

Southport and Ormskirk Hospital NHS Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust

Requires improvement 

Are services safe?

Requires improvement 

Are services effective?

Requires improvement 

Are services caring?

Good 

Are services responsive?

Requires improvement 

Are services well-led?

Inadequate 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Southport and Ormskirk NHS Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire. Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital. The trust also provides sexual health services for the metropolitan borough of Sefton. The North West Regional Spinal Injuries Centre is at Southport hospital and provides specialist care for spinal patients across the North West and the Isle of Man. Services at the trust are commissioned by West Lancashire and Southport & Formby Clinical Commissioning Groups.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement



What this trust does

Acute care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital. The trust also provides sexual health services for the metropolitan borough of Sefton. The North West Regional Spinal injuries Centre is at Southport hospital and provides specialist care for spinal patients across the North West and the Isle of Man. The trust employs approximately 2500 staff.

From April 2016 to March 2017 the trust had 50,773 inpatient admissions and 389,019 outpatient attendances. The trust had 76,212 A&E attendances (excluding walk in centre attendances), 2,237 deliveries and 935 deaths during the same time period. At the time of our inspection end of life services for the trust were provided by another organisation.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. At the last inspection, we rated some core services as requiring improvement and some as inadequate. At this inspection we inspected Urgent and Emergency Care (both sites), Medicine (Southport), Surgery (both sites) and Maternity. These inspections were undertaken between 20 November and 23 November 2017. We also inspected the North West Spinal Injuries Unit, which was rated good at our last inspection, as part of our continual checks on the safety and quality of healthcare services. This inspection was completed during 27 and 28 November 2017.

Summary of findings

Our comprehensive inspection of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question for the trust overall. What we found is summarised in the section headed Is this organisation well-led? The well-led inspection took place between 5 and 7 December 2017.

What we found

Overall trust

During this inspection we rated six of the trust's seven services we inspected as requires improvement and one as good. In rating the trust, we took into account the current ratings of the five core services not inspected this time. Overall, we rated safe, effective and responsive, caring as good and well-led for inadequate. We rated well-led for the trust overall as inadequate.

Our rating of services stayed the same. We rated them as requires improvement because:

- During our inspection we found areas of the surgical, medical and urgent and emergency care department at Southport hospital that weren't visibly clean. This included equipment in wards. We escalated this to the trust at the time of our inspection.
- In surgery, records we reviewed showed that not all theatre recovery staff had completed immediate or advanced life support training.
- At Southport hospital in spinal injuries, medicine and surgery we found that patients with transmittable infections were not nursed in accordance with the trust's policy or best practice guidance. This included staff not wearing suitable personal protection to minimise the spread of infection. We escalated this to the trust at the time of the inspection.
- At Ormskirk hospital we found a fire exit that was propped open. This is not in accordance with the trust's policy or legal requirements.
- In the emergency department and surgical wards at Southport, hazardous substances were not securely stored in ward areas. This represented a patient safety risk.
- In surgery we found that some medication, including oxygen, was not recorded when administered.
- At Southport in surgery we found the use of bed rails was not consistent with the trust's policy. Patients' needs were not always assessed, which represented a patient safety risk. We escalated this to the trust at the time of our inspection.
- In maternity, surgery, medicine and urgent and emergency care we found that thorough checks of emergency equipment, including resuscitation trolleys were not completed. During inspection we found out of date medications and missing equipment. We escalated this to the trust at the time of our inspection.
- During the inspection we identified that records were not securely stored across most areas we inspected, excluding urgent and emergency care at Ormskirk. Staff were not following the trust's policy. We escalated this to the trust at the time of our inspection.
- Across medical and surgical wards we identified there were insufficient numbers of staff to assist with patients' dietary needs.
- During our reviews of records we identified that staff had not completed documentation for Mental Capacity Act, Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately. This represented a patient safety risk. We escalated this to the trust at the time of our inspection.

Summary of findings

- In the emergency department at Southport records did not evidence that patients received access to analgesia in timely manner. We escalated this to the trust at the time of our inspection and immediate action was taken.
- In spinal injuries the overall security of the unit meant patients and their personal property and equipment were not sufficiently secure. We escalated this risk to the trust at the time of our inspection and they took immediate action.
- At our last inspection we identified concerns regarding mandatory training completion rates at the trust. At this inspection we found that mandatory training levels had generally improved. However, there was still further progress to be made. The trust needed to ensure that sufficient priority continued to be given to mandatory training.
- During our inspection, in urgent and emergency care and surgery at Southport, staff were using areas that were not suitable for the purpose they were being used. We escalated this to the trust at the time of our inspection and immediate action was taken.
- In urgent and emergency care and spinal injuries patients were not consistently treated with dignity and their privacy was not consistently maintained.
- Southport hospital continued to experience challenges in relation to patient flow. Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. This impacted on urgent and emergency care where patients were still experiencing long and unacceptable waits for treatment.
- During our inspection we identified that the trust's internal escalation policies were not followed appropriately. Senior staff were aware there was deviation from the process and immediately addressed this.
- Across the hospital we found a range of concerns relating to the systems and processes that should be in place to ensure the hospital runs effectively and efficiently. New systems and processes had recently been introduced to address this, but were not fully embedded to ensure all risks were identified and addressed.
- The trust did not have a current strategy. As a result staff did not understand how their role contributed to achieving the organisation's strategic goals.
- The absence of a strategy meant services did not have meaningful and measurable plans in place in order to achieve strategic goals.
- There was no credible statement of vision and staff awareness of the organisation's values was limited.

However:

- Safeguarding adults, children and young people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations, including when people experienced harassment or abuse in the community.
- Since our last inspection mandatory training levels had improved across the trust. Whilst they were still below the trust's target of 90%, they had significantly improved to average 78% across all areas.
- Across most areas of the trust staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Where relevant, there were effective handovers and shift changes to ensure that staff could manage risks to people who used services.

Summary of findings

- In most areas of the trust people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.
- People received coordinated care from a range of different staff, teams or services. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Across most areas of the trust, people were supported, treated with dignity and respect, and were involved as partners in their care.
- The majority of the trust was easily accessible for patients who required assistance with mobility, including patients who required the use of a wheelchair.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe.
- Monitoring whether safety systems were implemented was not robust. There were some concerns about the consistency of understanding and the number of staff who were aware of them.
- In medical wards we found there were periods of understaffing or inappropriate skill mix, which were not addressed quickly.
- Across most areas of the trust that we inspected, risks to people who used services were not consistently assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health and completion of risk assessments. We found risks assessments were not consistently in place or reviewed regularly.
- Across medical and surgical wards and the spinal injuries unit, systems to manage and share care records and information were uncoordinated. Staff did not always have the complete information they needed before providing care, treatment and support because records from different professionals were stored in different places.
- In surgical areas staff did not consistently meet good practice standards in relation to controlled drugs. Records did not consistently have two signatures and wastage records were not consistently completed.
- Across some areas of the trust, there was limited use of systems to record and report safety concerns, incidents and near misses. When things went wrong, reviews and investigations were not always sufficiently thorough. Necessary improvements were not always made when things went wrong. Learning from incidents was not consistently shared across the trust to prevent recurrence of incidents. However, the number of reported incidents had increased since our last inspection.
- Since our last inspection our rating for safe for the spinal injuries unit went down due to concerns about access to the unit, infection control and relating to completion of risk assessments for patients.

However,

- Since our last inspection, we noted improvement in safety in surgery services at Southport.
- Across the trust patients were safeguarded from abuse and staff knew when and how to use local safeguarding procedures whenever necessary. Since our last inspection there was significant improvement in safeguarding training completion levels.

Summary of findings

- Safeguarding adults, children and young people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focus on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations.
- Across most areas, staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Most staff shortages were responded to quickly and adequately. Where relevant, there were effective handovers and shift changes to ensure that staff could manage risks to people who use services.
- Across most areas, staff met good practice standards described in relevant national guidance, including in relation to non-prescribed medicines. People received their medicines as prescribed. Staff managed medicines consistently and safely. Medicines were stored correctly, and disposed of safely. Staff kept accurate records of medicines.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

- People did not consistently have comprehensive assessments of their needs, which included consideration of clinical needs (including pain relief), physical health and wellbeing, mental health and patients' needs when being moved.
- Outcomes for people who used services were below expectations compared with similar services.
- The results of monitoring were not always used effectively to improve quality.
- The learning needs of staff were not consistently identified and training was not consistently provided to meet these needs. There was not a clear approach for supporting and managing staff when their performance was poor or variable. This meant poor performance was not dealt with in a timely or effective way.
- There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation. Decision-makers did not always make decisions in the best interests of people who lacked the mental capacity to make decisions for themselves, in accordance with legislation. Restraint (where relevant) was not always recognised, or less restrictive options used where possible.
- Applications to authorise a deprivation of liberty using the Deprivation of Liberty safeguards were not always made appropriately or in a timely way.

However,

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice, legislation and technologies.
- Information about people's care and treatment, and their outcomes, was routinely collected and monitored.
- Most staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Most staff were supported to deliver effective care and treatment, including through meaningful and timely supervision. Where relevant, staff were supported through the process of revalidation.
- When people received care from a range of different staff, teams or services, it was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Across most areas, consent to care and treatment was obtained in line with legislation and guidance.

Summary of findings

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- Feedback from people who used the service and those who are close to them was mainly positive about the way staff treated people. Across most areas we observed that patients were treated with dignity, respect and kindness during their interactions with staff. Relationships with staff were mainly positive. People told us that they felt supported and said staff cared about them.
- Across most areas, staff responded compassionately when people needed help and they supported them to meet their basic personal needs as and when required. . Staff supported people and those close to them to manage their emotional response to their care and treatment. People's personal, cultural, social and religious needs were understood.
- During our inspection we observed that people who used services, carers and family members were involved and encouraged to be partners in their care and in making decisions, and received support they needed. Staff communicated with people and provided information in a way that they could understand it. People understood their condition and their care, treatment and advice. People and staff worked together to plan care and in most areas there was shared decision making about care and treatment.
- People who used services, those close to them and most staff understood the expectations of the service around privacy and dignity. Most staff recognised the importance of people's privacy and dignity and respected it at all times. Staff developed trusting relationships with people.

