number at this time.
- There was a system in place throughout the medical directorate, including H ward, to ensure that all staff were aware if a patient was living with dementia This was achieved using helping hand stickers on patient identification bands, care plans and on the boards at the back of patients' beds. All staff we spoke with were aware of the meaning of the helping hands stickers.
- We saw the use of yellow wrist bands on H ward, which indicated patients who could be at risk of falls.
- For patients whose first language was not English, staff could access a language interpreter if needed. British Sign Language interpreters were available for deaf people.
- Patients who required a blood transfusion while being cared for on H ward occasionally had to be transferred to Southport and Formby Hospital for this to take place. This was because only two senior nurses on H ward had up to date competencies for the administration of blood. This meant that if these staff members were not on duty then the patient would be transferred to Southport for the procedure. One of these staff members was due to go maternity leave imminently. The trust assured us that the admission criteria for patients on H ward was that patients would be haemodynamically stable. Therefore if a patient

required a transfusion they would be unwell and transferred back to SDGH. This was a conscious decision as rehabilitation patients would not require transfusions.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would signpost patients to the Customer Services team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- There was information displayed in H ward on how to complain. Patients we spoke with knew how to raise concerns, make complaints and provide comments, should they wish to do so.

Are medical care services well-led?

Good

The trust had a vision and strategy for the organisation, with clear aims and objectives which had been cascaded to staff on H ward. There was no local vision although risks within the medical directorate were discussed regularly but the system in place to communicate risks and changes in practice to nursing staff was not robust.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives which had been cascaded to the medical wards, including H ward. Most staff we spoke with had some awareness of these, particularly the trust values. However, there was no local vision or strategy.

Governance, risk management and quality measurement

- Risks within H ward were discussed regularly at both ward and divisional level and escalated where necessary.
- The medical directorate had a quality dashboard for each service and ward area, including H ward. This showed performance against targets and these were presented monthly at the clinical governance meetings.
- H ward's system for communicating risks and changes in practice to nursing staff was not robust. The ward manager relied on verbal dissemination of information during staff handovers and a 'read and sign' system. This system required staff to read information and sign to say they had done so. It was difficult to keep track of which staff had read the information, particularly when they were off on holiday or sick leave, and several weeks could pass without all staff accessing important risk-related information.
- An appropriate environment had not been provided for the on call resident medical officer. A public toilet had been closed to provide the resident medical officer with some privacy, but facilities were poor, particularly considering they were on duty for 2 weeks without being able to leave the hospital

Leadership of service

- The medical, nursing and allied health professional staff on H ward were well led, with senior managers that were well respected and provided positive role models for staff.
- Staff told us that their immediate line managers were accessible and approachable. We were given examples of how staff had been well supported by their senior managers through personal and professional difficulties.
- Staff told us they felt disconnected from the executive team and did not feel that the executive team appreciated the day to day operational challenges involved in delivering direct care and treatment to patients.

Culture within the service

- Most staff spoke enthusiastically about their work. They described how they enjoyed their work, and how privileged they felt to work on H ward.

Public and staff engagement

- Although data from the NHS staff survey 2013 put the trust in the worst 20% nationally for overall staff engagement, staff we spoke with on H ward did not feel that this applied to their ward. They told us they felt well motivated, and felt able to contribute to improvements at work. Several staff members described themselves as "lucky" to work on H ward.

Surgery

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

Information about the service

We visited Ormskirk and District General Hospital as part of our announced inspection on 11 November 2014. The hospital carried out a range of surgical services including ophthalmology, oral surgery, urology and general surgery There were three surgical wards and seven theatres that carried out day case surgery as well as some limited elective and emergency surgery procedures.

As part of the inspection, we inspected the main theatres, G ward (the orthopaedic ward), F ward (the day case and ophthalmology ward) and the maxillofacial unit, which provided day case oral, maxillofacial and orthodontic services.

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

Summary of findings

The overall rating for the urgent and emergency services at Ormskirk and District General Hospital is good however some improvements are needed in the safe domain.

Patients were supported with the right equipment; however there was no approved schedule for replacing older equipment used in the theatres. The staffing levels in the theatres were not sufficient. We found that there were 10.68 whole time equivalent vacancies in the theatres. The theatres department had plans in place to address this and had started to recruit additional staff.

There was a potential risk of unsafe care because the arrangements for medical cover on the wards were not sufficient. There was one resident medical officer who worked 24 hours per day continuously over a two week period. The trust had identified that the level of cover provided by the resident medical officer was inadequate and had prepared a draft proposal to recruit an advanced nurse practitioner and a prescribing pharmacist. However, this proposal had not been approved at the time of our inspection.

The theatre teams undertook the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. An audit to monitor adherence to the WHO checklist for September 2014 demonstrated that improvements could be made as the procedure was not fully completed in all cases.

Surgery

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

The majority of patients had a positive outcome following their care and treatment; however, the number of patients that underwent elective trauma and orthopaedic surgery and were readmitted to hospital following discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was better than the England average across all the elective specialties at the hospital.

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

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

The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. The number of cancelled elective operations was better than the England average, and there had been improvements in performance against 18 week referral to treatment standards. There were plans in place to improve theatre efficiency so that patients admitted to the surgical services received timely and appropriate care.

There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available across the surgical services. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and how to resolve these.

Surgery

Are surgery services safe?

Requires improvement

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Incidents

- The strategic executive information system data showed that there had been one 'never event' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers) reported by the hospital since March 2013 relating to surgery.
- The incident occurred when a swab was left inside a patient after breast surgery in July 2013. This was investigated and remedial actions were put in place to prevent recurrence, such as the standardisation of information on theatre white boards and increased monitoring of staff compliance to the world Health Organization (WHO) surgical safety checklist.
- There were no reported serious incidents in the surgical services at this hospital during 2013–2014.
- The staff we spoke with were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system. Complaints, compliments and allegations of abuse were also logged on the system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers, to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Information relating to lessons learned from incidents, such as medication errors, were displayed on notice boards in all the areas we inspected. Staff told us incidents and complaints were also discussed during routine staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.
- The number of patient deaths in surgical services was in line with national averages. Patient deaths were reviewed by individual consultants within their surgical specialty area and reviewed at monthly or bi-monthly audit meetings within each specialty. This information also fed in to trust-wide hospital mortality and morbidity review meetings.

Safety Thermometer

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

Cleanliness, infection control and hygiene

- Information supplied by the trust showed there were no cases of MRSA or Clostridium difficile (C. difficile) infections relating to surgery at the hospital.

Surgery

- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were sufficient hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment such as gloves and aprons while delivering care. Gowning procedures were adhered to in the theatre areas. Patients identified with an infection were isolated in side rooms and we saw that appropriate signs were used to protect staff and visitors.
- Staff carried out weekly commode audits and monthly hand hygiene audits. Trust data showed that there was a high level of staff compliance across the areas we inspected.

Environment and equipment

- The wards and theatres we inspected were clean, well maintained and free from clutter.
- The equipment we observed in the wards and theatre areas was clean, safe and well maintained. However, we found that equipment such as the anaesthetic machines and monitors were old. The surgical risk register stated that anaesthetic machines were greater than 8 years old and therefore at risk of breakdown. Staff carried out routine checks on the equipment so faulty equipment could be identified and replaced if needed.
- The associate medical director told us there was minimal impact to patient safety, because the theatre equipment was fully functional and well maintained. There was no formal planned and approved equipment replacement schedule for replacing the older equipment. The associate medical director told us this was mainly due to financial constraints.
- The staff we spoke with told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- Staff told us they used single-use, sterile instruments where possible. The single-use instruments we saw were within their expiry dates.
- Reusable surgical instruments were sent to a dedicated sterilisation unit at Southport and Formby District General Hospital. Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs. However, they told us that some surgical instruments, such as those in orthopaedic kits, were old and needed replacement.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

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

Records

- The trust used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for four patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition, and these were completed correctly.

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

Safeguarding

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

Mandatory training

- Staff received annual mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire safety, safeguarding children and vulnerable adults, manual handling, conflict resolution and resuscitation.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- Trust data between April 2014 and September 2014 showed that the majority of staff across the planned care division had completed their mandatory training (83.33%). However, the trust's internal target of 90% compliance in mandatory training had not been achieved.

Assessing and responding to patient risk

- The staff we spoke with were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the acting matron for ambulatory care to address these risks.
- Upon admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks. Patients at high risk were placed on care pathways, and care plans were put in place to ensure they received the right level of care.
- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical conditions could be promptly identified.
- If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- The theatre teams undertook the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. Staff carried out an audit to monitor adherence to the WHO checklist by reviewing completed records and by observing at least one surgical procedure within each theatre on a monthly basis.
- The results for September 2014 audit demonstrated that a briefing took place prior to the commencement of the operation list in 100% of cases although names were only recorded on a visible wipe clean board in 80% of cases and changes to the published Galaxy list were only discussed in 80% of cases. All checks during and post procedure were carried out in 100% of cases which was an improvement on the August audit where only 80% of documentation was completed at each stage of the process and not retrospectively.

Nursing staffing

- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.
- The wards we inspected had sufficient trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Staffing levels were monitored against minimum compliance standards, based on national NHS safe staffing guidelines. Information on staffing levels, including actual versus expected numbers of staff on duty was clearly displayed near the entrance to the ward and theatre areas and these were updated daily.
- The theatres did not have sufficient trained theatre staff. We found that there were 10.68 whole time equivalent vacancies in the theatres.

Surgery

- The matron for theatres told us that seven additional band 5 nurses/operating department practitioners had been recruited and were due to start work in the near future. Three of these recruits were not due to start until May 2015.
- The matron for theatres was also scheduled to travel to Eastern Europe in December 2014 to source band 5 theatre nurses and operating department practitioners.
- Staffing levels in the wards and theatres were maintained with the use of bank and agency staff. The matron for theatres told us the majority of agency staff working in the theatres were regular agency staff that had had induction training and were familiar with the theatre department's policies and procedures.
- Trust data showed that there was low usage of temporary staff in the surgical wards. The use of temporary staff only exceeded 10% for two of the past 12 months on the G ward.
- The ward staff we spoke with also told us they felt the wards were appropriately staffed. However, staff on the G ward told us they were routinely transferred to work on other wards at the trust's other hospital during the night shift to support areas where staffing levels were not sufficient.
- The patients we spoke with spoke positively about the staff and did not identify any concerns about staffing levels.

Surgical staffing

- Medical cover on the wards was provided by two resident medical officers (RMOs) that worked alternate shifts every two weeks. During their shift, the RMO was based at the hospital 24 hours per day over the 2 week period. The RMO was resident on site and was available on call outside of normal working hours.
- During their shift, the RMO was responsible for providing medical cover over three wards, prescribing medicines, carrying out patient discharges and taking patient blood samples due to a lack of phlebotomist cover on the wards.
- The associate medical director for planned care had identified that the level of cover provided by the RMO was inadequate and had prepared a draft proposal in October 2014 to recruit an advanced nurse practitioner 12 hours per day, seven days per week and a ward prescribing pharmacist five days per week. This proposal had not been approved at the time of our inspection.
- The ward staff we spoke with told us they received good support from the RMO but were instructed not to disturb the RMO outside of normal working hours unless absolutely necessary. The ward staff told us they could directly access the on-call consultant if needed.
- We found there was sufficient on-call consultant cover over a 24-hour period. However, the staff we spoke with told us on-call consultants were not always free from other clinical duties and could be involved in ward-based duties or have limited elective surgery lists.

Major incident awareness and training

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

Are surgery services effective?

Good

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services at the hospital performed in line with similar sized hospitals and performed within the England average for applicable safety and clinical performance measures.

The majority of patients had a positive outcome following their care and treatment; however, the number of patients that underwent elective trauma and orthopaedic surgery and were readmitted to hospital following discharge was higher (worse) than the England average. The average number of days patients stayed at the hospital was better than the England average across all the elective specialties at the hospital.

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

Surgery

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- Trust data showed that between April 2014 and September 2014 there were 121 clinical audits planned, of which 74% were being progressed. Findings from clinical audits were reviewed at monthly clinical governance and performance meetings.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline 83).
- Staff in the surgical wards used enhanced care and recovery pathways, in line with national guidance. However, these were only used for selected patients. The majority of patients admitted to the orthopaedic ward post-operatively still had cannulas and catheters in place. Enhanced recovery guidelines state that routine catheters should be avoided or removed early. The limited use of enhanced care pathways meant that patients could take longer to recover fully.
- The staff we spoke with told us that policies and procedures reflected current guidelines and were easily accessible via the trust's intranet.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.
- The patient records we looked at showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- All the patients we spoke with told us they received good support from staff and their pain relief medication was given to them as and when needed.

Nutrition and hydration

- The patient records we looked at included an assessment of patients' nutritional requirements.
- Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients were not eating enough, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk.
- The patients we spoke with told us they were offered a choice of food and drink, and spoke positively about the quality and portion sizes.

Patient outcomes

- There was participation in national audits such as the national joint registry database.
- The national joint registry data showed that the hospital had 100% compliance over the past three years, and hip and knee mortality rates were within the national average.
- Performance reported outcomes measures (PROMs) data between April and December 2013 showed that the percentage of patients with improved outcomes after hip and knee replacement procedures was similar to the England average.
- Hospital episode statistics 2013/14 data showed that the number of patients that had elective urology and general surgery and were readmitted to hospital after discharge was lower (better) than the England average. The readmission rate for elective surgery patients was worse than the England average for trauma and orthopaedics. The associate medical director for planned care told us readmission rates were routinely monitored to look for possible improvements to the service.
- Hospital episode statistics 2013/14 data showed that day surgery rates (number of patients seen) at the hospital were within acceptable standards for all specialities.
- The associate medical director for planned care told us that ophthalmology day case services were provided at this hospital and the trust was reviewing whether these services should be offered from Southport and Formby District General Hospital.
- Hospital episode statistics 2013/14 data showed that the average length of stay for patients across all elective and non-elective specialties at the hospital was either similar or shorter (better) than the England average.

Competent staff

- Newly appointed staff underwent an induction process and their competency was assessed before working unsupervised. Agency and locum staff also had an induction before starting employment.
- There was an education manager for theatres who supported the theatre manager to manage staff training.
- Trust data showed the majority of staff across the planned care division (74.63%) had completed their

annual appraisals during the April 2014 to March 2015. Appraisals were on-going, and the staff we spoke with told us they routinely received supervision and annual appraisals.
- Consultants had peer appraisals and were overseen by the medical director.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities, and told us they were supported well by their line managers.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff we spoke with told us they had a good relationship with consultants and the ward-based doctor (resident medical officer – RMO).
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed that there was routine input from nursing and medical staff and allied health professionals, such as physiotherapists.
- The ward and theatre staff we spoke with told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists and diagnostic support such as for X-rays and scans.
- The nursing and medical staff we spoke with told us they experienced connectivity issues with the bleep system and doctors could not be bleeped in certain parts of the hospital. The staff had identified alternative methods to manage this, but there was a potential patient safety risk if medical staff could not be accessed in a timely manner.
- There was effective multidisciplinary working between the Trust's two hospital sites so that patients that required emergency surgery could be transferred to Southport and Formby District General Hospital if needed.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside of normal working hours and at weekends on the orthopaedic ward (G ward).
- The day case ward (F ward) and maxilla-facial unit operated during normal week day hours and were not open overnight or at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical ward by the resident medical officer and on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctor.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on call outside of normal working hours and at weekends. The physiotherapist team was based on G ward and the ward staff spoke positively about the support they received.
- There was 24 hour access to theatres at weekends so any patients admitted over the weekend that required emergency surgery could be operated on.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives. The staff we spoke with were clear on how they sought informed verbal and written consent before providing care or treatment.