However,

- In the urgent care service at Southport there were times when people did not feel well-supported or cared for or their dignity was not maintained.
- People were sometimes not treated with kindness or respect when receiving care and treatment or during other interactions with staff.
- Across several areas of the trust, people's confidentiality was not respected at all times. This meant that legal requirements about data protection were not consistently met.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- At the trust Ormskirk District General Hospital was rated as good overall for responsive and Southport and Formby District Hospital were rated as requiring improvement.
- At Southport the hospital continued to experience challenges in relation to patient flow. Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. This impacted on urgent and emergency care where patients were still experiencing long and unacceptable waits for treatment.
- At our last inspection we told the trust it must improve patient flow in medical services at the hospital to ensure patients are cared for on wards appropriate for their needs. At this inspection we found that the trust had not reduced the numbers of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).

Summary of findings

- The Ambulatory Care Unit was being used as a bedded area for four patients due to the high demand for hospital beds. The patients in those beds had access to a toilet situated at each end of the unit, however did not have direct access to shower facilities.
- Passport documents were used for patients with dementia and patients with learning disabilities to identify additional support needs, communication methods, likes and dislikes. However we noted that these were not always completed.
- Medical patients who were being cared for and treated on surgical wards were not seen by the therapy team covering the surgical ward. This meant there was a risk that these patients did not receive the therapy they required whilst on a surgical ward.
- Average length of stay was longer for general surgery and trauma and orthopaedics for elective and non – elective procedures when compared to the England average. Average stay for urology patients was higher for non-elective surgery.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely in the form of standardised templates, which identified risks, but lacked clarity relating to the specific needs and wishes of the patient.

However,

- Facilities and premises were appropriate for the services being delivered.
- The needs and preferences of different people were taken into account when delivering and coordinating services, including those with protected characteristics under the Equality Act, people who may be approaching the end of their life and people who were in vulnerable circumstances or who had complex needs. Across most services, care and treatment was coordinated with other services and other providers. This included liaising with families and carers and ensuring that all services are informed of any diverse needs that need to be addressed.
- People could access the service when they needed it. In surgery waiting times for treatment were and arrangements to admit treat and discharge patients were in line with good practice.
- The trust's staff had worked to improve their handling of complaints. Complaints were responded to in a shorter time frame and the trust were meeting their legal requirements under the NHS complaints regulations.

Are services well-led?

Our rating of well-led went down. We rated it as inadequate because:

- There was no stable leadership team, with high unplanned turnover and vacancies across a range of areas within the trust.
- The need to develop leaders was not always identified and action was not always taken to address this.
- There was no current strategy. As a result staff did not understand how their role contributed to achieving the organisation's strategic goals. There was no credible statement of vision.
- The trust had systems for identifying risks. However; not all ward managers we spoke with were aware of risks identified on the risk register.
- Across most areas, the trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively. The trust was beginning to address this but plans were in their infancy.

Summary of findings

- The trust collected, analysed, managed but did not use information well to support all its activities.
- The trust did not use a systematic approach to continually improving the quality of its services. Focus for improvement was on external reports including CQC's previous inspection report rather than a proactive internal approach to sustainable improvement.
- Across the hospital we found a range of concerns relating to the systems and processes that should be in place to ensure the hospital runs effectively and efficiently. New systems and processes had recently been introduced to address this, but were not fully embedded to ensure all risks were identified and addressed.

However,

- Clinical business unit leaders had the experience, capacity, capability and integrity to ensure that a strategy can be delivered and risks to performance addressed.
- The trust was transparent and open with all relevant stakeholders about performance and the challenges to the system, in order to meet the needs of the population.
- The trust had managers at all levels with the right skills and abilities to run the service providing high-quality sustainable care.
- Staff we interviewed told us that managers across the trust promoted a positive culture that supported and valued staff and they tried to create a sense of common purpose based on shared values.

See guidance note 7 then replace this text with your report content. (if required)...

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings

Areas for improvement

We found areas for improvement including nine breaches of legal requirements that the trust must put right. We found 39 things the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issue requirement notices and take enforcement action against the provider. Listing them as shown below will include action relating to all problems in the trust's services, whether they are trust-wide or at service type, location or core service level.

Summary of findings

We issued requirement notices to the trust.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust **MUST** take to improve

We told the trust that it must take action to bring services into line with nine legal requirements. This action related to six services.

Trustwide:

Regulation 5: Fit and proper persons: directors

- The provider must ensure that the trust has an effective system in place to meet their legal obligations in relation to fit and proper persons employed at director level.

Regulation 17 Good Governance:

- The provider must ensure there are trust-wide effective governance systems in place.

Regulation 20: Duty of Candour

- The provider must ensure that the spirit of Duty of Candour is embraced in the service particularly in relation to notifiable safety incident investigations. Consideration should be given to wider involvement with relevant persons in the investigation and sharing of outcomes.

Spinal Injuries

- The provider must ensure that infection control risks are consistently and effectively managed at all times.
- The provider must ensure that the isolation room has proper signage and the door is kept closed when necessary.
- The provider must ensure the overall security of the unit and that patients and staff, as well as their personal property and equipment are protected at all times.
- The provider must ensure the security of patient records is maintained at all times.
- The provider must ensure that all risks on the spinal injuries unit are identified and appropriately managed.
- The provider must ensure that patients receive a Malnutrition Universal Screening Tool score where appropriate.
- The provider must ensure that risk assessments for moving and handling are undertaken, documented and reviewed.
- The provider must ensure that decisions about individual patients treatment and care incorporate review of all their separate clinical records which may be held on the unit

Summary of findings

- The provider must ensure that records of consent for patients are comprehensively reviewed to reflect any changes in patients' capacity.
- The provider must ensure that identification, assessment and documentation of the needs of patients who lack capacity is consistently implemented
- The provider must ensure that patients' privacy dignity and respect is maintained at all times and that patients cannot be overseen or heard by inappropriate persons when receiving care and treatment.

Urgent and Emergency Care

- The provider must ensure that all medications in the emergency department are within their expiry dates.
- The provider must ensure that patients receive access to analgesia in a timely manner.
- The provider must ensure that any areas used for clinical care are suitable for this purpose.
- The provider must ensure that patients' records are accurate, up to date and reflect the care the patient receives in the emergency department.
- The provider must ensure that patients are protected from infections by completing the relevant local pathways and cleaning areas where patients receive care in line with their infection control policies and procedures in the emergency department.
- The provider must ensure that patient risk is appropriately identified and all possible measures are taken to minimise risks to patients safety are in place. Specifically in relation to patients being accommodated in areas not designed for clinical care such as corridor areas.
- The provider must ensure that patients are treated with dignity and compassion and that their dignity and privacy is maintained at all times while they are in the emergency department.
- The provider must ensure that patients can access emergency care and treatment in a timely way.
- The provider must ensure that the trust's internal escalation policies are followed appropriately.
- The provider must ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.
- The provider must ensure that there is a clear vision and values set for staff to follow.
- The provider must ensure that staff are following evidence based practice and utilising the local and national pathways and policies required.

Medicine

- The provider must take action to ensure that all staff have the up to date training they require to be able to safely care and treat patients.
- The provider must take action to ensure that all wards and corridors are clean and well maintained.
- The provider must ensure that all records relating to patients are kept securely and computers are locked when left unattended to prevent breaches in data protection.
- The provider must take action to ensure that staff in medical services wear suitable personal protection to minimise the spread of infection.

Summary of findings

Surgery

- The provider must ensure that all staff completes mandatory training requirements.
- The provider must ensure that all theatre recovery staff have completed immediate or advanced life support training.
- The provider must ensure that all equipment in wards is clean and free from dust.
- The provider must ensure that any patient diagnosed with a transmittable infection is nursed appropriately.
- The provider must ensure that all fire exits are accessible at all times.
- The provider must ensure all hazardous substances are securely stored in ward areas.
- The provider must ensure that all medication, including oxygen, is recorded when administered.
- The provider must ensure oxygen and suction are available in all bed spaces.
- The provider must ensure that bed rails are used safely for all patients.
- The provider must ensure that all medication checks are completed appropriately.
- The provider must ensure that all emergency equipment, including resuscitation trolleys, are checked appropriately.
- The provider must ensure that all records are contemporaneous and stored securely.
- The provider must ensure that there are sufficient numbers of staff to assist with patients dietary needs.
- The provider must ensure that all staff can complete documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately.
- The provider must ensure that hazardous liquids are not accessible in dirty utility rooms.
- The provider must ensure that resuscitation trolleys are checked effectively and all medication and consumables are within date.
- The provider must ensure that clinical records are readily available to staff, are comprehensive and contemporaneous and maintained as per best practice guidelines and local policies and procedures. Records must be kept secure at all times.
- The provider must ensure that all staff complete mandatory training.
- The provider must ensure that duty of candour policies and processes are fully embedded across the service and that staff understand their responsibilities.

Maternity

- The provider must ensure that Modified Early Warning Scores (MEWS) are completed and appropriately escalated in order to detect deterioration in condition.
- The provider must ensure that medicines are stored correctly in accordance with manufacturer's recommendations and that room and fridge temperatures which fall outside the normal parameters are escalated and actioned.
- The provider must carry out regular checks of medical equipment including the anaesthetic machine and resuscitation equipment to ensure this is safe for use.

Summary of findings

- The provider must ensure that systems in place to assess, monitor and improve the quality of services are robust and effective.
- The provider must ensure that policies are reviewed within the specified timeframe and that robust systems are in place to identify policies past their review date.

Action the trust SHOULD take to improve

Spinal Injuries

- The provider should improve the levels of nursing staff that have completed mandatory training to meet trust targets.
- The provider should address the actions identified and consider implementing the recommendations of the Spinal injuries Unit peer review report March 2016.

Urgent and Emergency Care

- The provider should engage the public in relation to urgent and emergency services.
- The provider should raise awareness of FGM and have an appropriate policy in place for these cases.
- The provider should ensure that patient records are stored securely and confidentially.
- The provider should review and approves pharmaceutical patient group directives on a regular basis.
- The provider should monitor and report the impact of removing bed management services on nursing leadership capacity at Ormskirk and District General Hospital.
- The paediatric emergency department should comply with the new protocol to standardise observations meets the expected standard.
- The paediatric emergency department should display department quality and safety performance to people using the service.
- The paediatric emergency department should continue to audit and improve the standard of nursing and medical documentation.
- Staff in the paediatric emergency department should document offering food and drink and oral intake for children, when appropriate.

Medicine

- The provider should consider the use of Ambulatory Care Unit and discharge lounge as escalation areas as they do not currently provide all the necessary amenities to the patients.
- The provider should consider improvements in seven day services to provide an equitable service throughout the week.
- The provider should take action to provide staff with a clear vision and strategy of the direction of the medical services and senior managers should be visible and approachable to all staff.

Summary of findings

- The provider should review medical care and treatment when it is being provided on wards outside the staff specialty to assure itself that care and treatment is being provided to meet patients' need and conditions.
- Performance development reviews should be completed in line with trust policy.

Surgery

- The provider should monitor that all staff complete safeguarding training requirements.
- The provider should consider times of day to clean ward areas.
- The provider should consider monitoring the cleanliness of privacy curtains in wards and theatres.
- The provider should consider storage options for equipment in corridor areas.
- The provider should monitor venous thromboembolism's (VTE's) following admission.
- The provider should monitor all aspects of the World Health Organisation (WHO) 5 steps to safer surgery consistently.
- The provider should explore the reasons for higher readmission rates at this location for elective surgery.
- The provider should monitor the competencies and skills of all staff.
- The provider should encourage patient feedback to drive improvement.
- The provider should have feedback information available including in multiple formats.
- The provider should embed a strategy and plans for the future.
- The provider should encourage patient feedback to drive improvement.
- The provider should develop a strategy and development plan for the future.

Maternity

- The trust should consider how all midwives can have timely access to patient information including any safeguarding concerns.
- The trust should carry out a risk assessment in view of the storage of medical gases and equipment in the community.
- The trust should consider how appropriate translation services are used to explain clinical decisions and gain consent for procedures from women who speak another language.
- The trust should implement systems so that women are given individual times for antenatal clinic appointments and not booked into the same slot.
- The trust should implement robust systems to ensure that test results such as blood results are reviewed and followed up so that women can receive the treatment needed in a timely way.
- The trust should offer vaccination against seasonal flu to women at all stages of pregnancy including the postnatal period.
- The trust should consider how to monitor that World Health Organisation surgical checklists are fully completed for every woman undergoing a surgical procedure.

Summary of findings

- The trust should use audit results to drive improvement in consistency of documenting Fresh Eyes reviews for women in labour where applicable.
- The trust should use results from the NHS Safety Thermometer to improve care for women and their families.
- The trust should implement effective means of communication regarding referral to community midwifery following discharge from the maternity ward.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as inadequate, because the delivery of high quality care is not assured by the leadership, governance or culture:

- The trust had an unstable leadership team with regular changes to executive leaders. There has been no stable leadership team and this remained the case at the time of our inspection with both the chief executive and director of nursing and midwifery both leaving imminently. The substantive medical director was excluded from the trust and the interim medical director was on sick leave and was due to leave the trust without returning to work. Whilst most leaders had the skills and abilities to provide high-quality services, key roles were interim, which affected the pace and capability to progress improvements in care provided. The trust had recognised concerns with succession planning and this was entered onto the risk register.
- The trust did not have a current vision or strategy. The trust had identified that the previous strategy ran from July 2014 to July 2017 and did not produce the intended outcomes. This was recognised in the board meeting in October 2017, when the importance of a new strategy was emphasised. However, at the time of our inspection, a strategy had not been agreed and approved. Discussions around creation of a long-term strategy with partner organisations and stakeholders were very much in their infancy. The trust's own 'well-led review' highlighted the need to develop, implement, embed and review the strategic plan. Senior leaders told us plans to engage with staff and patients were in development. This represented a risk, highlighted on the trust's risk register, that could affect the trust's capability to deliver high quality, sustainable care, because staff may become disengaged and leave. They also needed to develop, implement and embed an operational plan. The values were re-launched during the week of our inspection (originally introduced in 2013). During our core service inspections staff at all levels did not understand the values in relation to their daily roles. This meant that work in this area was not effectively embedded and was not at heart of all the work within the organisation.
- Staff satisfaction was mixed. Improving the culture or staff satisfaction was not seen as a high priority. Staff did not always feel actively engaged or empowered. We found there were teams working in silos or management and clinicians do not always work cohesively. Staff told us that they did not always feel confident to raise concerns or they felt that they were not always taken seriously and that responses to concerns were not received in a timely way.

Summary of findings

Equality and diversity was not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably. Board members recognised that they had work to do to improve diversity and equality across the trust and at board level.

- The trust had a governance structure but the systems for reporting to the board were not fully established. This meant that there was limited oversight of issues facing the service. Whilst there had been improvements in the monitoring of quality and safety across the trust, systems were still relatively new. This meant that improvement was difficult to assess. The board reviewed performance reports that included data about the services, which divisional leads could challenge. During our inspection, we observed two trust board meetings. We were concerned about the effectiveness of the board, as we felt that during our observations there was insufficient challenge and explanation regarding key issues.
- Risks, issues and poor performance were not always dealt with appropriately or quickly enough. Discussions with staff identified confusion regarding the completion of actions. We also saw that improvements were reactive and focused on short term issues. This was evidenced by the action plan drawn up following the last CQC inspection and for issues identified during the core services' inspection. The approach to risk management and incident investigation were applied inconsistently. Clinical and internal audit processes had been implemented inconsistently. The sustainable delivery of quality care is put at risk by the current financial challenge facing the trust.
- The trust had recently completed a scoping exercise to identify measurable outcomes to demonstrate change and areas for quality improvement. The trust had begun to produce this information, which was currently being piloted to see whether it provided the correct level of assurance. Required data or notifications were inconsistently submitted to external organisations or were not completed in a timely manner. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not always robust.
- There was a limited approach to sharing information with and obtaining the views of others. The trust was not consistent in its communication with patients, staff, the public, and local organisations. The trust and divisions did not have their own communication and engagement strategies. In some areas, staff were encouraged to get involved with projects affecting patients. The trust was actively involved with the sustainability and transformation programmes and was aware of potential impacts to services provided. Despite this, the staff we spoke with told us they were not aware of and had not been engaged in these discussions. The service was transparent and open with all relevant stakeholders about performance and the challenges to the system, in order to meet the needs of the population.
- There was no strategic approach to service development improvements. There was limited knowledge and appreciation of improvement methodologies. Improvements were localised and best practice was not being shared across the organisation. The organisation had not identified all the risks, including patient safety risks we identified during our core service inspections. Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or always monitored.

However:

Senior leaders made sure they visited all parts of the trust and fed back to the board to discuss challenges staff and the services faced.

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Mar 2018	Requires improvement →← Mar 2018	Good →← Mar 2018	Requires improvement →← Mar 2018	Inadequate ↓ Mar 2018	Requires improvement →← Mar 2018

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for Southport and Formby District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018
Medical care (including older people's care)	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Inadequate ↓ Mar 2018	Requires improvement ↔ Mar 2018
Surgery	Requires improvement ↑ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Inadequate ↔ Mar 2018	Requires improvement ↔ Mar 2018
Critical care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016
Outpatients	Requires improvement Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Spinal Injuries	Requires improvement ↓ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Requires improvement ↔ Mar 2018
Overall*	Requires improvement ↑ Mar 2018	Requires improvement ↔ Mar 2018	Good ↔ Mar 2018	Requires improvement ↔ Mar 2018	Inadequate ↓ Mar 2018	Requires improvement ↔ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Ormskirk District General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018
Surgery	Requires improvement ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Good ➡️ Mar 2018	Requires improvement ➡️ Mar 2018	Requires improvement ➡️ Mar 2018
Maternity	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Services for children and young people	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Requires improvement Nov 2016
Outpatients	Good Nov 2016	N/A	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Requires improvement ➡️ Mar 2018	Requires improvement ➡️ Mar 2018	Good ➡️ Mar 2018	Good ⬆️ Mar 2018	Requires improvement ➡️ Mar 2018	Requires improvement ➡️ Mar 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Southport & Formby District General Hospital

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Key facts and figures

Southport and Formby District General Hospital provides acute healthcare in hospital. This includes an adults' urgent and emergency care service, intensive care and a range of medical and surgical specialities. The North West Regional Spinal Injuries Centre provides specialist care for spinal patients from across the North West, North Wales and the Isle of Man. Across the hospital there were 403 beds including 13 intensive care beds. From April 2016 – March 2017 Southport hospital had 29,115 inpatient admissions, 48,669 A and E attendances and 187,501 outpatient attendances.

Summary of services at Southport & Formby District General Hospital

Requires improvement

Southport and Ormskirk NHS Trust provides both inpatient and community healthcare to approximately 258,000 people across Southport, Formby and West Lancashire. Acute inpatient care is provided at Southport and Formby District General Hospital and Ormskirk District General Hospital. The trust also provides sexual health services for the metropolitan borough of Sefton. The North West Regional Spinal Injuries Centre is at Southport hospital and provides specialist care for spinal patients across the North West and the Isle of Man. Services at the trust are commissioned by West Lancashire and Southport & Formby Clinical Commissioning Groups.

Our rating of services stayed the same. We rated them as requires improvement because:

- Across the hospital patients' records were not securely stored. In spinal injuries, surgery and medical wards we found nursing, medical and notes from teams who supported patients were kept in different places. This presented a risk that staff did not have access to all a patient's records when making decisions. We escalated this issue to the trust at the time of our inspection and immediate action was taken.
- In urgent and emergency care, surgical wards and the spinal injuries unit, patients' risk assessments were not consistently completed. This meant the hospital's staff were not assessing all the risks to health and safety for patients and doing all that was reasonably practicable to minimise these risks. We escalated this issue to the trust at the time of our inspection.