- The patient records we looked at showed that verbal or written consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- The staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals, in accordance with the trust's 'safeguarding adults' and 'safeguarding and child protection' policies.
- The patient records we looked showed that staff carried out mental capacity assessments for patients that lacked capacity and where deprivation of liberties safeguards applications had been made, the records for these were in place and completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications. The staff we spoke with were aware of the process for contacting the safeguarding team if needed.

Are surgery services caring?

Good

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

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- The areas we inspected were compliant with same-sex accommodation guidelines.
- We spoke with seven patients. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included "the staff are caring and would do anything for me".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Test data between April 2013 and July 2014 showed that the orthopaedic ward consistently scored above the England average, indicating a positive response from patients about whether they would recommend the ward to friends and family.
- The average response rate on the ward was also better than the England average at 43% compared to the England average of 33%.
- A review of the data from the CQC's adult inpatient survey 2013 showed that the trust was about the same in comparison to other trusts for all 10 sections, based on 380 responses received from patients.

Understanding and involvement of patients and those close to them

- Staff respected patients' right to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- The patient records we looked at included pre-admission and pre-operative assessments that took into account individual patient preferences.
- The patients we spoke with told us they were kept informed about their treatment. Patients spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- The patients we spoke with told us the nursing staff kept them involved and medical staff fully explained the treatment options to them and allowed them to make an informed decision.

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients. The patients we spoke with told us they received good support from staff with their emotional needs.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.

Surgery

- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services. Patients and their relatives were also provided with a bereavement booklet if needed.
- Staff told us they were aware of how to seek support from the trust-wide bereavement team for support and advice during bereavement.

Are surgery services responsive?

Good

The surgical services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. The number of cancelled elective operations was better than the England average, and there had been improvements in performance against 18 week referral to treatment standards. There were plans in place to improve theatre efficiency so that patients admitted to the surgical services received timely and appropriate care.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, ophthalmology, urology and general surgery.
- Hospital episode statistics 2013/14 data showed that 82% of patients had day case procedures, 14% had elective surgery and only 4% were emergency surgical patients.
- The majority of emergency surgery procedures were carried out in the Southport and Formby District General Hospital. There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery and urology.
- There was routine engagement and collaboration with staff from these trusts, such as on-site outpatient clinics and routine multidisciplinary team meetings.

Access and flow

- Patient records showed that patients were assessed upon admission to the wards or before having surgery.
- During the inspection, we had no concerns about the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns about their admission, waiting times or discharge arrangements.
- Patients having day surgery were given morning and afternoon appointment times. The patients and staff we spoke with told us patients were treated in a timely manner and did not experience extended waiting times.
- Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- Trust data between September 2013 and September 2014 showed that bed occupancy on the G ward ranged between 29.9% and 45.2%, and this was reflected during our inspection. We saw that patients were being cared for in a calm and relaxed environment on the ward.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for before and after surgery.
- NHS England data showed that the number of elective operations cancelled was lower (better) than the England average from April 2014 to September 2014.
- Trust data from April 2013 to September 2014 showed that there had been 515 operations cancelled at the hospital. The most frequent reasons for operation cancellations were patients did not attend (11.8%), operation not necessary (11.8%), list overruns (10.7%), patients had pre-existing medical conditions (10.5%) and patients were unfit with acute illness (10.3%).
- There was an action plan in place to address the key reasons for cancelled operations and there were specific actions listed to address issues such as list overruns, unavailability of the surgeon, anaesthetist or theatre staff, and equipment issues.
- Remedial actions taken so far included a review of start times and delays in lists, reduced theatre activity during anticipated periods of high pressure on beds, the appointment of a business support manager in October 2014 to manage anaesthetic staff availability, and the implementation of scheduling meetings to identify theatre staff issues in advance.
- A number of the identified actions had not yet been completed, including the recruitment of additional theatre staff and the replacement of equipment overdue for renewal.

- NHS England data showed that between July 2013 and June 2014, all patients whose operation was cancelled were treated within 28 days. The directorate manager for theatres told us staff arranged a new date with the patient on the day of the cancellation and this had significantly reduced the number of patients not treated within 28 days.
- There was a theatres improvement action plan in place with specific actions to address cancelled operations and to review the way theatres are used to improve this.
- NHS England data showed national targets for 18 week referral to treatment standards for admitted patients at the end of September 2014 were being met for most specialties. The data showed that this hospital was just below the waiting time target of 90% for general surgery (89.4%). The data showed that performance against waiting time standards had improved significantly compared with June 2014, when this hospital was not meeting the standards for trauma and orthopaedics, general surgery, oral surgery or ear, nose and throat surgery.
- The associate medical director for planned care told us they were confident that the appointment of two additional orthopaedic and two colorectal consultant surgeons would improve compliance with referral to treatment standards.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats such as braille if requested.
- Staff could access a language interpreter if needed.
- Staff could contact a trust-wide specialist safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff also used a document for patients admitted to the hospital with dementia or learning disabilities. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to complain. This included information about the trust's customer services team. The patients we spoke with were aware of the process for raising their concerns with the trust.
- We saw that notice boards included information such as the number of complaints and compliments received during the month. The staff we spoke with understood the process for receiving and handling complaints.
- Complaints and compliments were recorded on the trust-wide incident reporting system. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the complaints and governance lead for planned care, who notified individual managers when complaints were overdue.
- The majority of complaints raised within the surgical services were reported, investigated and responded to within the trust timescales. Trust data showed that between April 2014 and September 2014, there had only been four complaints raised across the three surgical wards. During this period, there had been a total of 83 complaints raised across the planned care division.

Are surgery services well-led?

Good

There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available across the surgical services. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and how to resolve these.

Vision and strategy for this service

- The trust had a clear vision and strategy with clear aims and objectives. The trust vision of 'excellent, lifelong, integrated care' was clearly visible and displayed across the wards and theatre areas we inspected however we did not see a local vision or strategy.
- The trust quality strategy 2012–2015 incorporated this vision and included specific performance targets relating to patient experience, effectiveness of services and patient safety.

Surgery

- The trust's nursing and care staff strategy 2013–2016 was based on the NHS England compassionate care standards (also known as 6 C's) and information relating to this was displayed on notice boards in the areas we inspected.
- The majority of staff we spoke with understood the trust vision and values. The trust chief executive assured us before the visit that all staff were aware of the professional standards introduced throughout the trust. However, we received a mixed response from staff about their understanding of these.

Governance, risk management and quality measurement

- There was an effective clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- During the inspection, we looked at the risk register for surgery and saw that key risks had been identified and assessed. The risk register was maintained by the head of risk for planned care, and was reviewed at routine clinical governance, performance and quality and safety meetings.
- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through monthly performance dashboards, and these were visibly displayed in the areas we inspected.

Leadership of service

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

Culture within the service

- The staff we spoke with were proud and spoke positively about the care they delivered. The majority of staff we spoke with told us there was a friendly and open culture.
- We also received negative comments through our medical staff focus groups, in which some members of staff highlighted a culture of bullying and discrimination of medical staff by individuals in the senior management team.
- Staff told us they were supported with their training needs by the management team of their specific area. Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- Trust data showed that staff turnover was consistently low over the past 12 months.
- Trust data showed that between April 2014 and September 2014 staff sickness levels across the planned care division were 4.8%, which was worse than the England average during that period.
- Trust data showed that between April 2014 and September 2014 the average sickness levels for G ward were 4.9%, the average sickness levels for F ward were 8.2% and the average sickness levels for maxillo-facial unit were 0.4%.
- Staff sickness levels were reviewed daily and staffing levels were maintained through the use of bank and agency staff.

Public and staff engagement

- The theatre and ward-based staff we spoke with told us they routinely asked patients and their relatives for feedback. Information on the number of compliments and complaints was displayed on notice boards in each of the wards we inspected.
- Patient feedback was also obtained through monthly matron's checklist surveys, which were conducted in the surgical wards by the acting matron for ambulatory care and sampled at least five patients per ward. The survey asked for patient feedback in areas such as patient safety, cleanliness and the quality of food and drink. The findings from the surveys were reported in monthly performance dashboards and we saw that patient feedback was mostly positive.
- There was also ad hoc engagement with the public via patient support groups and patient and public involvement groups.

- The staff we spoke with told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via email blogs, newsletters and through other general information and correspondence that was displayed on notice boards in staff rooms.
- The findings from the 2013 survey of NHS staff were reviewed as part of divisional operation meetings. Meeting minutes showed that communication between managers and staff, staff appraisals and the ability of staff to contribute towards improvements at work were identified as key concerns, and actions on how to improve these were documented.

Innovation, improvement and sustainability

- The planned care division business plan 2014/15 outlined the strategy for surgical services and included plans to meet financial and performance targets.
- The matron for theatres and the associate medical director for planned care told us the key risks to the surgical services were staffing and ensuring vacancies were filled. They told us they were confident the services were sustainable going forward.
- The associate medical director for planned care told us they planned to increase the number of ophthalmology and oral surgery patients seen at the hospital by recruiting additional oral and ophthalmology surgeons.

Maternity and gynaecology

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

Information about the service

The maternity and family planning services for Southport and Ormskirk NHS Trust are based at Ormskirk District General Hospital. They serve the population of Southport and Ormskirk and the surrounding areas. The services included antenatal and postnatal care (inpatient and outpatient), a delivery suite, ultrasound scanning, an early pregnancy unit, a gynaecology outpatient clinic and an inpatient ward. The service also included community midwifery services providing ante natal care, home birth and postnatal care.

During our visit we spoke with seven patients, six doctors and 25 band 5, 6 and 7 midwives. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 24 patients. We gathered further information from the data we requested from the trust, reviewed other information during our visit and compared the trust's performance against national data.

The service was managed through the Southport and Ormskirk Hospital NHS Trust urgent care business unit and was led by a clinical director and a head of midwifery.

There were 2674 births at the trust in the year to April 2014. This number had decreased by 156 births in the three months prior to the inspection to the lowest number in the previous 2 years.

Summary of findings

The maternity services at Ormskirk District General Hospital were inadequate in the safety and well led domains. The safety of people using the service was compromised due to a lack of learning from incidents and adverse clinical data, inadequate and out of date staff training and reduced numbers of experienced midwives employed. There were risks to patients whose condition deteriorated and experienced delays in receiving blood transfusions and from inadequately trained staff assisting in the obstetric theatre.

Although the service had recognised some of these risks it had not taken sufficient actions to mitigate them. Consent for surgical procedures was incorrectly recorded, records were not always stored confidentially and recognised risks that were recorded did not have sufficient actions to mitigate them in place.

There were a higher than average number of deliveries using forceps and of peripartum hysterectomies (Peripartum hysterectomy is a major operation and is invariably performed in the presence of life threatening haemorrhage during or immediately after abdominal or vaginal deliveries). There were no plans in place to reduce these. There was a lack of monitoring of the quality of the service with resulting lack of plans for improvement.

Midwives described a culture that was not open and transparent and where the leadership was inconsistent resulting in staff feeling that they could not easily raise

Maternity and gynaecology

issues or concerns. There were many newly qualified midwives employed which resulted in inexperienced staff fulfilling roles for which they lacked experience and competence.

The maternity services were delivered by caring staff who treated people with respect and dignity. People who had used the service spoke highly of the care they had received.

Are maternity and gynaecology services safe?

Inadequate

The maternity services at Ormskirk District General Hospital were not sufficiently safe to protect patients from harm. This was due to a lack of learning from incidents and adverse clinical data, inadequate and out of date staff training and the numbers of experienced midwives employed being below that necessary to provide adequate and safe care at all times. Those patients whose condition deteriorated or who required treatment in the obstetric theatre were at increased risk. This was due to the lack of blood transfusion service on site after 9pm and at weekends and the use of midwives with inadequate training or experience to assist in theatre and help patients to recover after operations.

Consent for surgical procedures was incorrectly recorded, records were not always stored confidentially and recognised risks that were recorded did not have sufficient actions to mitigate them in place.

Incidents

- The data provided by the trust showed that no never events had been reported by the service. Never events are serious. largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- Two serious incidents had been reported. Staff discussed learning from one of these and changes in practice to reduce the risk of recurrence. This included a situation, background, assessment and recommendation being developed, in line with NHS guidance, to be used when care was transferred between areas of the maternity unit.
- Staff knew how to report incidents. There was a process in place whereby the person reporting the incident received feedback about the investigation and outcome. There was a formal mechanism in place to ensure other staff received this information in a quarterly newsletter however these were inconsistent and staff did not refer us to the newsletter which raised concern as to the awareness of staff to this form of sharing learning from incidents. We were told there used

to be meetings for staff where this was discussed but these no longer took place. Staff described waiting for periods of over 3 months without feedback about incidents.
- Some staff described a culture of blame in the service which led to a lack of openness about incidents and learning from them.
- The mortality and morbidity data was discussed at the monthly maternity care forums. Individual cases were presented and any learning was discussed.

Safety Thermometer

- Information from the NHS Safety Thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, pressure ulcers and urinary and catheter infections) was displayed in the unit and available for patients to see.
- We reviewed the information held on the maternity dashboard and found that the information contained was comprehensive with regard to management issues such as completion of checklists and staff training status. There was no evidence that this information was used to monitor the quality of the service as there was a lack of clinical outcome indicators.
- There were data provided from various audits which when discussed with senior clinicians was not being used to monitor the safety of practices within the service. This included data that 36% of major post-partum haemorrhages (greater than 1500mls) in the trust were associated with forceps deliveries, as oppose to 5% associated with ventouse deliveries. The proportion of forceps deliveries in the trust was high at 8.6% compared with the UK average of 3.4% in the year 2013/14. We were told medical staff chose their own preferred method of delivery and there was no central discussion or guidance based on evidence.
- The peripartum hysterectomy rate was higher than the UK Obstetric Surveillance System (UKOSS) national average. There had been no investigations into this to understand the underlying factors and ensure it was the correct clinical decision when this procedure was carried out.

Cleanliness, infection control and hygiene

- The wards and areas we visited were clean. Cleaning schedules were in place and completed.
- The infection control audits scored highly for example 99% on one ward.
- We saw staff washing their hands and visitors and patients being reminded to use hand gel on entry to the ward areas.
- Staff wore personal protective clothing as appropriate and there was a supply available in the wards and other areas.
- There had been no reported cases of Clostridium difficile or MRSA in the maternity unit in the previous 12 months.
- Staff told us that they had received no information of their role or responsibilities with regard to measures to prevent the spread of Ebola virus.

Environment and equipment

- The wards and unit areas were tidy. There was a shortage of storage space which resulted in some equipment being kept in the corridors. Where this was necessary it was in the least busy area of the ward.
- Some of the areas of the wards were showing signs of wear of tear, such as worn flooring. The decoration was stark, with no homely features, which made the environment clinical. This included the birthing pool room and the room used for bereaved parents.
- There was necessary and appropriate resuscitation equipment in each area. This included resuscitation equipment for adults and babies where required. These were easily accessible and staff were aware of their position on the ward. They were checked daily with records kept. To ensure staff could quickly locate necessary equipment each trolley had identical layouts and equipment.
- Staff reported that there were adequate numbers of equipment such as cardiotocography monitors, cots, birthing beds and infusion pumps available in the unit.
- The routine maintenance of equipment was up to date. Staff reported that any deficiencies were quickly rectified and they had experienced no issues with allocation of equipment.

Medicines

- Piped medical gases were available on the delivery suite. There were additional portable gases were present in the other ward areas.
- Medicine records were accurately completed. Checks of controlled drugs were completed and recorded in line with current guidance.
- All medicines were securely stored where necessary. Fridges were locked and temperatures were checked.