Summary of findings

- Across the hospital staff did not follow the trust's infection control policy in relation to nursing patients with communicable diseases. Patients were not barrier nursed, side room doors where isolated patients were located were open and appropriate signage was not consistently used. This represented an infection control risk, which we escalated at the time of our inspection.
- At the time of our inspection areas within the hospital were not visibly clean. This included areas within spinal injuries, urgent and emergency care, surgery and medical wards.
- In urgent and emergency care and surgery, care provided was not always person centred. Areas used by the hospital's staff to provide care for patients did not consistently allow staff to make reasonable adjustments to meet people's needs or ensure their privacy and dignity was maintained. We escalated this to the trust at the time of our inspection and immediate action was taken.
- In the emergency department and some surgical wards resuscitation equipment was not all in date including medicines.
- Investigation of incidents and learning from them was not consistent and comprehensive. This meant that opportunities to improve services were missed.
- Staff in medicine and surgery told us that although they were aware what constituted an incident, they did not consistently report them. This issue was also identified at our last inspection.
- In urgent and emergency care and surgery, staff did not manage medicines consistently and safely at all times. We found medicines were not consistently stored, oxygen was not consistently prescribed and there were omissions in procedures for checking and signing for controlled drugs. We escalated this to the trust at the time of our inspection.
- Staff in some areas where mandatory training completion was low reported that they had not been able to attend training. Across medicine and surgery not all staff had received an annual personal development review. We identified similar issues at our last inspection.
- Across the hospital staff did not consistently apply the principles outlined in the Mental Capacity Act 2005. We found delays in assessment of patients' mental capacity. There was a lack of consistency in how people's mental capacity was assessed and not all decision-making was informed or in line with guidance and legislation.
- In spinal injuries there was open access to the unit including wards where high risk patients were nursed. We escalated this at the time of our inspection and the trust took immediate action.
- In some areas of the hospital outcomes for people who used services were below expectations compared with similar services.
- In urgent and emergency care there were times when people did not feel well supported or cared for and their dignity was not consistently maintained.
- The hospital continued to experience challenges in relation to patient flow. Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services. This impacted on urgent and emergency care where patients were still experiencing long and unacceptable waits for treatment.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely in the form of standardised templates, which identified risks, but lacked clarity relating to the specific needs and wishes of the patient.
- Across surgery and medicine we found risks that had previously been identified at the last inspection. There was insufficient progress to improve these areas and/or improvement was not sustained.

Summary of findings

- Across the hospital we found a range of concerns relating to the systems and processes that should be in place to ensure the hospital runs effectively and efficiently. New systems and processes had recently been introduced to address this, but were not fully embedded to ensure all risks were identified and addressed.
- The trust did not have a current strategy. As a result staff did not understand how their role contributed to achieving the organisation's strategic goals.
- The absence of a strategy meant services did not have meaningful and measurable plans in place in order to achieve strategic goals.
- There was no credible statement of vision and staff were not aware of or did not understand the organisation's values.

However:

- Safeguarding adults, children and young people at risk was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification. They took steps to prevent abuse or discrimination that might cause avoidable harm, responded appropriately to any signs or allegations of abuse and worked effectively with others, including people using the service, to agree and implement protection plans. There was active and appropriate engagement in local safeguarding procedures and effective work with other relevant organisations, including when people experienced harassment or abuse in the community.
- Since our last inspection mandatory training levels had improved across the hospital. Whilst they were still below the trust's target of 90%, they had significantly improved to average 78% across all areas.
- Across most areas of the hospital staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Where relevant, there were effective handovers and shift changes to ensure that staff can manage risks to people who use services.
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and technologies.
- People received coordinated care from a range of different staff, teams or services. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Across most areas of the hospital, people were supported, treated with dignity and respect, and were involved as partners in their care.
- The majority of the hospital was easily accessible for patients who required assistance with mobility, including patients who required the use of a wheelchair.

Urgent and emergency services

Requires improvement   

Key facts and figures

The urgent and emergency care services at Southport and Ormskirk General Hospital serves the population of Southport and the surrounding area and predominantly sees patients over the age of 18.

They provide emergency care services including the treatment of minor injuries, urgent medical and surgical presentations and emergency presentations. The department saw 48,669 patients between April 2016 to March 2017. This equated to approximately 133 patients per day.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse. We previously inspected urgent and emergency services in April 2016 and rated them as requires improvement. At this inspection we found that services had stayed the same.

At the last inspection we rated three of more key questions for the service either inadequate or requires improvement so we re-inspected all five key questions.

We inspected the hospital as part of an unannounced inspection between 20 and 22 November 2017. During the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

We visited all areas of the emergency department including:

- the triage area;
- the majors and resuscitation room;
- the minor injuries unit; and
- the observation ward.
- We spoke to staff of different grades, including nurses, doctors and the management team from both the department and the medicine division.
- We also spoke to six staff from other areas of the hospital that had regular contact with the emergency department.
- We reviewed 36 sets of patient records, including emergency department record cards, prescription charts, assessments, observation charts.
- We also spoke to 18 patients and relatives about the care they received.
- We observed direct care and treatment being delivered.

Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Clinical risks experienced by patients were not always recognised and acted on appropriately.
- Some areas of the department were not visibly clean and important documents designed to protect patients from infection were not completed.
- We found that patients were not always treated in an appropriate area for clinical care to be delivered.

Urgent and emergency services

- Patients did not always have timely access to services.
- Patient records were not kept securely and were not always fully completed.
- Patients did not receive timely access to analgesia and did not always have their pain assessed.
- Although the department had evidence based pathways in place, patients were not always placed on these.
- Not all staff were aware of their duties and responsibilities in relation to the Mental Capacity Act.
- At the last inspection we raised concerns regarding patients' privacy and dignity within the department. At this inspection we observed patients were being cared for on the corridor in various states of condition and undress.
- At the last inspection we noted that there was adequate seating in the waiting area. During this inspection we observed there was routine crowding in the waiting room.
- There was no specific pathway in place to guide the care and treatment of patients living with dementia. However, the trust had recently launched a dementia strategy.
- The escalation area of the department was inappropriate. There was insufficient room, a lack of equipment and patients; dignity was not preserved.
- Patients were still experiencing long and unacceptable waits for treatment. During the last inspection we told the department and trust that they must improve performance, particularly in relation to wait times and ambulance handovers. During this inspection we found that the trust and department had tried to implement measures to address this issue. However, patients were still experiencing unacceptable waits on a daily basis, performance against the four hour standard was still below the expected standard and ambulance crews experienced waits of up to four hours to hand over a patient's care.
- The trust had a bed management policy in place which was not in use during the last inspection. Although this was in place, staff did not follow all the steps outlined to improve flow and manage periods of increased demand.
- Staff advised they were unaware of who was who within the executive team. While we were in the department we observed staff unsure who executives were and witnessed one member of senior nursing staff mistake a director for an estates worker. This had deteriorated since the last inspection where staff were aware of the executive team but did not find them supportive.
- There was no trust or local vision or values and no strategy to guide the emergency department.
- We observed that the culture was focused on the timings of care and patient flow and not always on the quality of care provided to patients.
- Some risks identified within the department during the inspection were not present on the risk register or the control measures were no longer in place. One example of this was the risk to patients being accommodated in the corridor of the department.
- The service made limited efforts to engage with the public.

However:

- Mandatory training uptake levels had improved since the last inspection. In particular the rates for safeguarding training had more than doubled.
- Incident reporting remained proactive and staff were still knowledgeable about what type of incidents constituted a reportable incident.

Urgent and emergency services

- The trust scored “about the same” as other trusts for all five of the emergency department survey questions relevant to safety.
- The staffing in the department remained sufficient during the inspection, with some periods of reduced staffing in areas because of last minute sickness and unexpected events.
- Data from the patient safety thermometer showed that the trust reported low levels of harm related to specific areas such as new pressure ulcers and falls from September 2016 to September 2017.
- The emergency department used both National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to guide the care and treatment they provided to patients
- In the 2016/17 RCEM audit for severe sepsis and septic shock, Southport and Formby District General Hospital was in the upper quartile compared to other hospitals for all eight agreed metrics.
- We observed good multidisciplinary working during the inspection.
- We observed staff treating patients with kindness and compassion during one to one interactions.
- The department had implemented measures to try and improve the patient flow in the department. There was an escalation policy and procedure in place.
- The local leaders within the department were visible and well respected. Staff told us that they provided good leadership and support.
- Staff told us they felt respected and valued and would feel secure raising a concern or issue with their line managers.
- There was a governance structure in place and staff were able to tell us how this fed up and down into the operational team.

Is the service safe?

Inadequate ● → ←

Our rating of safe stayed the same. We rated it as inadequate because:

- Patient risk assessments designed to recognise and mitigate risks to patients were not being completed consistently and in line with the trust’s policy.
- Patients were not always treated in the most appropriate area, which increased risks to their safety.
- Patients who presented with sepsis were not always placed on the trust’s sepsis pathway.
- Patients were not always monitored sufficiently.
- We reviewed six patient records in relation to the completion of documentation of the insertion of intravenous cannulas and in all six cases this section was either blank or partially completed.
- Resuscitation equipment and medications were out of date despite being checked daily by staff.
- Patients who would ordinarily require a heightened level of observation were accommodated in the waiting room. These patients included patients with severe abdominal pain, new onset stroke, confusion, skull fracture and abdominal pain in pregnancy. We found these patients did not receive an adequate level of observation. This included not receiving clinical observations, analgesia and clinical reviews of their condition.

Urgent and emergency services

- Patients were being categorised as receiving treatment when a nurse or doctor would attend to them and take blood tests, x-rays or checklists. In some cases patients were then left for a number of hours before receiving a full assessment from a doctor or nurse practitioner. In three cases we found that this time exceeded four hours.
- We found that on all three days of the inspection patients, including those with suspected high risk medical conditions, were held in the corridor area. The time they were resident in the corridor area ranged from 10 minutes up to 4 hours. This had not improved since the last inspection.
- There was a high usage of bank and agency staff to fill shifts.
- Records were not secure and were placed in clear paper holders on the wall of the main department where members of the public could see and access them.
- In 23 out of 23 full records we reviewed we found that at least one section not completed and key information missing such as dates, times and interventions. This had deteriorated since the last inspection.
- The department did not audit records routinely. This remained unchanged since the last inspection.
- The department did not always effectively manage cleanliness, infection control and prevention risks.
- Staff were not aware of specific trust wide policies and pathways designed to meet national guidance on key safeguarding issues such as female genital mutilation and child sexual exploitation.

However:

- All staff had access to the trust wide electronic incident reporting system. Staff were able to tell us and demonstrate how they would report an incident using this system. Staff had a good understanding of what would constitute a reportable incident and gave examples of when they had completed an incident report.
- Mandatory training uptake levels had improved since the last inspection. In particular the rates for safeguarding training had more than doubled.
- The trust scored “about the same” as other trusts for all five of the emergency department survey questions relevant to safety.
- The staffing in the department remained sufficient during the inspection, with some periods of reduced staffing in areas because of last minute sickness and unexpected events.
- Data from the Patient Safety Thermometer showed that the service reported low levels of harm related to specific areas such as new pressure ulcers and falls from September 2016 to September 2017.
- The service managed some areas of medicines well. This included the recording of controlled drugs.
- Staff were able to tell us how they would report a safeguarding issue and showed a good general level of knowledge in relation to the reporting and recognition of abuse in safeguarding adults and children.