- Ninety two per cent of staff were up to date with their medicines management training.

Records

- We reviewed four sets of patient records. All documentation was clear, legible and complete. There was a clear plan of patients' care. The records were in paper format.
- The child health record “red book” was issued at birth and women were talked through the purpose of the book and how to maintain the record.
- Various risk assessments were completed on an individual basis. These included identification of risks such as known infections and measures to be taken to minimise these risks
- The records were not always stored confidentially. On two wards we saw notes were unattended on the desk in the centre of the ward and open trolleys containing notes were left unattended.

Safeguarding

- Staff were aware of their responsibilities for reporting any concerns about the safeguarding of adults and children.
- According to records 22 staff members were not up to date with child protection training. This meant that staff who were caring for new-born babies may not have the knowledge required to safeguard them. The trust informed us there were issues with regard to monitoring of attendance at mandatory training on the Trust Oracle Learning Management System.
- Those we spoke with knew the procedure for raising concerns should they need to do so. This included the involvement of other agencies such as social services.
- There was a baby tagging system in place, which was checked daily. Staff were aware of the procedure to follow should an alarm be activated.
- The consultant midwife was the safeguarding lead for maternity. They attended monthly meetings with the clinical leads from each area to disseminate information and ensure they remained up to date.

Mandatory Training

- The midwives were supposed to do the trust mandatory training and specific midwifery mandatory training. Information provided by the trust showed that although some of the training was up to date other areas showed a high number of midwives who were not. This included 39% of midwives being up to date with cardiotocography training and 65% with neonatal resuscitation. The clinical lead midwife in each area was aware of the training needs of their own staff but there were difficulties releasing staff from the wards to attend training due to the shortage of staff. The trust informed us there were issues with regard to monitoring of attendance at mandatory training on the Trust Oracle Learning Management System.
- Midwives undertook skills and drills training for occurrences such as a vaginal breach birth and cord prolapse. They told us this was “very useful” training.
- The information provided about obstetric doctors' training showed the majority were not up to date including for emergency situations. Zero per cent of junior doctors and 13% of consultant obstetricians were up to date with maternal resuscitation training. Zero per cent of consultant obstetricians and anaesthetists and 24% of junior doctors had completed skills and drills training for ante-partum and post partum haemorrhage. The trust informed us there were issues with regard to monitoring of attendance at mandatory training on the Trust Oracle Learning Management System.

Assessing and responding to patient risk

- There were processes in place, throughout a woman's pregnancy, to identify signs of illness which may put the mother or baby at risk.
- An obstetric early warning chart was used to identify mothers whose condition was deteriorating. There was also a neonatal early warning score chart for new-born babies.
- The arrangements in place to provide additional midwives when the unit was busy relied on the goodwill of staff. There were a few temporary staff who could be called upon, but the majority of shifts were covered by permanent staff working extra hours.
- There were no pathology services on the site of Ormskirk Hospital during the night or at weekends. There was a limited supply of blood for transfusion (eight units) being immediately available. This put patients whose condition rapidly deteriorated because of a post-partum haemorrhage at increased risk. Measures had been put in place to reduce this risk, such as early blood cross matching for mother’s at known increased risk. This does not meet with the Royal College of Obstetrics and Gynaecology Guideline 47 which states "Women at high risk of losing greater than 1000mls should be strongly advised to deliver in a

setting where blood transfusion and intensive care facilities are available." One of the technicians from the Southport pathology laboratory would go to Ormskirk if the emergency obstetric haemorrhage protocol was initiated. We were told they would arrive within around 30 minutes. A third technician was also on call outside of normal working hours. Delays in treatment had occurred with one such incident leading to a 90 minute delay in a patient receiving a blood transfusion. This put patients whose condition was unstable, at increased risk.

- Information from the trust showed that 42% of all medical and midwifery staff were not up to date with skills and drills training for antepartum and post-partum haemorrhage management. Due to the risks associated with the lack of availability of blood for transfusion this could increase the risk to those patients.
- Patients whose condition required an increased level of care, such as that provided by a high dependency unit, could be managed on site. The midwifery staff, who provided care in this unit, received training for this level of care once every 4 years. The timescale of this training update was recognised as “not adequate” by senior staff and 25% of midwives were not up to date with this training. This could put patients at increased risk.
- Should a patient’s condition deteriorate further, or they required level one critical care, they would be transferred to the intensive care unit at Southport District General Hospital. The numbers of patients requiring transfer were not recorded on the maternity dashboard.
- Should a patient be transferred, their new-born baby would remain in the neonatal unit at Ormskirk District General Hospital. Staff recognised, by staff, that this resulted in the mother and baby being seperated immediately after birth, which is poor practice. There were some measures in place in the neonatal unit to account for this, such as daily photographs and a diary. Additional support was given to fathers and grandparents during this time.

Midwifery staffing

- All the midwives we spoke with, including the clinical leads, stated that staffing was their major concern. This was in terms of recruitment, poor retention, high sickness rates and not having sufficient staff available to ensure shifts were safely covered.
- The staffing requirement for maternity services within the hospital had been assessed using the Birth-rate Plus tool. This had been re-assessed in April 2014. At the time of the inspection there was a shortfall of 5.38 whole time equivalent midwives and five were off work on long-term sickness. This meant there was a reliance on the goodwill of midwives to work extra shifts and the use of bank midwives.
- The ratio of midwives to hospital births was one to 29. The recommended ratio is one to 28. The ratio of one to one care during labour was at risk due to this reduction of staff. The service should be providing one to one care in 100% of births and was achieving 98 - 99%.
- Eight new midwives had been recruited, two of whom had begun work. Seven of these were newly qualified and would require preceptorship mentoring by a band 6 midwife. This meant these new staff members could not complete all aspects of the work on the wards and departments, until they had been assessed as competent. The band 6 midwives told us that supporting the new staff also increased their workload.
- The sickness and absence rates for staff in the women's and children's division between October 2013 and September 2014 was an average of 2.62%. This was below the trust target of 3.7%.
- The midwives told us there was not always a suitably experienced staff member carrying out all aspects of the service. There was “often” a band 5 and a band 6 midwife on the antenatal ward which meant a band 5 midwife had to manage the triage system or the ward. Staff said they were concerned a midwife of this level did not have sufficient experience or knowledge to carry out this role.
- Concerns were raised by the midwives about the numbers of staff on the wards, particularly at night. We were told that staff needed to move between the wards to ensure there was adequate cover, which meant some areas were temporarily short of staff. One example given was of the person in overall charge of the hospital at night, who was not a midwife, being called to assist on the postnatal ward if a midwife had to assist on the delivery ward. Staff said these situations were not uncommon and were “unsafe.”
- Temporary casual midwives and agency health care assistants were used when required to increase the total number of staff. There was continuity in the use of the

same agency staff. There was an induction for these staff which covered all aspects of their work. Those we spoke with had completed this induction and were regularly working on the same units.

- Handovers were completed three times per day, at the beginning of every shift change. This included discussion of every patient on the ward, their current health status, any increased risks and the plan for the day's work.
- There were no operating department personnel working in the obstetric theatre. The midwives were part of the operating team, acting as the scrub nurse during caesarean sections. This practice does not meet recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The senior staff on the maternity unit were aware of this and it was on the risk register. The department planned to present a business case to employ operating department personnel for the obstetric theatre. There were no short-term measures in place to reduce this risk.
- Midwives who assisted in the obstetric theatre had not received adequate or appropriate training. The midwives who carried out these duties had received varied training for this role. Most had observed and assisted their midwife colleagues before them completing the tasks of the operating assistant themselves. There was no competency assessment in place for this role. We were told by the midwives that they completed a yearly self-declaration of competency. This meant that staff who did not have the skills, knowledge or competence to carry out the role were assisting in theatre.

Medical Staffing

- Seven full time consultants were employed and provided 9am to 8pm cover for the delivery suite Monday to Friday and two and a half hours on Saturday and Sunday. Outside these hours a consultant was on call and middle grade doctors reported they had "good support" from the consultants and did not have any issues with contacting them.
- There was no dedicated obstetric anaesthetist available 24 hours per day 7 days per week. The anaesthetist on call outside of normal working hours also provided cover for the accident and emergency department and paediatric units. This could lead to a delay in an anaesthetist being available in an emergency.
- A medical handover took place three times per day which we observed to be a thorough communication of the health status of each patient.
- Locums were being used to cover for maternity leave. It was discussed that there was consistency of locum doctors. Those we spoke with said they had received a thorough induction when they started, had been supernumerary (that is extra staff) for their first few shifts and received good support from their colleagues. They were included in the hospital training programme, including the skills and drills training.

Major incident awareness and training

- The staff we spoke with in the maternity department were not aware of their role, within the wider hospital, should a major incident occur. They had not taken part in any drills.
- There was a plan in place to ensure the maternity unit continued to provide a full service, in the event of severe staffing shortages. This constituted closure of the antenatal ward and both antenatal and postnatal care being delivered on the postnatal ward. The procedure included ensuring all equipment that may be needed was available. A dedicated lift would be used to transport women in labour to the delivery suite on the next level. This had been carried out for a 5 day period in the preceding month when decreased staffing levels had occurred over a weekend.

Are maternity and gynaecology services effective?

Requires improvement

There was no evidence that audits of clinical procedures were used to improve practices. Where relevant guidance was not met, such as the staffing of obstetric theatres, no measures to meet it were in place. The rate of forceps deliveries was higher than the England average and no action was being taken to reduce them. There were no clear strategies in place to improve patient outcomes, for example there was no support of other professionals such as dieticians or plans to reduce the rate of caesarean sections.

A system of midwives having their own caseload of women had been introduced. This had resulted in 240 women with

a need for increased support during their pregnancy receiving this support on a one to one basis. A strategy for increasing the number of women breast feeding had been introduced.

Evidence-based care and treatment

- The medical staff we spoke with were aware of the National Institute for Health and Care Excellence (NICE) guidelines that were pertinent to their area of work. The written policies we saw were based on the relevant latest best practice guidance.
- The specific clinical leads were aware of current practices or procedures that did not meet the relevant guidance. This included the use of midwives as operating department assistants in the obstetric theatres. There were no actions in place to reduce the risks recognised by this non-adherence to guidelines.
- There was no evidence that audits were being used to monitor and improve the quality of the service being provided. This included an audit of post-partum haemorrhage completed in 2013. This identified an increased number of occurrences when forceps were used of 8.6% compared with an England average of 6.9% and ventouse delivery of 4.6% compared with 5.7% nationally. No further investigations into the links between the mode of delivery and the haemorrhage rates had been carried out. This information had not been used to guide a change in practice to the use of ventouse delivery.
- There was no system of assessing performance of the service against set goals. The information provided by the trust did include specific targets to be achieved, for example a reduction in elective caesarean sections. The actions to be taken to achieve these goals were not recorded and those staff we spoke with could not explain a clear strategy for this.

Pain Relief

- Assessments of pain were carried out as part of the obstetric early warning charts.
- Various pain relief was available, such as Entonox and pethidine. We were told that pain relief of the mother's choice had been available to them in a timely manner. The options for pain relief were discussed as part of antenatal care.
- There was access to an anaesthetist 24 hours per day to provide epidural pain relief if this was the mother's choice.

Nutrition and hydration

- Patients told us they had "good food". There was a choice of food at each meal time and hot and cold drinks were available at all times.

Patient outcomes

- The number of deliveries in the unit had reduced by 156 in the previous quarter. This reduction meant the service was delivering fewer babies than their target with 2674 being delivered between May 2013 and April 2014 against a target of 3000. We were told there was no clear reason for this reduction and no strategy in place for increasing the use of the service.
- The trust's rates for mothers starting breastfeeding were worse than the England average. These had been audited by the trust and had improved by 10% over the previous 2 years. There was an infant feeding specialist who provided training for the midwives, support for new mothers and ongoing audit of the breastfeeding policies in the trust. Initiatives to improve the breastfeeding rates included drop in clinics in the local children's centres.
- We reviewed the data which that were collected as part of a maternity dashboard. This showed the overall caesarean section rate of 26.1% in the year to date was higher than the target set of 24%. There was no strategy in place to meet their target.
- The rate of delivery with forceps was 8.6% which was higher than the England average of 6.9%. There was no action plan in place to reduce this mode of delivery.
- The admission of babies into the neonatal unit was within the limits of the England average.

Competent Staff

- The ratio of supervisors of midwives was one to 15 which met the recommendations of the Nursing and Midwifery Council. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure mothers and babies receive good quality, safe care. They provide support, advice and guidance to individual midwives on practice issues and ensure they practice within the midwives rules and standards set by the Nursing and Midwifery Council.
- We were told there was a competency based training programme for band 5 midwives. This included competence assessments for practices such as perineal repair, cannulation and epidural top up. Some midwives discussed concerns that newly qualified midwives were

not offered the support they required through the preceptorship programme. They told us the shortage of band 6 midwives meant they were expected to work without adequate supervision at times, for example in the role of triage midwife in the ante-natal ward.
- Staff told us there were insufficient opportunities for learning on the ward environment and that they needed to "be persistent" in order to access these.
- The learning needs of midwives were assessed through annual appraisals. There were conflicting records about this. Those kept in the maternity service showed 95% of staff were up to date with their appraisals, but data provided by the trust showed that 69.11% of staff were in date. This meant it was not possible to understand if staff were having adequate opportunity to discuss their own learning and development.
- Competence assessments were in place, but these did not include all aspects of practice such as assisting in theatre.

Multidisciplinary working

- Staff reported that they felt they worked separately to the rest of the hospital. One senior midwife told us the task of supporting the whole hospital, as the manager out of hours, had helped them to understand more about how the other units operated.
- There was little evidence of multidisciplinary working within the maternity service. This included the lack of any formal arrangements between the maternity services and dieticians for pregnant women with a high body mass index and no availability of a dedicated obstetric physiotherapist although for in-patients physiotherapy was available as required with the physiotherapist attending the postnatal ward as requested on a daily basis. On –call physiotherapist services are available at the weekend.
- There were no facilities for the care of seriously ill mothers on the maternity unit. If a woman required care in an intensive care unit their condition would be stabilised in the high dependency unit then they would be transferred to Southport Hospital. Their new-born baby would remain on the neonatal unit in Ormskirk. This would mean separating the mother and new-born which is not in line with good practice guidance. Some measures were in place to reduce the anxiety of this separation for the mothers, in the way of a daily diary, photographs and flexibility of visiting arrangements for partners.
- We were told there was access to medical support in a timely fashion, which included outside of normal working hours.
- A system of caseload working had been introduced. This meant that eight midwives had 30 women each allocated to their specific care. They offered one to one support for mothers who needed additional help through their pregnancy. This had helped to increase the rate of home births to 4% which was above the England average of 2%. They were working towards this and reducing unnecessary admissions to the antenatal ward. No data were available to show the effectiveness of this.
- There was no neonatal outreach team. Whilst there was no physical transitional care unit, babies remained on the postnatal ward with their mothers with support from the Neonatal Unit Team.

Seven Day Services

- A consultant was available 60 hours per week. This included two and half hours on both Saturday and Sunday. Outside these hours a consultant was available on the telephone and it was reported they were always available when required.
- There was no sonography available out of hours for the early pregnancy unit. We were told extra clinics were held on Saturday if needed due to pressure on the service.

Access to information

- Women said they had been given the information they needed to make informed choices about their birth plans.
- Written information for parents, in the form of various leaflets, was available in the communal seating area.

Consent, mental capacity Act and Deprivation of Liberty Safeguards

- Consent for caesarean sections was not always recorded correctly. We looked at 20 consent forms, 10 for elective and 10 for emergency caesarean sections. Of those 50% were incorrectly or not fully completed. This included one form with no signature of the medical personnel completing the form, five forms where patient identification was not present on each page and one form that was not specific to caesarean sections.

Maternity and gynaecology

- Where an emergency operation had been required and the decision may have been made in the person's best interests while they were anaesthetised, this was not clearly recorded in the notes.
- 84% of staff had completed training on the Mental Capacity Act and the deprivation of liberty safeguards. They knew where to access further information on the trust policy system should they need it.
- There was one midwife with a lead role in the support of pregnant women with mental health issues. They held one antenatal clinic per week to offer specialist advice and support for example to women who had had postnatal depression after a previous pregnancy. They also had links with other organisations that could provide assistance.

Are maternity and gynaecology services caring?

Good

Midwives and other staff treated patients with respect and protected their privacy and dignity. Patients were involved in their own care, were given sufficient information to make informed choices and their decisions were respected. Patients spoke highly of the care they had received. A focus group had been set up to help midwives better understand how to support bereaved parents. A training package for all midwives was being developed with the help of parents who had been bereaved.

The clinic and ward facilities for women having a termination of pregnancy were not adequately separated from pregnant women.

Compassionate care

- We found the staff in the maternity services were polite and respectful and protected the privacy and dignity of the women they supported.
- People told us the staff were "fantastic" and "very caring." They were complimentary about the service provided and all the staff they had come into contact with. They said they would "not go anywhere else" to have their babies and would recommend the maternity unit to friends and family.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The results were comparable with the England average.
- Women were encouraged to complete the Friends and Family Test with a blank survey being placed on every bedside table. Staff said they did encourage people to complete the questionnaire.
- The results of the CQC's "Women's experiences of maternity services" survey in 2013 showed the trust scored better than other trusts with regard to people being treated with respect and dignity during labour and birth.

Understanding and involvement of patients and those close to them

- People we spoke with said they had been involved in the planning of the birth throughout their antenatal care and labour. This included one person who had required an emergency caesarean section who said they were "kept informed throughout" with their partner also being involved.
- One person said they had not felt listened to with regard to one aspect of their treatment. They said there was a contradiction between the information they had been given by the consultant obstetrician and the actual treatment given by the doctors on the labour suite. This meant the plan for treatment during delivery was not followed.
- Staff used hand-held records to ensure they understood any issues or plans that a person may have made before attending the maternity unit.

Emotional Support

- A system of eight midwives each working with a caseload of 30 women had been set up. This was designed to ensure women who required additional emotional support had one to one care throughout their pregnancy and labour. This may be because of a previous bereavement in pregnancy, a history of mental illness such as postnatal depression or more focused support for physical health problems. This showed an understanding that some people would benefit from increased emotional support through their pregnancy, labour and after birth.
- The maternity unit had a lead midwife for bereavement. They provided guidance for other midwives in supporting people through a bereavement. They were developing a bespoke training package. To assist with

this a focus group had been set up. This consisted of midwives with a special interest, the head of midwifery, the chaplain, a Stillbirth and Neonatal Death Charity (SaNDS) representative and bereaved parents. This showed staff wanted to work collaboratively to improve the knowledge and skills they had to support bereaved parents.

- A midwife with an interest and experience in mental health care provided an antenatal clinic weekly. They supported women were experiencing emotional issues and could offer one to one support and counselling or signpost them to other agencies.
- Support and advice was offered to women who had had a miscarriage. This included written advice and contact details should people wish to access support from the trust or from other agencies such as the Miscarriage Association.

Are maternity and gynaecology services responsive?

Requires improvement

The number of babies being delivered at the unit had significantly decreased in the 3 months before the inspection. There had been no investigation into this and no strategy regarding the future use of the facility. In order to continue to deliver care during busy times additional staff would be called on to work extra shifts. There was a reliance on the goodwill of staff to ensure the service could meet the needs of the patients.

A triage system was in place to assess patients, by telephone consultation or with a visit to the antenatal ward. This was planned to reduce the admissions to the antenatal ward by providing good and timely advice and support. There was no formal system to ensure all staff received information and learning from concerns or complaints.

Service planning and delivery to meet the needs of local people

- If the unit was very busy and there was decreased capacity to safely meet the care of the women who were booked for an induction of their labour, the women would be asked to consider delaying their admission. We were told this would be avoided if possible.
- The unit had a contract with a private midwifery agency which meant if a patient wanted to use their services and required the facilities of the hospital maternity unit in a non-emergency situation, this would be facilitated. This gave women in the local area an option to use a private midwifery service if they wished.

Access and flow

- There was a 24 hour seven days a week triage system in place, based on the antenatal ward. This involved one midwife who spoke to women on the phone if they had queries about their pregnancy or progression to labour. An assessment process was used that included a risk rating system the result of which was telephone advice or admission for examination. We were told this system was working well to help reduce unnecessary admissions. No data for this were available.
- Some women said the triage system had worked well for them, whereas others were not satisfied with the response they received or the advice given. Staff said sometimes an inexperienced midwife was put in the position of triaging the calls and they felt this was not suitable. We were aware that two patients had complained about the unsuitable advice they had been given and the potential risks it had posed.
- Patients moved from the antenatal ward to the delivery ward and on to the postnatal ward as soon as possible. We were told that the 12 bedded antenatal ward could get very busy, but there had never been occasions when the capacity was not managed.
- The average bed occupancy was below the England average with the average length of stay being 1 day.
- There was an emphasis on normalisation, which resulted in women leaving the maternity unit as soon as they and their baby were well enough to do so. A daily talk was given for those patients who wanted to attend, to give advice before discharge.

Meeting peoples individual needs

- The introduction of the midwife caseload team resulted in them providing one to one support for any woman with complex physical or mental health needs throughout their pregnancy and labour. This meant these women had consistency of support from their midwife. When suitable, after the birth, their care would continue to be provided by the community midwives.
- A birthing pool was available in the delivery suite and we were told this was well used.

Maternity and gynaecology

- There were no facilities to ensure mothers and babies could stay together if the mother required care in the intensive care unit as they had to be transferred to Southport. This meant they would be separated for a length of time shortly after birth.
- There was no written information available in any language other than English or in any other format.
- The layout of the waiting areas for women having a termination of pregnancy or investigating a miscarriage, were unsuitable; it was part of the ante-natal and fertility clinic. There was also no structural separation of ward areas on the gynaecology ward for patients having surgical termination of pregnancy. This meant any emotional upset those women may be experiencing could be exacerbated by being close to pregnant women.

Learning from complaints and concerns

- The head of midwifery received all complaints about the service. They then delegated the investigation to the unit managers and clinical leads for the area in question. Some complaints and concerns were discussed at a monthly maternity care forum. The managers said they used them to assess the need for changes to the service and make improvements. One such change was to the consent form for the management of a foetus after a miscarriage.
- Midwives told us there was no formal system for them to learn from complaints and concerns. These had been discussed at the team meetings but these meetings no longer took place. There was a quarterly newsletter, available on e-mail, used to share information and we were told some changes as a result of complaints may be in this. There was a formal mechanism in place to ensure other staff received this information in a quarterly newsletter however these were inconsistent and staff did not refer us to the newsletter which raised concern as to the awareness of staff to this form of sharing learning from incidents.
- Should a complaint be made about the practice of an individual their line manager would discuss the issues with them and instigate any necessary further training or support. The midwives we spoke with said this was not always a constructive procedure and learning was not always used to ensure practices were changed.

Are maternity and gynaecology services well-led?

Inadequate

There was no clear vision or strategy for the development or improvement of the maternity service. Risks we identified during the inspection were not recorded on the risk register for the service. Other risks did not have any control measures or actions to mitigate them in place. There were audits in place which measured the provision of aspects of the service but there was no emphasis on monitoring the quality of the service delivered.

A large number of midwives contacted us during and after the inspection about their concerns regarding the culture and leadership of the maternity service. They said it was not open or transparent and there was a culture of blame which meant they felt unsupported if they raised concerns.

Vision and strategy for this service

- Staff were aware there was a vision for the trust and some medical and nursing staff could share this vision with us. They were not aware of a vision for the maternity services or any strategy for change or improvements.
- Senior staff were unable to share with us a vision or strategy for the development or improvement of the service.

Governance, risk management and quality measurement

- There was a risk register in place for the maternity service. This had 40 risks identified on it the most recent of which was dated 14 October 2014 and the longest standing being dated 9 July 2012. This showed that although newly identified risks were being included some risks were long standing with no action plans recorded to reduce them.
- Not all risks we identified were included on this register. Access to pathology services, including those for blood transfusion following a major haemorrhage, were from the trust site at Southport. This could lead to a delay in a patient receiving lifesaving treatment. This risk was not present on the risk register.

- The most serious risk recorded had no controls or action plan for reducing the risk documented. This meant there was no measurable plan in place to reduce the most serious risk within the service.
- Both medical and nursing senior staff told us that staffing was their main concern for the service. The risk of insufficient staff to run the unit and both theatres was recorded on the risk register dated 9 July 2012. The plans in place were for managing staff shortages as they occurred. This meant risks were identified but there were no long-term plans, with measurable goals and timescales, for actions to be taken.
- There were some systems in place to monitor aspects of the service being delivered. These included attendance at the vaginal birth after caesarean section clinic and monitoring the number of women who required an emergency caesarean section following induction of labour. There was a limited number of audits of the service. The midwives were not aware of any plans for improving the quality of the service, or their part in monitoring and improving quality. This showed the governance arrangements in place were not focused on quality improvement and did not include all staff who delivered a service.

Leadership of service

- The leadership structure consists of The Assistant Director of Operations, Clinical Director, Head of Midwifery, Consultant Midwife, Matron for Women's Health and 6 Clinical Lead Midwives for each designated area. They communicated with each other to ensure the entire service was providing the care required.
- Junior doctors told us they felt able to discuss issues with senior medical colleagues. They said they felt well supported and could approach the consultants at any time, including out of hours, to seek guidance.
- Midwives told us they could discuss issues with some of their line managers, who were approachable and supportive. However not all those in leadership positions were open to discussion or easy to communicate with. This included approaching them about suggested improvements to the service or issues affecting patient care such as their training and development needs.
- Some midwives stated there were issues of bullying in the maternity services by a staff member in a leadership position. This included being spoken to aggressively and there being "recriminations" if they spoke out. However there was no evidence of any issues of concern being formally raised by staff with regard to bullying and harassment. They said this had resulted in midwives leaving because they felt unsupported and worried that they could not raise concerns. Staff turnover had been rated as a high risk for 3 of the first 6 months of the year.

Culture within the service

- Many midwives told us the culture in the maternity services was not transparent or open. They described it as one of "blame" and "results driven." They stated a high number of staff were off work sick. There were five midwives on sick leave at the time of the inspection.
- Staff told us they were often contacted at unsociable hours to be informed they may need to work if it became busy so effectively they were on standby. Staff felt this was not an acceptable way of working; the expectation was they would go in, even at night, regardless of whether they had worked that day.

Public and staff engagement

- The NHS Fiends and Family test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Staff actively asked patients to complete it.
- Formal patient / public engagement was via the Maternity Services Liaison Committee meetings which took place on a bi-monthly basis and were attended by the Consultant Midwife / Head of Midwifery.
- The formal mechanisms for the inclusion of staff in the management of the service were not functioning effectively. Unit or ward meetings did not take place. Alternative methods of communication were being applied.

Innovation, improvement and sustainability

- There were no clear plans for improvements to the service such as reducing the number of caesarean sections.
- Staff expressed concerns about the reducing number of births in the unit and whether this would lead to a reduction in the services being offered. We were not provided with any plans for the short or long term development of the service to ensure sustainability in the future.

Services for children and young people

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

Information about the service

Southport and Ormskirk Hospital NHS Trust provides care to children and young people through 19 inpatient beds located at Ormskirk District General Hospital. This includes seven day case beds and a six bedded assessment unit.

The ward admitted children under 16 years directly from their GP or accident and emergency (A&E), for a range of treatments including general paediatrics, orthopaedics, day case surgery for ear, nose and throat conditions and special needs dentistry. Six consultants worked in the paediatric speciality.

Twelve neonatal (new-born) cots were available, with provision for parents to stay on the ward if necessary. Intensive care services were available for babies born after 28 weeks' gestation. A lead clinician for neonates and three consultants were responsible for the care delivered on this unit.

The children's outpatient department was a designated children's outpatient facility. There was a large child-friendly waiting room available for children and families and a toilet with disabled access and baby changing facilities. A 'family room' was available and provided a non-clinical environment for discussions with families. An emergency service was located in the accident and emergency department, and had direct access to the inpatient paediatric beds. The inpatient service was available 7 days a week and provided cover for 24 hours a day. Oncology care and support was offered by Alder Hey Hospital, with open access for urgent care.

The community children's nursing outreach service was a community based 'acute nursing' service consisting of a team leader, registered children's nurses and administrative staff. Referrals to the community children's nursing outreach team were received from A&E, the children's ward or the paediatric assessment unit. The purpose of the service was to enable children with acute or chronic health needs to receive nursing care in their home and avoid admissions. Working closely alongside other agencies they provided holistic family-centred care, which was respectful of individual cultural needs. The service promoted the empowerment of children, young people and their families by providing opportunities that enabled them to live ordinary lives. The team aimed to reduce readmissions and improve patient and family satisfaction.

Services for children and young people

Summary of findings

Overall we rated this service as good.

Services were provided in a child friendly environment by a workforce with a range of specific skills, competencies and training relating to children. All staff had relevant professional registration and were encouraged to be up to date with required training programmes. The close location of the paediatric services supported smooth processes and strong team work. Feedback from relatives and children using the service was positive. They described caring, friendly staff that were approachable and compassionate.

The work of the children's community nursing outreach team had been further recognised by a successful publication in the British Journal of Nursing 2014. Staff on the neonatal ward was proudly displaying their 2013 team award trophy.

Safeguarding measures were understood by staff and escalation processes were well managed by the lead nurse and consultant. Staff morale was high. We heard examples of motivated managers who displayed strong leadership, open door policies and encouraged staff progression. The paediatric ward sisters highlighted ongoing concerns with bed management cover and the increase in requests to hold the 'on call' bleep, when required to support other areas of the hospital. Seven incident forms being submitted since April 2014 as a result of holding the bleep.

We spoke with 24 nurses, seven support workers, a play therapist, one student midwife, six consultants including two in radiology, and one anaesthetist. We also spoke with a pharmacist, ten patients, seven relatives and two doctors.

Are services for children and young people safe?

Good

Staff told us that they knew how to report incidents, both electronically and to their manager. Child protection policies and systems were regularly reviewed and included a process for following up children who missed outpatient appointments, and a system for flagging children for who there were safeguarding concerns. The trust was assured of emergency paediatric support from Alder Hey Hospital.

Planned and actual staffing numbers were displayed on the wards. Each ward had a designated pharmacist who monitored stock control and prescriptions. They arranged medication for patients being discharged, and discussed the use of certain medications with parents and children.

We saw that resuscitation trolleys were checked and signed confirming that the equipment was in place and the trolley in good order.

All ward areas we visited were exceptionally clean and tidy, and catered for children and young people of different age groups.

Incidents

- Incidents were reported using the electronic Datix system.
- Staff told us that incidents and learning from them was discussed during staff handovers and at team meetings.
- There were 54 incidents reported between April 2014 and October 2014. Three were low harm requiring first aid, seven were classed as near misses, 18 related to medication administration and 10 were staffing concerns. Seven incidents were reported for the neonatal unit between August 2014 and October 2014. Two related to pathology and five were medication issues, including one omission and one late cannulation.
- Staff told us that they knew how to report incidents, both electronically and to their manager.