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- A number of care pathways and protocols had been developed to support staff when providing patient care, however staff were not using these in all cases. This meant that patients did not receive evidence based care and treatment at all times.

Urgent and emergency services

- Patients did not always receive pain relief when they required it and pain was not always assessed effectively. We reviewed 26 records specifically in relation to the completion of pain scoring. We found that 26 out of 26 patients did not have pain scores recorded.
- Patient group directives were not used to ensure patients had timely access to analgesia.
- In the CQC Emergency Department Survey, the trust scored 4.3 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was worse than other trusts.
- From September 2016 to August 2017, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%.
- Staff were not fully aware and did not understand their obligations and duties under the Mental Capacity Act 2005. Staff did however display an understanding of the Deprivation of Liberty safeguards (DoLs). However:
- The emergency department used both National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines to guide the care and treatment they provided to patients.
- A range of evidence based clinical care pathways were available and staff were required to put these in place for patients with relevant conditions.
- Patient’s nutrition and hydration needs were well managed.
- In the 2016/17 RCEM audit for severe sepsis and septic shock, Southport and Formby District General Hospital was in the upper quartile compared to other hospitals for all eight agreed metrics. The department also had an action plan in place to address any shortfalls.
- 20.2% of patients aged over 30 admitted to Southport and Formby District General Hospital for chronic chest pain in the 2016/17 audit, 20.2 were seen by a consultant, which was in the upper quartile when compared to other hospitals, and 38.5% were seen by an ST4 or above. This did however fail to meet the RCEM standard of 100%.
- Managers within the department showed us records which showed that over 90% of staff had received an appraisal at the time of the inspection.
- Staff had good working relationships with other staff and disciplines within the hospital and trust.
- Seven day services operated fully, including diagnostic services.
- Staff told us that they routinely undertook health promotion as part of their roles, this included smoking cessation and lifestyle advice.

Is the service caring?

Requires improvement  

Our rating of caring went down. We rated it as requires improvement because:

- Two patients told us they felt uncomfortable about the arrangements for their dignity and privacy.
- Patients were being held on the corridor in various states of condition and undress. This was highlighted in the last inspection report but the situation remained the same.

Urgent and emergency services

- Patients received clinical care in the corridor area including blood tests and insertion of cannulas. This was highlighted as an issue during the last inspection however we observed that the practice continued during this inspection.
- Patients who were stable were re located to the corridor to make space. In one case we observed a sleeping patient moved from the cubicle area while sleeping and left there.
- Patients told us that they felt the escalation was not 'ideal' and felt exposed.
- We asked five staff if they would be happy for their relative to be treated in the escalation area or corridor and they all stated they would not. They told us it was undignified, unacceptable and made them feel ashamed to work in that area of the hospital.
- Triage area was able to be overheard in the corridor area and we overheard staff talking about sensitive conditions and information.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) fluctuated from August 2016 to July 2017 but was generally worse than the England average. However this had improved since the last inspection from 79%.
- In the escalation area we observed bad news being broken to a patient who became very distressed. This interaction could be fully overheard by members of the public waiting for x rays and they told us this made them upset and uncomfortable.

However:

- We found that staff provided compassionate care during one to one interactions
- Staff involved patients and those close to them in decisions about their care and treatment.

Staff made efforts to provide emotional support to patients and their relatives.

Is the service responsive?

Requires improvement ● ➡ ➡

Our rating of responsive stayed the same. We rated it as requires improvement because:

- During our inspection the department was near to full capacity on occasions. We observed that during these times there were insufficient trolley and cubicle spaces to accommodate patients.
- There was not sufficient seating for patients in the waiting room.
- There was no specific pathway in place to guide the care and treatment of patients living with dementia.
- In the escalation area of the department there was insufficient room to make reasonable adjustments. This was not an issue during the last inspection.
- Patients were still experiencing long and unacceptable waits for treatment. During the last inspection we told the department and trust that they must improve performance, particularly in relation to wait times and ambulance

Urgent and emergency services

handovers. During this inspection we found that the trust and department had tried to implement measures to address this issue. However patients were still experiencing long waits on a daily basis, performance against the four hour standard was still below the expected standard and ambulance crews still experienced waits of up to four hours to hand over.

- The trust had a bed management policy in place which was not in use during the last inspection. Although this was in place staff did not follow all the steps outlined to improve flow and manage periods of increased demand.

However:

- The majority of department was easily accessible for patients who required assistance with mobility, including patients who required the use of a wheelchair. However the temporary area referred to as the escalation area was not.
- The department had access to relative's rooms, canteens and vending machines.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity). The department also had a strategy to help and support individuals experiencing domestic violence including an assessment tool.
- During this inspection we found that the trust and department had tried to implement measures to address issues with long waits and patient flow.
- The trust had implemented an escalation policy.
- Complaints were well handled and opportunities for learning were identified.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Staff advised that they were unaware of who was who within the executive team.
- A new matron had recently taken up post within the department and had made positive changes. They had a clear plan about they saw the journey of improvement in the future. Staff were very positive about the new matron and told us that she acted on their concerns and they had confidence in her leadership.
- There was no trust or local vision or values and no strategy to guide the emergency department.
- We observed that the culture was focused on the timings of care and patients flow and not always on the quality of care provided to patients.
- Some risks identified within the department during the inspection were not present on the risk register or the control measures were no longer in place. One example of this was the risk to patients being accommodated in the corridor of the department.
- There were limited efforts to engage the public by the service.

However:

- The local leaders within the department were visible and well respected. Staff told us that they provided good leadership and support.

Urgent and emergency services

- Staff told us they felt respected and valued and would feel secure raising a concern or issue with their line managers.
- There was a governance structure in place and staff were able to tell us how this fed up and down into the operational team.

Areas for improvement

Action the hospital **MUST** take to improve:

- The provider must ensure that all medications in the emergency department are within their expiry dates.
- The provider must ensure that patients receive access to analgesia in a timely manner.
- The provider must ensure that any areas used for clinical care are suitable for this purpose.
- The provider must ensure that patients' records are accurate, up to date and reflect the care the patient receives in the emergency department.
- The provider must ensure that patients are protected from infections by completing the relevant local pathways and cleaning areas where patients receive care in line with their infection control policies and procedures in the emergency department.
- The provider must ensure that patient risk is appropriately identified and all possible measures are taken to minimise risks to patients safety are in place. Specifically in relation to patients being accommodated in areas not designed for clinical care such as corridor areas.
- The provider must ensure that patients are treated with dignity and compassion and that their dignity and privacy is maintained at all times while they are in the emergency department.
- The provider must ensure that patients can access emergency care and treatment in a timely way.
- The provider must ensure that the trust's internal escalation policies are followed appropriately.
- The provider must ensure that all risks identified in relation to the emergency department are appropriately risk assessed and appropriate control measures are in place.
- The provider must ensure that there is a clear vision and values set for staff to follow.
- The provider must ensure that staff are following evidence based practice and utilising the local and national pathways and policies required.

Action the hospital **SHOULD** take to improve:

- The provider should engage the public in relation to urgent and emergency services.
- The provider should raise awareness of FGM.
- The provider should ensure that patient records are stored securely and confidentially.

Medical care (including older people's care)

Requires improvement   

Key facts and figures

The medical care service at Southport and Formby District General Hospital had 265 inpatient beds across 11 wards.

The hospital had 21,890 medical admissions between July 2016 and June 2017. Emergency admissions accounted for 10,617 (48.5 %), 314 (1.4%) were elective, and the remaining 10,959 (50.1%) were day case.

Admissions for the top three medical specialties were:

- General Medicine
- Clinical Haematology
- Pain management

Medical services are managed by the medicine division at Southport and Formby District General hospital. These are divided into smaller clinical business units such as cardiology, nephrology, acute and emergency medicine, respiratory and diabetes. There are various wards and specialist services within the division including stroke services (including 2 hyper acute stroke beds), cardiology, respiratory, endocrinology, nephrology, gastroenterology, general medicine, endoscopy and the care of older persons. They also managed the urgent and emergency care services provided at the accident and emergency department but this is reported in a separate core service report.

The Care Quality Commission carried out a comprehensive inspection between 20 and 23 November 2017. During this inspection we visited wards 7A (cardiology) and 7B (discharge lounge), 9A (short stay Unit), 9B (Frail elderly), 10B (stroke), 11B (gastroenterology), 14B and 15A (General Medicine) and the Ambulatory Care Unit.

We spoke with 30 patients and relatives. We also spoke with 18 members of staff including senior managers, specialist nurses, registered nurses, student nurses, health care assistants, consultants, middle grade doctors, junior doctors, allied health professionals including physiotherapists, dieticians, pharmacists, domestics, ward clerks, and nursing agency staff.

We observed care and treatment and looked at 27 patient care records.

Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not consistently follow the trust's Mental Capacity and Deprivation of Liberty safeguards operational procedure. Staff we spoke with did not have a clear understanding on how to assess patients' capacity to make decisions about their care. Staff training relating to the Mental Capacity Act 2005, and Deprivation of Liberty safeguards, was not fully embedded.
- The medical care services had failed to make significant improvements in relation to staff training. With training falling below 60% in areas such as resuscitation, infection prevention [level 2], hand hygiene and manual handling.
- The service had not made sure staff were competent for their roles. Managers had not appraised all staff's work performance.

Medical care (including older people's care)

- At the last inspection we found staff in medical care services did not always wear suitable personal protective equipment to minimise the spread of infection. At this inspection we found the service still did not control infection risk well. They did not always use control measures effectively to prevent the spread of infection.
- Not all of the wards and corridors we inspected were clean and well maintained. Wards and corridors were cluttered with equipment, some of which was in front of fire escapes. Some of the ward floors were not clean and some ward storage areas were not well kept. Patient records were not always stored securely. We also found that computers were not always locked to prevent data from being seen by unauthorised personnel.
- Services were not always provided seven days a week. This was because Allied Health Professionals such as dieticians and speech and language therapists were unable to provide a full seven day service across all medical wards.
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. Qualified nurse staffing remained an ongoing challenge and an identified risk.
- There were pockets of low morale amongst staff who told us they felt pressured to compromise their standards and the care delivered to patients due to reduced staffing numbers and issues with the environment in which care was provided.
- The service had significant issues with the access and flow through the medical wards and departments.
- The use of escalation areas meant that issues with staffing and the environment impacted on patients receiving the appropriate care they required. There were high numbers of delayed discharges and high numbers of medically fit patients occupying beds on medical wards.