Services for children and young people

- The recent increase in the number of bed manager night shifts that a senior member of staff from the unit had been required to cover had resulted in seven incident forms being submitted since April 2014.
- Medication incidents had been monitored and action taken to avoid reoccurrence. On the children's ward the clinical room had been split to accommodate a separate medication room, which would reduce interruptions while dispensing.
- There had been one serious case review. A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future. The named nurse for child protection attended the serious case review panel for Lancashire and a report and an action plan was completed. The overview report was completed by Lancashire Local Safeguarding Children's Board and its publication was awaited.
- Ward dashboards showed compliance with the quality measures set by the trust. In October 2014 the early warning score for pain was recorded below average at 75% and the staff had been reminded to complete documentation correctly.

Cleanliness, infection control and hygiene

- Staff followed the trust's infection control policy. Staff were seen to be and promoted 'bare below the elbow' and used personal protection equipment.
- Infection control audits were completed monthly. The matron's checklist for infection control was assessed as 98.6% and the environment score was 100%.
- Hand hygiene scores were consistently 100%. The neonatal unit had scored 100% for 15 consecutive months. Hand washing facilities were available and the use of hand gel was encouraged.
- There was an updated trust infection prevention and control policy and procedure available.
- Staff had access to personal protection equipment in all the departments we visited. Gloves and aprons were available in all areas. We saw that hand gel was available at the entrance to wards, departments and all clinical areas. Staff were observed using the hand gel at every opportunity.

Environment and equipment

- All ward areas we visited were exceptionally clean and tidy, and catered for children and young people of different age groups.
- We saw cleaning schedules signed and dated.

Medicines

- Each specialty had a designated pharmacist who monitored stock control and prescriptions. They arranged medication for patients being discharged, and discussed the use of certain medication with parents and children. On occasions the demand for their time exceeded their capacity and this caused the department to be under excessive pressure.
- The pharmacy team audited the efficiency and the safe practice of the staff. They looked for consultant prescribing trends and dispensing data. The 18 incidents reported that related to medication were reviewed by those involved, and action plans were put in place. Where necessary, staff were retrained.
- All trained staff had received medication administration training and completed ward level trust competencies.
- We looked at the processes on the wards. We found that medication was in date, stored correctly and the prescription charts were completed correctly.

Records

- We found patients' records to be stored in accessible, open trolleys in public areas.

Safeguarding

- From 1 April 2013 to 31 March 2014, 210 referrals were made to children's services. The main referrers were Southport accident and emergency department (A&E), followed by midwifery and paediatric departments. The named nurse for child protection was currently working with the data analyst to devise a system to extract more detailed data.
- The trust had a named doctor, nurse and midwife for child protection and they had also identified a safeguarding lead in children's A&E. We spoke with the named staff and they were all clear about their roles; however, at times they did not have sufficient time and lacked support to undertake them.
- Southport and Ormskirk Hospitals Trust met the statutory requirement with regard to the carrying out of disclosure and barring service checks.

Services for children and young people

- Child protection policies and systems were regularly reviewed, and included a process for following up children who missed outpatient appointments and a system for flagging children for whom there were safeguarding concerns.
- Safeguarding training was provided within the trust, and compliance levels were regularly reviewed and monitored.
- Safeguarding procedure flowcharts were displayed in ward areas.
- The director of nursing and quality was the board level director for safeguarding children. The board reviewed safeguarding across the organisation and regularly audited the safeguarding processes to assure that that safeguarding systems and processes are working.

Mandatory training

- Staff training and attendance was monitored by team managers and senior managers.
- The trust's target for compliance with mandatory training was 90%. We saw that overall this target was mostly met.
- The mandatory training levels ranged between 90% and 100% in all areas. Basic paediatric life support and manual handling scores ranged between 56% and 66%. The trust has told us there is a lack of reliability of the current Trust training database and current reliability is on locally held records.
- Issues relating to data handling had resulted in what appeared to be poor compliance, but we saw evidence that this was not the case. Managers had returned the correct information, confirming that identified staff had attended training, but training data remained inaccurate. The trust was aware of this issue and action was being taken to rectify this.

Assessing and responding to patient risk

- The trust was assured of receiving emergency paediatric support from Alder Hey Hospital.
- A paediatric early warning score was in place. This tool quickly determined how ill patients were and what the escalation process to senior doctors should be.
- The neonatal unit was developing its own early warning system. Individual parameters were measured and alarms were set and documented. We saw that documentation was signed on each shift.
- Twenty nine babies had been ventilated in the previous 12 months in the level two unit for a maximum of 2 days.
- The paediatric liaison visited all areas within paediatrics and the neonatal unit on a daily basis to review any new admissions.
- Staff were concerned at the reduced availability out of hours of the child and adolescent mental health service (CAMHS). The ward had no accommodation or suitable facility to detain a child safely.
- Children requiring review and care by the orthopaedic team were assessed as to the best place for them to be treated. The on call doctor reviewed each child admitted at the weekend when all trauma cases requiring emergency surgery were transferred to Alder Hey Hospital.

Nursing staffing

- Planned and actual staffing numbers were displayed on the wards. There were no vacancies on the neonatal unit. Sickness/absence was covered by the department staff. Agency staff had only covered four shifts in the previous 12 months.
- The neonatal staff gave one-to-one handovers at the change of each shift. The children's ward completed board and ward handovers ensuring each member of staff knew the area they were covering. Printed handover sheets were given to each member of staff.
- The children's unit had a full complement of staff. Staff absence was covered by their own staff on most occasions.

Medical staffing

- There were six consultants supported by a clinical director. We heard that the staff all felt listened to by the clinical director and they had put things in place to improve practice.
- Six registrars, with one vacancy, were supported by eight senior house officers. A twilight shift had been put in place to support the team and ensure the day's tasks were completed.
- A consultant of the week was assigned to the hospital, supported by an on-call consultant.
- Medical staff told us they felt supported as a team, were well informed and were kept up to date with current

practices. On occasions when children were transferred out of the hospital it did put pressure on the staffing levels. This had been brought to the attention of the management.

Major incident awareness and training

- Staff were aware of the trust major incident policy and senior staff were aware of their responsibilities in the event of a major incident being declared.

Are services for children and young people effective?

Good

Children and young people's services were effective. There were good working relationships between all departments, including multidisciplinary team working. The rate of readmissions within 2 days was in line with England average for non-elective patients. The neonatal unit had achieved the first stage accreditation of the 'baby friendly' programme, which included standards for maternity, health visiting, neonatal units, children's centres and universities.

Staff appraisals were recorded as 93.7%. Nursing and medical staff told us they had received a comprehensive trust induction with time to ensure they were fully informed and competent. The trust paediatric diabetes service underwent a peer review in July 2014. Multidisciplinary team service scored 94% and hospital measures scored 100%. The diabetes service was the top performer in North West and was shortlisted in the National BMJ awards diabetes category for 2015

Evidence-based care and treatment

- The trust's intranet contained details of all the current policies and procedures. These were based on national guidelines and standards. Robust systems were in place for the ratification of new policies and guidance. Policies and guidance were reviewed and updated regularly..
- All relevant National Institute for Health and Care Excellence (NICE) guidance was reviewed in the paediatric and neonatal clinical governance meetings.
- The paediatric service participated in a variety of clinical audits, including the national neonatal audit programme. The paediatric diabetes team has been actively involved in research within the remit of the Medicines for Children's Research Network (MCRN) and the National Institute of Health Research (NIHR). Three studies were active at the time of our inspection: one study screened and observed relatives of people with type 1 diabetes, the second study aimed to learn more about why diabetes started and what happened to people with diabetes, and the third study was a controlled trial of diabetes medicine management in children between 6 and 18 years old.
- The neonatal unit was part of a national pain audit study. We were told of non-pharmaceutical ways to calm babies, for example, oral glucose.
- The unit had achieved the first stage accreditation of the 'baby friendly' programme, which included standards for maternity, health visiting, neonatal units, children's centres and universities.

Pain Relief

- The records contained a trust pain relief scoring system with evidence of it being used appropriately. We saw staff offering analgesia and checking that it had been effective.

Nutrition and hydration

- There was evidence of accurate food and fluid balance charts in the nursing records.
- Parents staying on the wards with their children were offered meals.
- Meals were brought to the ward and served from a trolley.
- We heard mostly positive feedback about the meals. One person told us the meals did not look appetising.
- Mothers were encouraged to breast feed on the neonatal unit. The unit had a CQUIN for breast feeding. The commissioning for quality and innovation (CQUIN) payment framework (which enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals). The unit aimed for babies of 39 weeks to go home feeding on breast milk if possible. In April to June 2014 this was 72.7% achieved.

Patient outcomes

- The trust paediatric diabetes service peer reviewed in July 2014. Multidisciplinary team service scored 94%

and hospital measures scored 100%. The diabetes service was the top performer in North West and was shortlisted in the National BMJ awards diabetes category for 2015. Some good practice was recorded, including having a support group, and the national audit data demonstrating a percentage of patients with HbA1c level less than or equal to 58mmol/mol that was well above the national average.

- The neonatal unit was part of the neonatal network, from which it could source information at all times to support the staff and parents. The unit submitted data to Badgernet for the National Neonatal Audit Programme (NNAP).
- The radiologists reported 95% same day reporting data and 3–5 day reporting for outpatients.
- Transition from children's to adult services was considered where possible. For example, Joint Transitional clinics for diabetes patients will occur at the ages between 16+ to 18+ years of age with the four transition clinics a year held jointly between the paediatric diabetes consultant and nurse and the adult diabetes consultant and nurse. Joint clinics (adult/child) were organised for some specialities, where for example, the paediatric respiratory nurse accompanied the child to the first appointment to the adult clinic, where possible, without their parents.

Competent staff

- All trust staff had access to advice and supervision on an informal basis, via their line managers or the named professionals. In line with the key performance indicators produced by the Liverpool Clinical Commissioning Group, a draft supervision policy had been completed and an action plan was in place to meet this. The named nurse and named midwife had completed supervision module level 7 at Edge Hill University. Senior staff in key areas had been identified as supervisors and arrangements had been made for these staff to attend accredited training in order to meet these standards. The named nurse for child protection had made arrangements to receive supervision from the designated nurse from the Sefton Clinical Commissioning Group. Supervision had started with staff from maternity and paediatrics. Progress throughout 2014–2015 was to be monitored via the safeguarding children steering group and reported to the safeguarding committee.
- Staff appraisals were 93.7%; the remainder of staff were absent on long term sickness .
- Trust and specialist paediatric/neonatal competencies were recorded; 80% of the staff had completed the neonatal course and others were on the pathway.
- Medical staff told us they had received a comprehensive trust induction with time to ensure they were fully informed and competent.

Multidisciplinary working

- Ward staff worked closely with speech and language therapy, physiotherapy, occupational therapy, dietetics, ophthalmology and audiology services.
- The neonatal unit had developed a bereavement pathway, which it hoped would be published as a trust document.
- We met and spoke with two specialist nurses who support respiratory and diabetic care. They attended clinics, made school visits to compile school care plans, educated children and parents, and trained school staff at a variety of levels.
- The community team visited the ward daily to review any child who was potentially ready to be discharged. They would meet the parents and child and discuss a plan of care for home.

Seven-day services

- Ward rounds took place 7 days a week. The multidisciplinary team joined the staff Monday to Friday.
- Out of hours physiotherapy and radiography was available on call.
- The neonatal network supported the staff when transfers of babies were anticipated, for example they looked for the most appropriate cot within an hour of the hospital site.

Access to information

- In all areas of the hospital we saw advice and information leaflets and patient notices. Leaflets were available in different formats. We saw child friendly signs, notices and leaflets.
- Parents told us they were well informed about their child.
- Interpreters were available when necessary.

Services for children and young people

Consent

- Parents gave verbal consent for general care and treatment and signed consent for surgery.

Are services for children and young people caring?

Good

We heard positive feedback overall from children and their families about the care and treatment they had received. We were told about compassion and empathy being given.

Staff had developed trusting relationships with parents and representatives that focused on promoting the independence of children and young people. There was evidence that staff promoted and maintained the dignity of children. Parents with whom we spoke on the neonatal unit told us they had received great support and clear communication that assisted their understanding of the situation.

Compassionate care

- We found staff had developed trusting relationships with parents and representatives that focused on promoting the independence of children and young people.
- Each child and family's culture, beliefs and values had been taken into account in the planning and delivery of care.
- Patients and parents told us they had been treated with respect and their was dignity protected.
- We heard about many examples of compassionate care.
- We observed staff showing compassion to new parents on the neonatal unit. The curtains were closed and staff spoke quietly to protect their privacy.
- The play therapist told us how they respected the older children's wishes and supported them with activities of their choice.

Understanding and involvement of patients and those close to them

- Parents and relatives told us they felt well informed about the plans of care. They told us the consultants had been approachable and discussed the care with them.
- Staff ensured that they delivered child-centred care within all the services. Children, with their parents, were involved in all decision making about the care and continued support that was needed.
- Parents and children were supported by the community teams, to enable the transition from inpatient services into the community to be seamless.
- Parents were able to stay with their babies in one of the private bedrooms on the neonatal unit, before going home.
- Education leaflets were available to inform patients and relatives of a wide variety of aftercare.

Emotional support

- We saw staff offering emotional support to parents and children.
- Staff told us they received emotional support from their work colleagues and managers.
- On the neonatal unit parents were taught to give their babies medication and care for them independently, encouraging and promoting the earliest possible discharge.

Are services for children and young people responsive?

Good

The children's ward liaised with the local schools to ensure children had support when missing lessons. Support and quiet time was given to allow work to be done.

A process had been agreed for all children subject to a child protection plan from Sefton and Lancashire areas to be flagged on the system to alert staff to contact the appropriate social care department.

Bed occupancy official data showed a score of 49%. These levels were reported as manageable due to staffing numbers and occupancy by short stay patients.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The average length of stay on the paediatric ward was 1 day, however four children had stayed on the ward for between 24 and 28 days due to issues relating to discharge.
- The children's ward liaised with the local schools to ensure children had support when missing lessons. Support and quiet time was given to allow work to be done.
- Specialist paediatric nurses were employed to support children with diabetes and respiratory conditions. They held specialist multidisciplinary clinics on a regular basis. We heard of exemplary good practice such as specialist nurses visiting schools to give support and training to teaching staff. We were told that the specialist nurses were visible in the children's ward and departments, offering advice and guidance wherever possible.

Access and flow

- Close links with Alder Hey Hospital assured the staff that children who deteriorated could be transferred when necessary.
- Access to the paediatric service did not raise concerns for the trust. Bed occupancy official data showed a score of 49%. These levels were reported as manageable due to staffing numbers and occupancy by short stay patients.

Meeting people's individual needs

- Same sex bays were promoted on the adolescent ward including the side room areas.
- We were told that individual cultures, beliefs and values were considered when planning and delivering care. Documentation showed that each child and their families were asked on admission to discuss and document their cultural and dietary preferences.
- Southport and Ormskirk Hospital NHS Trust had a set of equality information that demonstrated its commitment to promoting equality. All staff, patients and visitors to the trust could expect to be treated with dignity and respect. The trust advertised that it would not tolerate any form of harassment, discrimination or victimisation.
- A process has been agreed for all children subject to a child protection plan from Sefton and Lancashire areas to be flagged on the systems to alert staff to contact the appropriate social care department. Implementation of this system will form part of the work plan for 2014–2015.
- The play therapist escorted children to theatre, using distraction techniques when necessary. The pre-operative clinic, where children had been familiarised with the staff and the ward environment, was no longer running. This now happened on the day.

Learning from complaints and concerns

- Six complaints were received in September 2014. Clinical treatment, staff competence and communication were the themes of the complaints.
- Staff had considered a focus group, but this had proved difficult to organise with short stay patients only.
- People were encouraged to participate in the NHS Friends and Family Test, but this had not taken up much so far. Only one positive comment was posted on the NHS choice website.
- There was evidence of many complimentary thank you cards displayed in the ward areas. The children's ward had received 10 compliments for November at the time of our inspection.

Are services for children and young people well-led?

Good

Staff we spoke with were familiar with the trust's vision and the values. The trust expected staff to articulate the values and beliefs of the organisation, resulting in the adoption of a number of behaviour statements including supportive, caring, open and honest, professional and efficient.

Five items were listed on the risk register all supported by risk assessments, action plans and with evidence of intermediate action been taken.

Staff told us they felt listened to and that action was taken to address their concerns and issues. We saw effective and committed leadership at team and senior clinician level. On many occasions staff told us they felt valued and were well supported by their managers.

Services for children and young people

Names of children that did not attend clinic appointments were referred to the liaison nurse for investigation and follow up.

The work of the children's community nursing outreach team had been further recognised by successful publication in the British Journal of Nursing ("Paediatric community home nursing, acute paediatric care" British Journal of Nursing, 2014, vol 23, No. 4).

Vision and strategy for this service

- Staff we spoke with were familiar with the trust's vision and the word SCOPE. The trust expected staff to articulate the values and beliefs of the organisation, resulting in the adoption of a number of behaviour statements including supportive, caring, open and honest, professional and efficient.
- Staff told us they felt listened to and that action was taken to address their concerns and issues.

Governance, risk management and quality measurement

- Five items were on the risk register. There was a risk of other personnel accessing individual's accounts on the booking system when access was left open on the computer. Bed management cover at short notice left junior staff to cover the unit; in the event of an emergency nurses covering bed management were not adult trained and had little experience of bed management. Access to cots required a lift and drop movement which caused issues with moving & handling due to staff height and weight of the cot sides. Paediatric monographs were out of date which was within pharmacy remit, with a risk of medication errors. Within the community a risk of anaphylactic reaction to intravenous antibiotics had been identified and staff had been trained to treat as an emergency.
- The monthly safeguarding children steering group, chaired by the head of midwifery and nursing, and was attended by the named professionals and representatives from key areas. The steering group fed into the safeguarding committee, which was chaired by the director of nursing and quality, and included commissioners from both Sefton and Lancashire. A decision had been made that due to high profile cases and lessons learned from local and national cases, the level of resources to support the role of named professionals was to be reviewed for the year 2014–2015.
- Perinatal mortality and morbidity meetings were held. These multidisciplinary meetings discuss complex cases and areas of concern, and involved staff with the relevant expertise.
- Names of children that did not attend clinic appointments were referred to the liaison nurse for investigation. The consultant telephoned some families to discuss the importance of future appointments and follow-up care.
- Lone working incidents for staff in the children's outpatient department had led to a change in the environment to ensure staff safety. We found that healthcare support workers worked independently in the department, supported by trained staff in adjacent areas

Leadership of service

- We saw effective and committed leadership at team and senior clinician level. On many occasions staff told us they felt valued and were well supported by their managers.
- Matrons and ward managers worked in partnership to deliver a high quality service.

Culture within the service

- Staff felt able to report incidents and near misses, which was a result of the open 'no blame' culture.
- Staff were committed to providing safe and caring services for children and young people.
- Staff we spoke with were positive about the care they provided within the multidisciplinary team.
- Twenty five staff in the hospital were asked three questions. The answers 'I would recommend this ward/unit as a place to work' scored 76%, 'I would recommend the standard of care on this ward/unit to a friend or relative if they needed treatment' scored 88%, and 'I am satisfied with the quality of care I give to the patients, carers and their families' scored 92%.

Services for children and young people

Public and staff engagement

- Comment cards and post boxes were visible on the wards. Parking fees had been raised as an issue and patients that were in for a length of time had been offered a reduced parking fee, which showed that the service listened to public comments.

Innovation, improvement and sustainability

- The work of the children's community nursing outreach team had been further recognised by successful publication in the British Journal of Nursing ("Paediatric community home nursing, acute paediatric care" British Journal of Nursing, 2014, vol 23, No. 4).

End of life care

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

Information about the service

Southport and Ormskirk NHS Trust provides palliative and end of life care to patients as one service across the two sites and in the community. Most care is provided on the general wards at Southport Hospital, but at Ormskirk Hospital, end of life care was occasionally provided on two wards. The staff on these wards were supported by a dedicated, consultant-led palliative care team who maintained close links with the hospice near Southport Hospital. The trust had recently created a 'transform team' which supported both hospitals as part of a national programme aiming to improve the quality of end of life care provided by acute trusts.

At Ormskirk Hospital we visited the two wards where palliative/end of life care was being provided. We observed care, looked at records and spoke with healthcare assistants, nurses, junior doctors, consultants and ward sisters. We received feedback about the service from patients and relatives at the local listening event. We also met with the specialist palliative care consultants who lead the service, the palliative care team and the transform team, and visited the mortuary.

Summary of findings

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

Staff from both the general wards displayed enthusiasm to provide safe, effective and compassionate care to patients reaching the end of their life. The multidisciplinary team worked well together to achieve this. This enthusiasm and desire to maintain competencies was particularly commendable considering the small number of patients at the end of life that the staff came into contact with.

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

There were no patients at Ormskirk Hospital at the time of the inspection on the end of life pathway, so no evidence could be gained by talking to patients or relatives, or inspecting individual patient records.

End of life care

Are end of life care services safe?

Good

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

Anticipatory medicines could be prescribed and administered to patients at their end of life, and innovative support materials had been devised by the trust to ensure that symptoms of deterioration were recognised and acted upon.

Incidents

- Incidents were logged on the trust wide electronic reporting system. Staff were aware of the procedure of reporting incidents and received feedback and learning was shared in multidisciplinary meetings.
- No never events or serious incidents relating to this service had been reported.

Medicines

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

Records

- All records were stored securely to ensure they could not be accessed by people who did not have the authority to do so.
- No 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were available for inspection at this site due to the low number of patients at the end of life cared for at this hospital.

Safeguarding

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

Mandatory training

- The trust was part of the 'Gold standards framework' training programme, with 1074 staff having completed some or all of the training package.
- All of the transform team had taken educator development training, and taught basic palliative care to staff caring for patients at the end of their life and their relatives, using key enablers.
- Since the withdrawal of the Liverpool care pathway, the transform team has trained 832 hospital staff in 'New priorities for the care of the dying', and many of the staff spoken to advised how this training had empowered them to speak confidently to patients and families of patients at the end of life, even though this was not a regular occurrence.

Assessing and responding to patient risk

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

Nursing staffing

- Patients with palliative/end of life care needs were nursed on general wards in the hospital, meaning nursing care relied on the staffing arrangements on the particular wards.

End of life care

- We observed that there were sufficient nursing staff, many with specialist training, along with other clinical and support staff to ensure that, patients at the end of life were safe and well cared for.

Medical staffing

- For patients with palliative/end of life care needs, medical cover was provided on the general wards of the hospital.
- The hospital provided specialist consultant support along with access to the hospice near to Southport Hospital for advice.

Major incident awareness and training

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

Are end of life care services effective?

Good

All the trust's policies and procedures relating to end of life care were evidence based from national guidelines and were easily accessible to staff. Pain relief was available on both wards, and could be reviewed by a palliative care specialist, although remotely, 24 hours a day. However, if a patient at the end of life was being cared for by the service in the community, a district nurse was not always on call to visit the patient in a timely fashion.

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

Evidence-based care and treatment

- All policies and procedures relating to end of life care were easily accessible to staff using the trust's intranet system and had been updated in line with National Institute for Health and Care Excellence (NICE) guidelines, with updates communicated to staff by email.
- All patients considered to be within a year of the end of life were registered on the 'End of Life Skillset Challenge' once confirmation had been received from their GP. This ensured that the GP was fully informed of their care needs and they had better coordinated services with easier access to emergency care. Once patients were thought to be likely to be dying, a 'My vigil' individualised plan of care was completed with the patient and their family.
- The trust had a proactive attitude to local audit. All staff undergoing the 'End of Life Skillset Challenge' training had to complete a local audit as part of their qualification. Evidence of audits completed and resulting action plans were provided, along with a list of potential audits the trust would like to complete.
- Every ward visited had a set of drawers containing all the main cross-boundary documentation required for palliative and end of life care. The numbered documents in care coordination, specialists palliative care, future care planning, respecting patient choices, care of the dying and symptom control could be tracked for future audits. Resource folders to support the use of this documentation were also available. All information was based on the Department of Health's national 'End of life' strategy information.
- All staff had been given pocket-sized cards defining appropriate end of life terminology and summarising the role and contact numbers of the transform team.

Pain relief

- Appropriate pain relief was available when required and anticipatory medicines were prescribed to ensure pain medication could be administered in a timely manner.
- The acute pain team was available to advise staff on appropriate pain relief, and most of the palliative care nurses were advanced prescribers.
- The prescription of opioids had been audited, resulting in a leaflet being developed providing patients with more information about opioids in palliative care.

Nutrition and hydration

- Patients would be supported to eat and drink for as long as possible, and their wishes about food and drink were documented in their 'My vigil' individualised care plan.
- In the 'National care of the dying' audit (May 2014) the trust achieved better than the England average in reviewing patients' nutritional and hydration requirements.

Patient outcomes

- All staff were highly motivated and committed to meeting patients' preferences of where they wanted to end their life.

End of life care

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

Competent staff

- All new staff undertook an induction programme that included mandatory training in care of the dying.
- Staff told us that they received annual appraisals and had regular supervision within their ward area.
- All nurses received an initial 3 days, and healthcare assistants received four half days of palliative care education, with regular update days. Junior doctors attended seminars with the specialist palliative care senior medical team.
- Along with their initial training, the specialist palliative care team received 1 hour's training/updating every week.

Multidisciplinary working

- We observed the weekly cross-site multidisciplinary team meeting, which was attended by the palliative care team, two specialist palliative care consultants, student nurses, medical students, a social worker and representatives from the transform team, chaplaincy, occupational health, physiotherapy and pharmacy. Each new patient referred to the palliative care team and their plan of care was discussed along with information about who had died and whether they had been able to die in their preferred place of death.
- The transform team also provided training to staff at care homes, under the Six Steps to Success principles, with 85 staff trained this year.
- The palliative care consultant told us that patients at the end of their life wishing to die outside of hospital could usually be discharged within 2 hours of the decision being made. This was achieved by effective communication between the ward staff, palliative care and transform team, pharmacy and the ambulance service.
- The ward staff could access speech, language and dietetic services to support patients who were at the end of life.
- We saw an electronic palliative care system being updated during the multidisciplinary team meeting.

Seven-day services

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

Access to information

- Information for patients was available in multiple formats.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As there had not been any patients approaching end of life for two years at the hospital we were unable to assess this at the inspection.

Are end of life care services caring?

Good

We observed that the mortuary team especially provided excellent compassionate care to patients and their relatives at the end of life.

There was a chapel and quiet room for relatives and the mortuary was designed so relatives visiting loved ones experienced the minimum amount of distress.

Compassionate care

- All staff we spoke to were aware of the importance of treating patients and their families in a sensitive manner.
- The mortuary staff demonstrated an exceptionally caring attitude to patients and their relatives. A detailed procedure for care after death was documented in order to ensure that all spiritual and physical care was carried out in accordance with cultural and religious beliefs of

End of life care

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

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

Understanding and involvement of patients and those close to them

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

Emotional support

- The 'National care of the dying' audit (May 2014) reported that the trust was below the English average in the assessment of the spiritual needs of the patient and friends/relatives.
- During the inspection, the Chaplain discussed the care of the dying audit figures. He explained the massive improvement since his employment. The Chaplain explained the Trust had employed a full time chaplain and since that time there had been major improvements in practice. The action plan was fully discussed with explanation of the input from the chaplain and a number of documents were shared including the submission to European Association of Palliative Care demonstrating the improvement and methodology and the raw data information from the audit completed by Trust Chaplain in October 2014 showing the 100% spiritual assessment. The consultant led audit of 200 sets of Palliative Care notes across the ICO supported this.
- We visited the chapel in which a well-used multi-faith 'prayer tree' was displayed, and there was a comfortable quiet room next door where relatives could rest and make refreshments.
- The transform team facilitators have a non-clinical role and provide emotional support and information for patients at the end of life and their families.
- The mortuary environment had been carefully considered so relatives visiting their loved ones experienced the minimum of distress.

Are end of life care services responsive?

Good

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

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

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

The mortuary team was outstanding in its responsiveness and its innovative approach to caring for the patients and relatives who used their services.

Service planning and delivery to meet the needs of local people

- The trust implemented the 'New priorities for care of those thought to be dying', 2 weeks before the compulsory withdrawal of all references to the Liverpool care pathway.
- The trust had a very close relationship with Queens Court Hospice, sharing training and ensuring that medical and nursing support was available 24 hours a day, 7 days a week.
- From April to September 2014, there were 75 documented end of life transfer discussions, and 31 successful transfers home of those who were dying. During this period, of the 433 patients who died and were on the 'End of Life Skillset Challenge', 92% had a documented preferred place of care and 85% died where they chose to.
- A patient satisfaction questionnaire had recently been completed by the palliative care team, there was a 68% return rate and results were very positive. Staff were highly praised and the service was described as "Wonderful" by a number of people. An area for improvement would be around the 12 people who said they were not given information on how to feedback compliments, comments, concerns or complaints?

End of life care

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

Access and flow

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

Meeting people's individual needs

- The palliative care team had produced a 'planning for your future' pack which was given to all patients thought to be at the end of life. This pack included information for advance care planning, and provided prompts about finances, wills, pet care and so on. There was also practical information for families on what to do when someone dies.
- Mortuary staff demonstrated their awareness of and sensitivity to a wide range of cultural and faith practices. Since Ormskirk Hospital provides maternity services, the mortuary had a special viewing room for parents to visit their babies, with a sophisticated lighting system to ensure the babies are viewed in a pleasant environment.
- Mortuary staff had identified that they were not able to accommodate significantly obese patients, so they had put together a business plan in order to purchase equipment that would make this possible.
- Spiritual and religious care was provided to dying patients and their families by a chaplaincy service, who also provided pastoral care to trust staff.

Learning from complaints and concerns

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

Are end of life care services well-led?

Good

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

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

There was strong leadership within the service, although the structure was not clear. Although some succession planning to lead the service was evident, it still relied on two individuals.

Vision and strategy for this service

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

End of life care

Governance, risk management and quality measurement

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

Leadership of service

- The service was led by two specialist palliative care consultants at the ICO and one, based at the local hospice near the Southport Hospital site. However, there was a lack of clarity of roles with the palliative care consultants taking on clinical, educational, audit and managerial responsibilities.
- The senior palliative care consultant appeared to be the main leader of the service, with evidence of succession planning by the recruitment of the second consultant.

Culture within the service

- Throughout the trust, staff demonstrated a caring and enthusiastic approach for supporting patients approaching the end of their life, and felt well supported and had positive working relationships with the palliative care team and the transform team.
- Staff within the transform team and palliative care team spoke positively about the care they provided for patients.
- The mortuary and bereavement staff culture was very caring and innovative about the care they provided at the end of a patient's life. This was demonstrated through their approach to patient care.