However:

- The service had arrangements in place to assess and respond to patient risk. Arrangements to recognise the development of sepsis known as the “sepsis 6 bundle” were implemented in April 2017 to assist in recognising changes in patients’ conditions.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. In the main, managers checked to make sure staff followed guidance. Medical services participated in all relevant national audits they were eligible to complete.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The majority of patients and relatives stated they were happy with their care and that staff worked hard and were kind and caring.

Is the service safe?

Requires improvement ● ➡ ⬅

Our rating of safe stayed the same. We rated it as requires improvement because:

Medical care (including older people's care)

- The service provided mandatory training in key skills to all staff but had not made sure that everyone completed it. At our last inspection in April 2016, we told the medical care services it must take action to improve staff completion of mandatory training. During this inspection we found that they had failed to make significant improvements in relation to staff training.
- At the last inspection we found staff in medical care services did not always wear suitable personal protective equipment to minimise the spread of infection. At this inspection we found the service still did not control infection risk well. They did not always use control measures effectively to prevent the spread of infection.
- The wards that we visited were not all visibly clean and tidy.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk. There was no clear signage outside the rooms to ensure staff and visitors were aware of the increased precautions they must take when entering and leaving the room.
- We saw that staff followed 'bare arms below the elbows' guidance; however we noted on three occasions that staff had not washed or cleansed their hands before and after patient contact.
- There was insufficient storage for essential equipment on many wards in the medical directorate. This meant that corridors and bays in the wards were cluttered with medical care equipment, making it difficult for staff and patients to move freely around the wards. Managers told us that investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However records we reviewed showed that investigations weren't comprehensive in all cases and all root causes weren't always identified.
- Staff were able to explain what types of incidents they would report; however some staff told us they did not always report near misses or incidents that caused no harm to patients. This meant there may be missed opportunities to learn from these types of incident.
- Patient records were not always stored securely. We also found that computers were not always locked to prevent data from being seen by unauthorised personnel.
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- At the last inspection we found there was not always sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients. At this inspection we found that staffing levels remained a challenge and an identified risk, particularly nurse staffing.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse. There was a safeguarding policy in place which accessible to staff.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The service had arrangements in place to assess and respond to patient risk. Arrangements to recognise the development of sepsis known as the "sepsis 6 bundle" were implemented in April 2017 to assist in recognising changes in patients' conditions.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- Resuscitation trolleys were available in all areas we visited and were tagged with tamper proof seals.

Medical care (including older people's care)

Is the service effective?

Requires improvement   

Our rating of effective stayed the same. We rated it as requires improvement because:

- The trust took part in the quarterly Sentinel Stroke National Audit Programme. On a scale of A-E, where A is best, the trust achieved an overall SSNAP level of grade C in the latest audit which showed overall improvement. However, the stroke unit had patient and team centred scores of E throughout the whole period, October 2015 to March 2017.
- Results for the Heart Failure Audit covering the time period from April 2016 to March 2017 were worse than the England and Wales average for all four of the standards relating to in-hospital care.
- Following assessments, patients identified as requiring a further assessment by a dietician were not always referred in a timely manner.
- Not all therapy services were available 7 days a week. For example, speech and language therapists were only available Monday to Friday.
- Staff did not consistently follow the trust's Mental Capacity and Deprivation of Liberty safeguards Operational Procedure. Staff we spoke with did not have a clear understanding on how to assess patients' capacity to make decisions about their care. Staff training relating to the Mental Capacity Act 2005, and Deprivation of Liberty safeguards, was not fully embedded.
- The service had not made sure staff were competent for their roles. Managers had not appraised all staff's work performance.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. In the main, managers checked to make sure staff followed guidance.
- Medical services participated in all relevant national audits they were eligible to complete.
- The most recent Heart Failure Audit showed Southport and Formby District General Hospital were better than the England and Wales average for all seven standards relating to discharge.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- There was access to a range of medications for pain relief, this included patient controlled analgesia. Patients we spoke with told us that they had access to regular pain relief.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- From June 2016 to May 2017, patients at Southport and Formby District General Hospital had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England average.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

Medical care (including older people's care)

- Staff explained care and treatment in a way that patients could understand and provided opportunities for them to ask questions. Relatives were involved in decisions about care and treatment.
- Patients we spoke with were very positive when they discussed the care they received.
- A range of specialist nurses were available in medical services. These nurses provided additional information and emotional support.
- We saw staff communicating with patients and their family members in a respectful, compassionate and considerate way.
- Patients told us they were given information about their treatment. They also told us that they were given opportunities to ask additional questions of nursing staff and consultants.
- Staff provided emotional support to patients to minimise their distress. Staff we spoke with understood the emotional impact that care and treatment had on patients and their family members. We observed staff providing reassurance and comfort to patients.

However:

- One family whose relative was living with dementia told us they had received conflicting information from different members of staff regarding their relative's care.
- The Friends and Family Test response rate was worse than the England average. The percentage of patients recommending the service as a place to receive treatment was quite variable across the different wards.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service continued to experience challenges in relation to patient flow. Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely in the form of standardised templates, which identified risks, but lacked clarity relating to the specific needs and wishes of the patient.
- The discharge lounge was not in full operation, as a part of it was being used as a bedded area due to demand for beds.
- At our last inspection we told the trust it must improve patient flow in medical services at the hospital to ensure patients are cared for on wards appropriate for their needs. At this inspection we found that the trust had not reduced the numbers of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers).
- The Ambulatory Care Unit was being used as a bedded area for four patients due to the high demand for hospital beds. The patients in those beds had access to a toilet situated at each end of the unit, however did not have direct access to shower facilities.

Medical care (including older people's care)

- Passport documents were used with patients with dementia and patients with learning disabilities to identify additional support needs, communication methods, likes and dislikes. However we noted that these were not always completed.
- Medical patients who were being cared for and treated on surgical wards were not seen by the therapy team covering the surgical ward. This meant there was a risk that these patients did not receive the therapy they required whilst on a surgical ward.

However:

- Patients were admitted to medical services via A and E, through GP referral to AMU or by pre-arranged appointments for elective admissions.
- The service supported John's Campaign which supports collaborative working between health care services and those close to patients with dementia, such as relatives and carers.
- We reviewed medical notes for the patients outlying on the observation ward and found that they had been reviewed by the responsible medical team.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the service.

Is the service well-led?

Inadequate ● ↓

Our rating of well led went down. We rated it as inadequate because:

- The service had not improved since our last inspection in 2016. We found changes that we required the service to take had not been completed.
- There had been insufficient oversight of compliance with the Mental Capacity Act 2005. Monitoring of compliance with trust policy had been insufficient to identify failure to act in accordance with the law.
- The trust had several interim executive board leaders and so a new change in direction was being developed. This had not changed from our last inspection where we found that staff were unclear of the direction of the trust due to several changes in the senior management team. As a result there was no clearly defined vision or strategy for Medical Care services.
- The service did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However it was unclear if these systems were being used effectively.
- The NHS staff survey for 2017 highlighted that communication between the senior management and staff was poor.
- Staff reported that members of the senior management were not visible and approachable. Not all staff knew the interim executive team and said that they did not feel senior management were visible on the wards.

However:

- Some nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role.

Medical care (including older people's care)

- Ward managers reported that they had good relationships with their immediate matron and would see them often on the ward.

Areas for improvement

Action the hospital **MUST** take to improve:

- The provider must take action to ensure that all staff have the up to date training they require to be able to safely care and treat patients.
- The provider must take action to ensure that all wards and corridors are clean and well maintained.
- The provider must ensure that all records relating to patients are kept securely and computers are locked when left unattended to prevent breaches in data protection.
- The provider must take action to ensure that staff in medical services wear suitable personal protection to minimise the spread of infection.

Action the hospital **SHOULD** take to improve:

- The provider should consider the use of Ambulatory Care Unit and discharge lounge as escalation areas as they do not currently provide all the necessary amenities to the patients.
- The provider should consider improvements in seven day services to provide an equitable service throughout the week.
- The provider should take action to provide staff with a clear vision and strategy of the direction of the medical services and senior managers should be visible and approachable to all staff.
- The provider should review medical care and treatment when it is being provided on wards outside the staff specialty to assure itself that care and treatment is being provided to meet patients' need and conditions.
- Performance development reviews should be completed in line with trust policy.

Surgery

Requires improvement  

Key facts and figures

Southport and Formby District Hospital is one of the locations providing inpatient care as part of Southport and Ormskirk NHS Trust Hospitals. They provide 24 hour surgical care from the hospital for patients that reside in and around Sefton and West Lancashire. Between July 2016 and June 2016 the trust had 17,095 surgical admissions. Emergency admissions accounted for 3,657 (21.4 %), 11,010 (64.4%) were day cases, and the remaining 2,428 (14.2 %) were elective.

Southport and Formby District Hospital has 68 beds; 14 planned investigation unit, 30 trauma and orthopaedics and 24 surgical.

We visited:

- the planned investigation unit (Ward 11A)
- the trauma and orthopaedic ward (Ward 14A)
- the surgical ward (Ward 15B)
- the theatre suite
- the preoperative assessment clinic.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse.

We inspected the hospital as part of an unannounced inspection between 20 and 23 November 2017. During the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

- We reviewed 18 patients' records and other documentation about theatre checks, medicines administration and risk assessments.
- We spoke with 20 patients, six relatives, and 50 staff of all grades including doctors, nurses, allied health professionals and senior managers.

Summary of this service

Surgical services had improved from inadequate since the last inspection. We rated it as requires improvement because:

- Not all staff had received mandatory training updates and there was no evidence that staff in theatre were trained in immediate or advanced life support.
- Staff we spoke with did not always recognise incidents or report them when required. Staff were not clear about duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).
- Monitoring equipment was dusty and doors to the side rooms of patients with infections were left open.
- Routine checks of emergency equipment were not carried out appropriately on the wards.

Surgery

- Fridge temperatures were not always checked and there were some omissions in the administration and disposal of controlled drugs in theatres.
- Care of patients was recorded in multiple locations and difficult to follow. Paper records were not always stored securely and electronic records were visible to all visitors to wards.
- On wards where patients required assistance with meals, there were not always enough staff available to provide support during mealtimes.
- Information from the provider showed that compliance with appraisal rates was below the trust target.
- Staff did not always understand the requirements of the Mental Health Act 1983, the Mental Capacity Act 2005 and Deprivation of Liberties safeguards and their application to patients.
- Surgical services were organised across two hospitals. Patients assessed as higher risk were care and treated at Southport. This meant that there may be no choice of location for certain patients.
- We did not see any leaflets or posters on the wards, for patients to share their experiences and the response rate to the NHS friends and families test was low.
- There was no strategy currently in place for surgical services and there had been a number of changes in senior leadership.