Public and staff engagement

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

Innovation, improvement and sustainability

- The transform team was only funded for one year on May 2014, and further funding to continue this service had not been identified.
- The mortuary team demonstrated innovative practice, bidding for funding outside of its budget (for example, for items such as infant cool carriers and bariatric cooling equipment) from trust central funds.

Outpatients and diagnostic imaging

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

Information about the service

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

The CQC outpatients inspection team consisted of a CQC inspector, a deputy director of nursing and an expert by experience.

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

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

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

Summary of findings

Overall the outpatient and diagnostic services was found to be good but required improvement in the safety domain. We found that there were no formal meetings between radiologists and radiographers; this led to barriers between the staff groups and prevented learning.

A small quantity of eye ointment was found to be out of date and a number of small electrical appliances and equipment checked in the Ophthalmology clinic were found to have expired portable appliance tests (PAT). We found four items had not been safety tested which represented a third of all the equipment available in the room.

National targets for referral to appointment times were exceeded in all area but one, reports following chest x-rays at Ormskirk had a target of 5 days and on occasions had taken up to twelve days to complete. We were told this was due to current demand on the service.

Staff were well trained and encouraged to take additional training. Outpatient staff of band 5 and below were rotated between departments and sites to increase their skill base.

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

Outpatients and diagnostic imaging

We observed staff interacting in a friendly and helpful way. Patients could not speak highly enough of nursing staff. Doctor's, nurses and receptionists had all taken time to explain things to patients in terms which they understood.

Audits were completed and services reviewed. We saw how information was used to make improvements including improving the waiting rooms for patients and staff; the privacy and dignity for bedded patients in diagnostics department; introduction of children's activity boards and the production of a video to show young children or patients with a learning disability what it would be like when they attend the department.

Additional services had been created, such as the 'dressings' clinics which had freed-up consultants time and reduced delays in fracture and orthopaedic clinics. Reviews were conducted into clinics which consistently ran late to identify blocks in patient flow.

We found that staff respected their local managers who had a good understanding of their teams and recognised where improvements could be made and led on the issues on behalf of the teams.

Are outpatient and diagnostic imaging services safe?

Good

Outpatients and diagnostic imaging services at Ormskirk were good. We did identify areas where individual services could improve, but these were not so poor as to affect the overall judgment.

The general environment was safe, passageways and waiting rooms were free from clutter and trip hazards. Staff were trained in and understood how to prevent or control infection and we saw they adhered to best practice with bare below the elbow, hand washing, use of personal protective equipment and hand gel sanitizers.

Most equipment was clean well maintained and ready for use. Not all portable appliance testing (PAT) had been completed which meant staff could not be sure that the untested items would be safe to use.

There was no formal liaison or meetings between teams of radiologists and radiographers which prevented learning and an appreciation of each other's role.

Incidents

- The trust used an electronic incident reporting system. The system was used to record all incident types. Staff were familiar with the reporting system, and most staff told us that they found the system easy to use.
- Staff we spoke with told us that they did not always receive feedback after submitting incidents. They told us that the system had changed recently and feedback on incident trends was now a regular feature at handover and team meetings.
- Outpatient and diagnostic imaging services at Ormskirk had not reported any 'never events'. Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
- When we spoke with radiologists at Ormskirk they told us that they did not have regular meetings and were not able to discuss issues with the radiographers they worked with. This meant that learning could not be shared and the teams could not develop an understanding of each other's roles.

Outpatients and diagnostic imaging

- The chief executive of the trust described how breast screening services had been suspended at the trust to ensure patient safety. An incident had occurred resulting in a radiologist being excluded. The screening process required two specialist radiologists, and as the trust had been unable to find a replacement, it had been forced to suspend the service. This showed that the trust responded positively to incidents to ensure patient safety.

Cleanliness, infection control and hygiene

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

Environment and equipment

- Throughout the inspection we checked equipment to ensure that it had been properly checked, cleaned and was ready for use. When we inspected equipment in the ophthalmology (eye) clinic at Ormskirk we found four pieces of portable equipment that had not had recent portable appliance testing (PAT). PAT tests are required on all portable electric appliances to ensure that they are safe to use. The equipment consisted of two portable split lamps, an ophthalmoscope and an optometrist's Topcon. The senior sister stated that the untested equipment would be removed from use until it had been tested. We did see that there were other devices that had been tested, which meant the service could still be provided safely.
- Resuscitation trolleys had log books showing that they had been properly checked at regular intervals by staff. We saw that the contents were correct and ready for use.
- Imaging equipment had been maintained under a long-term contract with an external provider. We saw that log books were maintained with details of any faults or routine maintenance that had been carried out. We checked a number of entries against the manifest sheets provided by the maintenance engineers and saw that they had been completed correctly.
- Staff told us that they did not experience problems with equipment. Broken or damaged equipment had been repaired or replaced quickly.
- There were two main routes into the hospital for patients going to the outpatient or diagnostic imaging departments. We found that signs were clear and relatively easy to follow.
- Routes were uncluttered and free from trip hazards.
- The hospital had a calm and unhurried atmosphere.

Medicines

- During the inspection we checked how medicines used in outpatient departments were stored and administered. When we checked the medication room in the general outpatient area at Ormskirk we found the room itself was very cluttered with trolleys and equipment, making access difficult.
- Medicines were stored appropriately in locked cabinets.
- Appropriate records were kept of medication use including details of who had accessed the cabinets. We were asked to sign the record to show why we had accessed the cabinets.

- When we checked the medicines themselves we found that some medicines were past their expiry date. We found that a chloramphenicol 1% ointment expired in October 2014, and two Fibro-Vein 1% for injection expired in August 2014.
- The expired medication was removed immediately by the department sister. When we asked why the medication had not been identified and removed earlier they told us that their understanding was that the medication was checked weekly by the pharmacists and they must not have noticed the expired drugs.
- We asked about the process staff went through when collecting medication. We were assured that staff always check the name of the drug, its strength and the expiry date. Even though we were told that it would be extremely unlikely that expired medication would be used, it should have been identified and removed before its expiry to eliminate the risk.
- We asked the matron about the expired drugs and the controls in place to prevent such errors. The matron explained that such checks formed part of the sisters' responsibilities and it appeared that the sister who had been in an acting capacity during the period had misunderstood the practice. We were assured that the correct procedure would be put in place and monitored to prevent a recurrence.
- We found that medicines and practice we checked in other areas of the outpatient services were correct.

Records

- Doctors or specialist nurses updated patient records during consultations. This meant that information was recorded properly and ensured it was correct and up to date. Patients we spoke with confirmed that they had seen both written notes and electronic records updated. We were able to observe a small number of consultations between clinicians and patients during which appropriate notes were completed.
- Staff told us that they rarely experienced problems obtaining patient health records. If main records were not available, clinics were provided with temporary notes. The temporary notes were then used to update the main records.
- We did speak with a patient who described having visited Ormskirk outpatient department and when they were with the consultant it became clear that the wrong patient notes had been forwarded from their GP. They told us that the consultation had been stopped. Staff had made enquiries into the error and the patient was given an appointment the next day at the Southport clinic. The patient told us that they were very pleased how the two hospitals had worked together to correct the problem and organised the new appointment so quickly.

Safeguarding

- The trust had a comprehensive safeguarding policy. Staff had had safeguarding training in line with their role. Staff we spoke with had a clear understanding of how to recognise different forms of abuse and how to escalate or report issues.
- The trust had a whistle blowing policy. Staff we spoke with at Ormskirk had a good understanding of the policy and how to report any concerns.

Mandatory training

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

Assessing and responding to patient risk

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

Outpatients and diagnostic imaging

Nursing staffing

- The matron's responsibilities extended to one of the inpatient wards at Ormskirk. The matron had introduced a system to rotate nurses and healthcare workers between the areas, which enabled them to increase their skills and understand different disciplines.
- The flexibility of staff also meant that vacancies could be covered from within the department. We were told that no agency staff had been employed in the department for a number of years and only occasionally did they need to resort to bank staff.
- The outpatient department matron explained that the department had a number of staff who were approaching retirement. This meant that some very experienced and skilled staff would be lost. In order to encourage new staff to join, the matron had been liaising with senior board members to introduce additional staffing grades, which would encourage staff to develop and progress as well as encourage other staff to work in the area.

Medical staffing

- Clinical staffing in all outpatient and imaging departments was good. Some specialist clinics were run by consultants from neighbouring trusts. This enabled people to be seen closer to home and if required they would then be transferred to clinics at the consultant's own trust for follow-up treatment. We saw that clinical staff worked well with the local Southport and Ormskirk nursing staff.
- Following the exclusion of a radiologist from the diagnostic imaging department the trust was unable to comply with best practice guidance for breast screening services and could not guarantee patient safety, and so withdrew the service. Nursing staff were concerned about the effect this had on patients who then faced longer journeys to unfamiliar locations.
- Imaging services provided a seven days a week service to the inpatient wards.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Outpatient and diagnostic imaging provided effective services. Care pathways followed national guidance and best practice, resulting in anticipated outcomes for patients.

Processes were in place that encouraged staff to fulfil their training obligations. Staff were also encouraged to increase their knowledge and skills, and supported by their managers to do so.

Audits were completed locally and services were reviewed, which had resulted in changes to and improvements in services.

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

Services were not always available at times that were convenient to all sections of the public. Patients described having to take time off work in order attend clinics, although some patients had contacted the hospital and been given appointments at more convenient times.

Evidence-based care and treatment

- Diagnostic services were delivered in accordance with Department of Health and Royal College of Radiologists guidance.
- Breast services had been withdrawn on the basis of patient safety, which meant that patients now had to travel to neighbouring trusts for diagnostic services. We were not able to speak with anyone who had been affected by this, but some staff said that patients having to travel outside the area caused them increased anxiety in addition to the inconvenience.

Outpatients and diagnostic imaging

- We saw how changes were being made to outpatient departments as a result of the matron's audits and reviews. Many of the changes affected outpatient sites across the trust.
- The matron had reviewed the services and environment of the department along similar lines to the Royal College of Physicians 'patient shadowing framework'. This had involved following the whole patient experience through the service, looking at the environment, staff interactions, the expectations of patients, and the timeliness and effectiveness of services. A member of the trust board and a patient had been asked to accompany the matron on a walk-through of the department. As a result of the audits and reviews the following improvements had been implemented at Ormskirk:
  - The outpatient department waiting rooms and treatment rooms had been decorated, improving the environment for patients while they waited.
  - We were shown where large trestle screens had been removed from the main waiting room. This had reduced the infection risk posed by the difficult-to-clean trestles, and it had created a lighter open plan area. Staff and patients could see each other as they went about their business, increasing security for staff, and giving patients an understanding of what was happening in the department.
  - New seating had been installed, which provided a cleaner and more comfortable environment. We were concerned that the new seats did not have arms, which meant it could be difficult for some patients to get up from or lower themselves into the seating. The matron explained that the new furniture had only just been fitted and that arms were available but had yet to be fixed. We were also advised that the need for seating for obese patients was being assessed.
- Improvements on both sites included:
  - Activity boards for children.
  - Authorisation for the production of an access film to reduce anxiety for children and patients with learning disabilities.
  - Uniforms for reception staff, to provide a more professional image and make them feel more like part of the team.
  - A dressings clinic had been introduced at Southport. Early assessment of the impact had been positive and the matron was hoping to introduce a similar system at Ormskirk.

Pain relief

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

Patient outcomes

- Patient referral to appointment times met or exceeding national averages for all outpatient and diagnostic service disciplines. For example all urgent cancer patients were seen within the national target time of two weeks.
- We were told that current workload of radiologists had caused some chest x-ray reports to miss the trusts five day reporting target, this suggested that the trust might fail to meet national guidelines when the next national figures are published.
- Outpatient and diagnostic imaging services participated in national audits of its services, for example; outpatient diagnostic service waiting list for September 2014 compiled by the Department of Health for Southport and Ormskirk showed that the trust had a total of 2150 on its waiting list. Of these only seven patients had waited longer than six weeks which represented 0.3%. No patients had waited longer than 8 weeks.
- Diagnostic imaging services provided a seven day service to inpatient and emergency services. Services to outpatient departments operated on working days between 8am to 8pm.
- Patients told us they had received their initial appointments quickly after being referred by their GP. Some patients told us that on occasions they had experienced long waits when attending clinics, some up to two hours. However; we were told that they had been kept updated by staff about delays and understood that emergencies occurred which impacted on clinic times.
- Patients said they understood the advice and guidance they had been given. They had confidence in the medical and nursing staff and they believed they had a genuine interest in their wellbeing.

Outpatients and diagnostic imaging

- The matron described the matrons monthly check sheet which enabled the services to be monitored and reviewed. The audits which had been completed led to improvements in the overall environment of the outpatient clinics.

Competent staff

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

Multidisciplinary working

- We saw and were told about good examples of multidisciplinary working. We saw how clinics took place that were run by consultants from neighbouring trusts. These enabled people to be assessed locally to determine if they would need to travel to the neighbouring trust for treatment. Nursing and support staff were all local and provided the same level of care and support as they did to the locally run clinics.
- We saw how patients had been able to attend a number of clinics including blood tests, physiotherapy or occupational therapy sessions, and diagnostic imaging services during one visit, reducing the number of visits patients needed to make. Patients who had visited several services were very complimentary of the way their care had been planned.
- We saw how nursing staff were trained to work in all the clinic areas. The matron described how staff rotate between the clinics and also work on one of the inpatient wards; this had enabled them to create a flexible and responsive workforce.

Seven-day services

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

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Outpatients and diagnostic imaging

- We were told that people with dementia, learning disabilities or mental health conditions were always accompanied by relatives or carers when they attended clinics.

Are outpatient and diagnostic imaging services caring?

Good

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

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

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

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

Compassionate care

- Staff we spoke with were very proud of the care and support they provided to patients and their families.
- Before our inspection we received information that suggested that staff were not always polite and courteous towards patients. During our inspection, patients told us that the staff had been very polite and appeared genuinely interested in their welfare. Patients who had attended outpatient appointments on a number of occasions told us that they had always found staff to be the same.
- Because of the availability of services at both Ormskirk and Southport hospitals, some patients told us they had attended clinics at both locations. These patients told us that they had found staff equally as polite at both locations, although they found that staff at Southport had less time because the clinics were busier.
- We observed interactions between patients and staff in the clinics and imaging areas we visited. We saw that staff were respectful, polite and listened attentively to patients and their families.
- All the patients we spoke with were very complimentary of the nursing staff. They told us how they had been able to ask about their treatment or clarify things the doctor had said. Patients told us that staff had given them time to consider and understand what had been said. Many told us they thought the staff were "brilliant", "angels", "fantastic" and similar terms.
- We saw that doctors and consultants were polite and respectful, speaking with people in a way that enabled them to understand complex conditions.
- Receptionist were welcoming, friendly and helpful. We saw housekeeping staff and porters going about their work but interacting with patients, giving directions or exchanging pleasantries.

Understanding and involvement of patients and those close to them

- From our observations and as a result of comments from patients it was clear that patients were fully involved in and informed about their condition and the options for treatment.
- Patients described how doctors or specialist nurses had explained how their condition could be treated or how it might progress over time and how that might affect their lives. Patients described being able to question the diagnosis, suggested treatments and how the issues had been explained to them in a way that they understood.
- Some patients said they hadn't really been given options about treatment – that they had been told what was proposed and had accepted it. However, they did say that had they not been happy with what they had been told they would have challenged it.
- Staff told us that they always took people's views into account and that alternative options were always discussed and documented in patients' records.

Outpatients and diagnostic imaging

- People's privacy and dignity were for the most part respected. We saw that reception areas had notices asking patients to wait a short distance away so that patients at the desk could not be overheard. Consultations were always conducted in closed rooms.
- The directorate manager of diagnostic imaging services had only been in post for a few weeks. They had identified that in some areas of the department, patients could be left in embarrassing positions while waiting for their x-ray or scan. Patients from wards or emergency departments were transferred on hospital beds or trolleys. The only place these could be left had been at the front of the waiting rooms, which meant the patient could be seen by all the seated patients in the area. As patients in beds would be wearing pyjamas, nightdress or hospital gowns, this compromised their privacy and dignity. A review of the waiting area had been completed and a block of changing cubicles at the side of the waiting room had been identified which could be removed and replaced by a curtained area where beds or trolleys could be parked. This would also make it easier to get into and out of the area in the event of an emergency. The work had been authorised and was waiting to be completed.
- The service had a chaperone policy to protect patients and staff.

Emotional support

- We asked staff how they would deal with patients who were distressed or disruptive. They told us they would speak with them and suggest they might be more comfortable in the 'quiet room'. They showed us the quiet room, which had been furnished in a more homely way and provided a more informal and less clinical atmosphere.
- If further emotional support was required, staff could refer people to counselling services appropriate to their needs.
- Disruptive patients would be spoken with and reminded how their behaviour affected both staff and patients, and they would be asked to cooperate with procedures. Staff told us that ultimately if someone was threatening they would ask them to leave and porters or police would be called to escort them out.
- Specialist nurses and clinicians had received additional training in line with their role to enable them to deal with patients who had received distressing news or an unexpected diagnosis.

Are outpatient and diagnostic imaging services responsive?

Good

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

Services were planned to meet local need. Local and national audits were completed and reviewed and services were tailored according to results.

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

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

Breast screening services had been discontinued in the trust which meant that patients now had to travel outside the area to neighbouring trusts if they required this service.

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

Service planning and delivery to meet the needs of local people

- Services were reviewed to ensure they met local needs. This was demonstrated by the introduction of the dressings clinics, which provided a drop in service, reducing the need for people to make appointments.
- We were provided with the analysis of a recent outpatient satisfaction survey, to which 95 patient responses had been received. We saw how the information had been used to identify and target areas for improvement. These included providing better information before appointments, and improving visibility of staff infection control measures such as using hand gel and hand washing.

Outpatients and diagnostic imaging

- The removal of the breast screening service meant that patients had to travel to neighbouring trusts. We were told that the difficulty in recruiting suitably qualified radiologists meant that the service would not be reinstated in the near future.
- We spoke with a number of patients who described having to visit clinics or diagnostic imaging services at both the Southport and Ormskirk sites. One patient had been given an appointment for a scan at Ormskirk and then had to attend clinic in Southport to discuss the results with the consultant. Other patients told us that as clinics operated on different days at the two sites it gave them the flexibility to choose where they wanted to be seen.
- The phlebotomy clinic, which was operating during our inspection of Ormskirk, was extremely busy. Patients did not have set appointments but attended the clinic and waited in turn. There was only one phlebotomist in the clinic. We were told that there should have been two, but due to sickness one had been moved elsewhere in the hospital. We were told that as the service was a morning clinic and there had been no warning that the staff would be moved, it was not possible to arrange bank staff to provide cover – the clinic would be over before anyone could be called in.

Access and flow

- Waiting times for first outpatient appointments were within NHS England target times. In October 2014, 90.1% of patients referred were seen within the 18 weeks target against a NHS operational standard of 92%. Before our inspection we received information suggesting that the trust was not providing accurate figures about waiting times. When we spoke with patients they confirmed that they had been seen within a few weeks of being referred to the hospital.
- When patients attended clinics, most were seen quickly – often within 10 or 15 minutes of their allotted time.
- Patients had timed appointments and in some clinics it was not unusual for appointments to run over as the day progressed. Notice boards were updated to keep patients informed and if large delays occurred, patients were spoken invited to go to the cafeteria rather than having to sit in the clinic waiting rooms.
- Patients expected that when they attended outpatient or diagnostic imaging services that they would have to spend time waiting. We asked some patients why they had this expectation and they told us that it was what they had always thought happened, either because of previous visits, or things they had seen or heard in the media.
- The matron explained how they were reviewing ways of reducing waiting times. She described how each patient appointment has a fixed consultation period which is set by the commissioning service that who funds the service. Some patients may not require all the allotted for their consultation, but some patients may need more support or have more complex needs which meant their appointment would take longer.
- To enable her to assess the impact on patient flow, the matron was working with the senior clinicians to conduct a survey of the doctors' and consultants' start and finish times in all the outpatient clinics. The results were still awaiting analysis but we were advised that they would enable more accurate planning.
- We asked patients about attendance at appointments. Some patients told us that they had cancelled appointments in the past due to personal commitments and availability. They told us that when they had contacted the clinics they had been dealt with politely and alternative appointments had been given.
- We asked patients if they had ever had appointments cancelled by the trust. A small number of patients said they had been contacted by the trust and asked if they could attend on alternative dates. The patients who told us this said they saw this as acceptable practice, and because they had been given an alternative date they didn't think of it as a cancelled appointment.
- We saw that regular audits were completed along with the monthly matron's checklist. Staff were very supportive of the matron and were aware of the reviews and audits that were done, but we were told that they don't get feedback about what the audits have identified.

Meeting people's individual needs

- We observed wheelchairs were available inside the main entrances of the hospital for patients and carers to use.
- Hearing loops were available to assist people with hearing disabilities, and interpreter services were available for people for whom English was not their first language. Staff explained that most patients who need assistance to communicate attend the clinic with a

relative or carer. They could use telephone interpreter services, but if they were aware that an interpreter was needed, this could be arranged in advance of the appointment.

- Ormskirk outpatient department had a large waiting room where people waited to be called through to their consultation. There was enough seating for all the patients and their family members or carers. We saw that new seating had been installed, but there were no arm rests on the seats, which meant some people may find it difficult to raise and lower themselves into the seating. The matron explained that the seating had only recently been installed as part of a 2 year improvement plan. The seating did have arm rests and these were waiting to be fitted. She also explained that a risk assessment was being done for the installation of seating for obese people.
- Staff told us that people with complex needs, learning disabilities, mental health problems or dementia always attended clinics with a carer or family member who understood their needs. Patient health records also contained information about people to help staff understand who they were and how best to support them. Staff had received dementia awareness training.
- Children's activity boards had been purchased and were being put up on the walls in waiting rooms, to provide children and young people with activities while waiting to be seen or when accompanying parents.
- Authorisation had been given for the production of an access film aimed at young children and people with learning disabilities. The film will be available on the trust website for parents or carers. It will show the journey through the outpatient department from arrival at the hospital, reception areas, waiting rooms and activities, and consultation and diagnostic services. The matron explained how this would reduce anxiety for patients and their families and carers as they would have some idea of what the hospital looked like, who they would meet and what they would be doing.

Learning from complaints and concerns

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

Are outpatient and diagnostic imaging services well-led?

Good

Local leadership at Ormskirk was good. Staff respected and trusted their managers. The trust values were known to and understood by staff, although efforts to reinforce these with mandatory professional standards had not been well received by staff, who saw them as repetitive and unnecessary.

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

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

Outpatients and diagnostic imaging

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

Vision and strategy for this service

- The trust values were to provide safe, clean and friendly care, which was supportive, caring open and honest, professional and efficient (SCOPE). The outpatients matron provided us with a copy of the departments 2 year plan, which had been produced under the trust SCOPE for change agenda.
- Elements of the plan had already been introduced; some at Ormskirk and some at Southport. The intention was to review progress and consider mirroring the elements at both sites if they proved to be sustainable.

Governance, risk management and quality measurement

- There were clearly defined processes for staff to raise concerns, which ensured that matters were recorded and escalated as appropriate.
- Local managers completed regular reviews and audits of their departments. This was evident in both departments. In the outpatient department the matron was currently reviewing all the local policies and procedures to ensure they were still relevant and fit for purpose.
- The directorate manager of diagnostic services had been in post for only a few weeks. Staff told us they had been impressed by the visibility of the new manager and their apparent willingness to engage with them and improve the service.
- Staff at all levels understood their role and how they and their department enabled the trust to meet its goals and targets. Staff were proud of their contribution and proud of the trust.

Leadership of service

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

Culture within the service

- Most staff knew the chief executive by name and many told us that they regularly saw him and spoke with him as he toured the hospital. Other members of the executive team were less visible or unknown to grass roots staff.
- We saw notices with pictures of the executive team in various locations around the hospital. Staff told us these had only recently been put up, together with copies of the trusts SCOPE values.

Public and staff engagement

- The trust had introduced a number of mandatory professional standards, which they encouraged staff to adhere to. Most staff we spoke with did not understand what these were; they either hadn't heard of them or had heard about them but had not been told what the individual standards were. Some staff were able to describe the standards, but commented that they were things that staff did automatically as part of their job or would be expected of a health professional, such as ensuring they were properly dressed, and attending work on time. Staff told us the mandatory professional standards were an unnecessary distraction.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. Friends and Family Tests are not compulsory in outpatient departments until April 2015, however we found that a large number of staff were familiar with the test and applied it informally to their own performance.
- The trust provided us with details of how it engages with the public and patients. Although none of the patients we spoke with quoted specific events, they all spoke of Southport and Ormskirk as being 'their' hospitals and part of their community. Most people only engaged with the hospital when they or a family member needed to use the services which showed overall people were satisfied with their appointment but identified some areas for improvement;
  - Being given a choice of appointment time?

  - Being told that you could bring a significant other to your appointment?
  - Patients not being told how long they would have to wait.
  - Did you witness our staff washing/applying alcohol gel to their hands

- Local patient satisfaction surveys were completed in the outpatient department. We were provided with the results and analysis of the November 2014 survey.
- Patient satisfaction surveys were collated at trust level, and results were circulated on the trust intranet.
- Staff satisfaction surveys were completed and data submitted to NHS England.
- Staff told us that the chief executive attended all staff induction courses to introduce himself and describe the trusts work.

Innovation, improvement and sustainability

- As part of the 2 year outpatient plan the matron was undertaking a feasibility study to assess the potential introduction of a band 4 role to encourage staff to progress and make the department more inviting to wider staff base. Currently staff that do not have a nursing qualification can only progress to band 3. The theory was that adding an additional level of advancement would attract high performing staff into the department.
- The outpatients matron had identified that the department had an aging staff group. Many valuable members of staff were reaching retirement age and if/when they left there would be heavy loss of experience and skill. In order cushion the effect of these staff leaving the matron was looking at ways to attract new staff. She told us how she was “trying to raise the profile of the department to demonstrate the importance of outpatient services to the trust”.
- Diagnostic services had long-term contracts ending in 2027 covering the maintenance and replacement of most of the imaging equipment in the department.

Outstanding practice and areas for improvement

Outstanding practice

- Compassionate improvements and re-design of the outpatients departments to reduce anxiety for young children and patients with a learning disability. Child friendly activity boards are being erected. An access film showing the experience of a child attending an outpatient department is being posted on the Trust website. This will allow parents of young children or carers of patients with learning difficulties to view the film with them and explain the process and what to expect before they attend for their own appointment.
- The work of the children's community nursing outreach team had been further recognised by the successful publication in the British Journal of Nursing ("Paediatric community home nursing, acute paediatric care" British Journal of Nursing 2014, vol 23, No. 4).
- Specialist paediatric nurses were employed to support children with diabetes and respiratory conditions. They held specialist multidisciplinary clinics on a regular basis. We heard of exemplary good practice such as specialist nurses visiting schools to give support and training to teaching staff.
- The trust paediatric diabetes service was peer reviewed in July 2014. Multidisciplinary team work scored 90% and hospital measures scored 100%. Some good practice was recorded, including having a support group.
- The trust and hospital had implemented the 'New priorities for care of those thought to be dying', before the compulsory withdrawal of all references to the Liverpool care pathway. This had been supported by a robust training programme.
- Patients at the end of life and their relatives were supported by the palliative care team to plan for their future, and a national system was in place to identify them when accessing emergency care in order to speed up admission and discharge.
- 85% of patients who had a documented preferred place of death died where they chose to, facilitated by an effective end of life rapid transfer programme.
- The mortuary team was outstanding in its responsiveness and its innovative approach to caring for the patients and relatives who used their services.

Areas for improvement

Action the hospital MUST take to improve

- Ensure adequate medical and nurse staffing levels and appropriate skill mix and medical and senior nurse cover out of hours is safe and fit for purpose.
- Ensure consent for obstetric operations is recorded accurately.
- Ensure all staff working in obstetric theatres are appropriately trained and experienced to ensure safe care and all newly qualified midwives receive support and supervision, as per their preceptorship guidance, taking into account the number of experienced midwives working with them on any shift.
- Ensure the incident of peripartum hysterectomies and the use of forceps for delivery are appropriate and safe.
- Ensure the leadership of the maternity services encourages and enables an open and transparent culture.
- Ensure all equipment is fit for purpose and older equipment is replaced under a planned replacement schedule.

Action the hospital SHOULD take to improve

Urgent and emergency

- Keep a list of appropriate staff that have had the required scene safety and awareness training.
- Ensure sufficient numbers of staff are recruited.
- Ensure the department is safely staffed when staff are called away from the A&E department to assist in other duties such as covering the bed management and being the designated on call person for the site.

Medicine

- Improve feedback and learning from incidents.
- Increase seven day working for all disciplines across the medical directorate.

Outstanding practice and areas for improvement

- Improve the way risks are communicated to nursing staff within the medical directorate.
- Improve access to blood transfusions for medical patients.

Surgery

- Ensure there is suitable medical staffing cover on the orthopaedic surgical ward.
- Ensure there are sufficient numbers of trained staff in the theatres department.
- Improve performance relating to patients having elective trauma and orthopaedic surgery who are readmitted to hospital.

Maternity

- The records in the maternity services should be stored securely at all times.
- Staff in the maternity services should be aware of their role within the major incident plans.
- The layout of the waiting areas for patients in the termination of pregnancy outpatients area should be separated from the ante-natal and fertility clinic.
- Ensure all staff receive information of lessons learnt following incidents.

Outpatients

- Ensure that people are protected from the risks associated with unsafe use and management of medicines. This is something that is required as part of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010, in relation to the management of medicines. However it was considered that it would not be proportionate for that one finding to result in a judgement of a breach of the Regulation overall at the location.
- The trust should consider the process for formalising team and multidisciplinary team meetings in order increase understanding and information flow.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were insufficient numbers of suitable qualified skilled and experienced nursing staff to safeguard the health, safety and welfare of service users. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Patients using the maternity services were not protected against the risks of receiving care or treatment that was inappropriate or unsafe because the planning and delivery of care and treatment did not reflect, where appropriate, published research evidence and guidance issued by the Anaesthetists Association of Great Britain and Ireland and the Royal College of Obstetrics and Gynaecology. Regulation 9 (1) (b) (iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Patients using the maternity services were not being protected against the risks of inappropriate or unsafe care and treatment due to a lack of assessment and**

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Compliance actions

monitoring of the quality of the services provided. Risks identified did not have actions in place to mitigate them and protect the health and welfare of patients. Regulation 10 (1) (a) (b)

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Midwives providing care and treatment in the obstetric theatre and during a patient's recovery from regional or general anaesthetic were not appropriately trained in relation to their responsibilities. Regulation 23 (1) (a)

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Consent for obstetric operations is not always recorded accurately. Regulation 18

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Surgical procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Not all equipment was fit for purpose and older equipment was not being replaced under a planned replacement schedule. Regulation 16 (1) (a)