However:

- The service displayed details about safety information for staff, patients and visitors to view on the wards.
- Staff we spoke with understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The wards displayed numbers of staff and details of ward managers to show that there were sufficient numbers of nursing staff, trained and health care assistants to provide care and treatment.
- The service planned for emergencies and staff we spoke with were clear about how to respond.
- The service based care and treatment on national guidance and submitted data for internal and external audits in order to benchmark performance.
- There was a multi-disciplinary approach to care on the wards with doctors, nurses and allied health professionals very visible.
- Patients told us that staff took account of their individual needs and provided us with positive feedback about care and treatment.
- Managers we spoke with promoted a positive culture that supported and valued staff.
- The surgical service was committed to improving care and treatment for the local population.

Is the service safe?

Requires improvement   

Our rating of safe improved. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff however; not everyone had completed it.

Surgery

- The service managed patient safety incidents well, although there was recognition of under reporting. Staff did not always recognise incidents or report them appropriately.
- The service did not always control infection risks. Staff kept themselves and the premises clean however; monitoring equipment was dusty and doors to the side rooms for isolated patients were left open.
- The surgical doctors prescribed medicines well however; there were occasions when not all medication was recorded and checks had not been completed consistently.
- Staff kept records of patients' care and treatment however; they were difficult to navigate and not stored securely.

However:

- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

Requires improvement ● ➡ ➡

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff did not always give patients enough food and drink to meet their needs and improve their health.
- The service did not ensure staff were competent for their roles. Managers appraised staff's work performance however; only around half the staff had received an appraisal in the last 12 months.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment, however; staff would need to navigate multiple records systems. All staff had access to an electronic records system that they could all update.
- Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They did not know how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Surgery

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress.

However:

- Electronic boards, with patient names, were visible to visitors which could compromise patient confidentiality.

Is the service responsive?

Requires improvement   

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not always plan and provided services in a way that met the needs of local people as not all services were available at each location.
- Average length of stay was longer for general surgery and trauma and orthopaedics for elective and non – elective procedures when compared to the England average. Average stay for urology patients was higher for non-elective surgery.
- There were a number of outliers of surgical patients on other wards in the hospital with patients experiencing bed moves during their stay.
- There had been a number of cancelled operations and theatre utilisation was low.

However:

- People could access the service when they needed it. Waiting times from treatment were and arrangements to admit treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Inadequate   

Our rating of well led stayed the same. We rated it as inadequate because:

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. However, there were plans for a strategy but it was not currently in place.

Surgery

- Due to changes in management we were not assured that the service had staff with the right skills and abilities to run the service and provide high-quality sustainable care.
- The service had systems for identifying risks, however; not all ward managers we spoke with were aware of risks identified on the risk register.
- The service did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively.
- The service did not always engage timely with senior trust meetings.
- There was a lack of systemic performance management of individual staff.
- The service collected, analysed, managed but did not use information well to support all its activities.
- The service did not use a systematic approach to continually improving the quality of its services. Focus for improvement was on external reports including CQC's previous inspection report rather than a proactive internal approach to sustainable improvement.
- There was little innovation or service development. The impact of service changes on the quality and sustainability of care was not understood.

Areas for improvement

Action the hospital **MUST** take to improve:

- The provider must ensure that all staff completes mandatory training requirements.
- The provider must ensure that all theatre recovery staff have completed immediate or advanced life support training.
- The provider must ensure that all equipment in wards is clean and free from dust.
- The provider must ensure that any patient diagnosed with a transmittable infection is nursed appropriately.
- The provider must ensure that all fire exits are accessible at all times.
- The provider must ensure all hazardous substances are securely stored in ward areas.
- The provider must ensure that all medication, including oxygen, is recorded when administered.
- The provider must ensure oxygen and suction are available in all bed spaces.
- The provider must ensure that bed rails are used safely for all patients.
- The provider must ensure that all medication checks are completed appropriately.
- The provider must ensure that all emergency equipment, including resuscitation trolleys, are checked appropriately.
- The provider must ensure that all records are contemporaneous and stored securely.
- The provider must ensure that there are sufficient numbers of staff to assist with patients dietary needs.
- The provider must ensure that all staff can complete documentation for Mental Capacity Act Deprivation of Liberty safeguards and do not attempt cardiopulmonary resuscitation plans appropriately.

Action the hospital **SHOULD** take to improve:

- The provider should monitor that all staff complete safeguarding training requirements.
- The provider should consider times of day to clean ward areas.

Surgery

- The provider should consider monitoring the cleanliness of privacy curtains in wards and theatres.
- The provider should consider storage options for equipment in corridor areas.
- The provider should monitor venous thromboembolism's (VTE's) following admission.
- The provider should monitor all aspects of the World Health Organisation (WHO) 5 steps to safer surgery consistently.
- The provider should explore the reasons for higher readmission rates at this location for elective surgery.
- The provider should monitor the competencies and skills of all staff.
- The provider should encourage patient feedback to drive improvement.
- The provider should have feedback information available including in multiple formats.
- The provider should embed a strategy and plans for the future.

Spinal injuries

Requires improvement  

Key facts and figures

The North West Regional Spinal Injuries Centre (NWR SIC) is located at Southport and Formby District General Hospital site in a two-storey, purpose-built, building that is attached to the main hospital by a corridor. The unit opened in 1992 and is one of eight similar centres in England. The unit treats patients with spinal cord injuries or related neurological disorders as inpatients, outpatients or through an outreach programme.

The unit serves a population of over 6.5 million across the north west of England but also admits patients from Wales and the Isle of Man. In addition, the unit provides ventilator support and weaning to people with spinal injuries from the West Midlands. Most new patients to the unit are referred by the major trauma centres in Salford, Liverpool and Preston. There is also an outreach team who provide support to the major trauma centres and to other trusts who are caring for patients with spinal cord injuries.

There are 43 patient beds in total. Nine of these beds can be allocated to ventilator dependent patients at any one time, although there were ten ventilator-enabled beds in total. Four of the beds are managed by the intermediate community outreach team. There are nine additional static community beds in three community healthcare settings (two in Southport and one in Preston). In 2016, 62 patients utilised the outreach beds. A further 33 patients utilised the four beds managed by the outreach team in the Spinal Injuries Centre.

From April 2017 to October 2017 there were 80 patients admitted to the unit from the three major trauma units and other referring hospitals and a further 30 patients were admitted through elective or non-elective admissions.

From April to October 2017 there were 1095 outpatients seen in the unit, an average of 156 per month.

From April to October 2017, a total of 104 patients were discharged from the unit with 32 of these discharges being delayed.

Summary of this service

We visited the unit as part of our unannounced inspection on 27 and 28 November 2017. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust. During the inspection visit, the inspection team:

- Reviewed the environment and staffing levels.
- Looked at 10 sets of patient notes.
- Spoke with 10 patients and two relatives.
- Spoke with 27 staff of different grades, including nurses, health care assistants, doctors and consultants, physiotherapists, psychotherapists, case managers and senior managers who were responsible for the regional spinal injuries unit.
- Observed a goal planning meeting involving a patient and their relative and an admission planning meeting involving 14 staff from different professions.

Spinal injuries

- Observed daily practice and reviewed management arrangements.

Our overall rating of this service went down. We rated it as requires improvement because:

- Nursing staff were not meeting trust targets for a number of mandatory training modules.
- The service was failing to minimise the risk of the spread of infections in the ward areas.
- There was a lack of security throughout the unit. People who had no business in the unit could freely gain access to all areas and this did not ensure that people were kept safe and personal property and equipment was kept protected at all times.
- Patient records were not always stored securely in locked trolleys and during inspection we saw patient details were left open on computer screens.
- Not all patient risk assessments were being completed fully and appropriately.
- Patient records were not stored centrally and were split into medical, nursing, therapy, case management and psychology notes and stored in separate places around the unit. This meant there was a risk that the full picture of a patient was not known when decisions were being made.
- In one instance, the decision to not resuscitate a patient in the event of a cardiac arrest had not been properly reviewed. The “Do not attempt resuscitation” documentation was not discontinued, despite the fact that the patient had regained capacity and this was against their wishes.
- There was only one isolation room. This meant that patients with existing infections could not be admitted to the unit in a timely way if this room was already in use.
- Patients’ privacy and dignity was put at risk when they were receiving treatment or therapy in the gym because the area was overlooked from above and the gym was also used by members of the public.
- Procedures and documentation for assessing patients who lacked capacity were inconsistently recorded.
- Trust leadership was new and local governance systems were not embedded. There was a lack of oversight of some key risks in the unit.
- Staff expressed the view that they often felt separate from the trust as a whole and there was a need to keep reinforcing the work of the unit within the organisation.

However,

- Staff understood how to protect patients from abuse and the service planned for emergencies.
- Equipment was looked after well and medicines were stored and prescribed appropriately.
- Care and treatment was based on national guidance and evidence of its effectiveness was monitored.
- Patients were supported to be self –managing for their care needs and families were educated in how to assist patients in this approach.
- Patients received adequate pain relief, nutrition and hydration.
- Patients reported that they were treated with dignity and respect. They were very positive about staff and the care that they received and told us that nurses went the extra mile to ensure that their needs were met.
- The spinal injuries unit team was strongly person centred in its approach to patient care. Patients’ individual needs were considered as a priority and assessed on a case by case basis, with appropriate support available.

Spinal injuries

- Staff received appraisals and at 30 June 2017 the appraisal rates for staff on the ward areas of the unit were only marginally below the trust target of 90%. All staff in administration and the allied health professionals in the case management team had received an appraisal.
- Staff received adequate training and competencies were assessed.
- Patients were admitted to the unit in a timely way and all referred patients were assessed for suitability to be admitted to the unit within five working days.
- There were very few complaints against the unit (four in the year from July 2016 to June 2017). Complaints were treated seriously, investigated and lessons learned were shared.
- There was a set of vision and values local to the unit and the service had a work plan in draft for service improvements from 2017 to 2019.
- Information was collected, analysed and managed to support activities and make improvements.
- The unit led and participated in spinal injuries research and development activities, involved in regional and national specialist networks.
- There was wide engagement activity with patients, staff and different community groups related to spinal injuries care.
- Staff spoke highly of the unit management team and told us that they were very supportive and responsive to new ideas to improve the service. Managers were knowledgeable, competent and communicated well with staff at all levels.

Is the service safe?

Requires improvement  

Our rating of safe went down. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff. However, statistics provided by the trust showed that the trust target of 90% or more staff to have undertaken training modules was not being met by nursing staff on the unit in 10 out of 11 required modules. The target was not being met by support staff in 10 out of 14 of the required modules at June 2017.
- The service was failing to minimise the risk of the spread of infections in the ward areas. Cleaning schedules for some ward areas and equipment were not always followed.
- The service did not secure access to the premises to ensure that people were kept safe and personal property and equipment was kept protected at all times. The entire unit was unsecure except out of hours when the doors to the unit from outside were locked, but it could still be accessed from the main hospital.
- Assessing the risks to the health and safety of service users receiving the care and treatment was not always carried out fully and appropriately. This included completion of Malnutrition Universal Screening Tool (MUST) scores, meaning that the risk of malnutrition was not being monitored appropriately. Risk assessments for moving and handling were not being undertaken or reviewed, meaning there was a risk to patients being moved inappropriately.

Spinal injuries

- Patients' case notes were separated by department (medical, nursing, therapy, case management and psychology). Due to the length of patient stay and volume of notes, each set of notes were stored in a different location around the unit. This meant there was a risk that decisions about care and treatment were being made without access to full information about the patient.
- Patient records were not always stored securely.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.
- The service planned for emergencies and staff understood their roles if one should happen.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Patients received adequate pain relief and pain scores were assessed.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- There was a positive and comprehensive patient centred approach to working. Patients had access to support from an extensive range of specialist professionals for their needs.

However:

Spinal injuries

- Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. There was inconsistent identification and recording of best interests decisions for patients who lacked capacity. Procedures for assessing patients who lacked capacity were unclear and inconsistently recorded.
- There was a failure to ensure that a patient was fully and properly consented for the treatment they were to receive and whether resuscitation should take place if the patient suffered a cardiac arrest.

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff treated patients and their families with dignity and respect, asking their permission before undertaking personal care.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Families were encouraged and assisted to support their relatives throughout their care.
- Patients were supported to be self-managing for their care needs and families were educated in how to assist patients in this approach.
- Staff provided emotional support to patients to minimise their distress. Close consideration was given for patients' emotional experience and specialist staff were available to provide support
- Feedback from patients and carers was appreciative and positive about care they received from all staff on the unit.

However:

- During our inspection we observed that patients receiving physiotherapy or other treatments in the gym could be seen from a corridor above. At certain times of the day the gym was also used by members of the public. At these times, physiotherapy beds were screened off but there was a risk that patients and staff could be seen and overheard.

Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- The spinal injuries unit team was strongly person centred in its approach to patient care. Patients' individual needs were considered as a priority and assessed on a case by case basis, with appropriate support available.
- The service made adjustments for patients' religious, cultural and other preferences

Spinal injuries

- People could mainly access the service when they needed it. Waiting times from treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Discharge planning began from the date of a patient's admission. Patients' care needs were assessed, reviewed and prioritised throughout their inpatient stay.
- The service was working with external organisations to address the issues of delayed discharges.
- We saw evidence that the service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

However:

- Patients with existing infections could not always access the service when they needed it. The lack of more than one isolation room prevented patients with existing infections being admitted in a timely way.
- Data showed that delays from the dates patients were medically fit for admission following referral, to the date of admission was between 24 and 37 days.

Is the service well-led?

Requires improvement   

Our rating of well-led went down. We rated it as requires improvement because:

- The service did not have a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The service had identified a local strategy; however this was new and relatively undeveloped.
- The service did not use a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Whilst governance systems were in place, these were not well embedded.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, or cope with both the expected and the unexpected. There was a risk that decisions about care and treatment were being made without access to full information about the patient.
- Although risk registers were maintained on the unit, several key risks had not been identified or actions implemented. The overall risks to patients due to lack of security in the unit had not been identified.
- Staff at different levels said they felt somewhat separate from the trust as a regional spinal unit. Managers felt they needed to spend a lot of time raising awareness about the work and different needs of the unit.

However:

- The service had managers at all levels with the right skills and abilities to run the service providing high-quality sustainable care.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service collected, analysed, managed and used information well to support all its activities

Spinal injuries

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service carried out numerous engagement activities with patients, staff and a wide range of different organisations related to spinal injuries.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. As a regional spinal injuries unit, the service led and participated in research and development programmes.
- Staff spoke with pride about the work of the unit and consistently described good working relationships.

Outstanding practice

The service had identified and implemented a care pathway for patients who required long-term ventilation.

Areas for improvement

Action the hospital **MUST** take to improve:

- The provider must ensure that infection control risks are consistently and effectively managed at all times.
- The provider must ensure that the isolation room has proper signage and the door is kept closed when necessary.
- The provider must ensure the overall security of the unit and that patients and staff, as well as their personal property and equipment are protected at all times.
- The provider must ensure the security of patient records is maintained at all times.
- The provider must ensure that all risks on the spinal injuries unit are identified and appropriately managed.
- The provider must ensure that patients receive a Malnutrition Universal Screening Tool score where appropriate.
- The provider must ensure that risk assessments for moving and handling are undertaken, documented and reviewed.
- The provider must ensure that decisions about individual patients treatment and care incorporate review of all their separate clinical records which may be held on the unit
- The provider must ensure that records of consent for patients are comprehensively reviewed to reflect any changes in patients' capacity.
- The provider must ensure that identification, assessment and documentation of the needs of patients who lack capacity is consistently implemented
- The provider must ensure that patients' privacy dignity and respect is maintained at all times and that patients cannot be overseen or heard by inappropriate persons when receiving care and treatment.

Action the hospital **SHOULD** take to improve:

- The provider should improve the levels of nursing staff that have completed mandatory training to meet trust targets.
- The provider should address the actions identified and consider implementing the recommendations of the Spinal injuries Unit peer review report March 2016.

Ormskirk District General hospital

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Key facts and figures

Ormskirk District General Hospital provides acute healthcare in hospital with a focus on women's and children's care. Services provided include a children's urgent and emergency care service, maternity services, paediatric and neonatal units alongside a range of surgical specialities. Across the hospital there were 104 beds including 42 maternity beds. From April 2016 to March 2017 the hospital had 21,658 inpatient admissions and 201,518 outpatient attendances. The paediatric urgent and emergency care department had 27,545 attendances.

Summary of services at Ormskirk District General hospital

Requires improvement   

Our rating of services stayed the same. We rated them as requires improvement because:

- There was evidence of under reporting of incidents in surgery services. Staff did not always recognise incidents or report them appropriately. In maternity services, learning from incidents was not always disseminated in an effective way to staff.
- Processes and procedures in relation to the duty of candour requirement were not fully embedded and staff did not fully understand and discharge their duties in relation to this requirement. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).
- The patient group directive (PGD) documents in urgent and emergency care services did not evidence regular review and approval since 2009. Whilst pharmacy had provided interim approval for the current use of paediatric PGDs, this was recorded as a risk on the directorate risk register.
- The quality of documentation and approach to frequency of observations was inconsistent. In urgent and emergency care services, both issues were being addressed through repeated audit and the issue of a new protocol to standardise observations. However, in maternity services, staff did not complete Maternity Early Warning Scores (MEWS) assessments in accordance with trust policy in order to detect deterioration in a woman's condition. Women did not always receive a medical review when their assessment identified this was required and the World Health Organisations' surgical safety checklist was not always fully completed.

Summary of findings

- In urgent and emergency care services, documented evidence that staff offered food and fluids, where appropriate, to children during their stay in the department was inconsistent.
- Records in maternity services were not always up to date. We saw examples of delay in scanning records onto the online system meaning there were gaps in women's care records. Only one member of staff could open a particular patient record at a time which meant that records around caesarean sections were not always entered onto the system in a timely manner.
- Care and treatment in surgery services was fully recorded. However, care records were kept in multiple locations and were difficult to follow. Staff also did not consistently print their name or document their designation when completing records, as per best practice guidance.
- Staff in maternity services did not follow the trust's schedule consistently for checking all equipment was present and in working order. This included the anaesthetic machine in theatre and resuscitation equipment available on the wards. Whilst staff in surgery services completed emergency equipment checklists, we found equipment inside resuscitation trolleys that was out of date or with damaged packaging.
- In maternity services, we found that trust policies were not always reviewed in line with the schedule set out and there were some omissions within policies which made them difficult to follow. Staff were unaware if there was a review panel which had input into creating policies within the service.
- Due to staff shortages in surgery services, urology and gynaecology patients were sometimes moved between the urology and gynaecology wards at short notice. As a result patients recovering from gynaecology surgery could be moved to the urology ward shortly after surgery and vice versa. This compromised patient privacy and dignity as it often led to mixed sex breaches.
- In surgery services approximately one third of staff had not completed mandatory training and dashboards were not up to date and therefore did not reflect current completion rates. However, completion levels of mandatory training had improved since the last inspection.
- Staff in surgery appraisals stated they had appraisals annually however dashboards we reviewed did not reflect this.
- In surgery, unlocked doors to the dirty utility on all wards meant anyone could gain access. One ward had a fire door propped open on three consecutive days. Staff rectified this when highlighted by inspection staff.
- There was no clear vision or strategy in place across all services and this hindered innovations and improvements within the services. A potential risk to leadership capacity was developing in urgent and emergency care services following the recent transfer of bed managers from the Ormskirk site to Southport by trust management. Senior nurses across the paediatric department were required to support bed management duties on the site.
- Managers across maternity services did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. This has significantly improved since the last inspection. Safeguarding supervision had been made part of mandatory training for all midwives and staff reported receiving good support from the safeguarding midwife.
- Mandatory training levels for nursing staff had improved since the last inspection. A practice development midwife had been appointed to ensure the training needs of midwifery staff were being met.
- In surgery and urgent and emergency care, medicines were stored, administered and recorded in line with best practice guidelines.

Summary of findings

- The service had arrangements in place to recognise and respond appropriately to patient needs and risks.
- Incidents in urgent and emergency care were reported and managed well.
- Specialist midwives had been appointed since our last inspection to support midwives in the provision of care to women with complex needs.
- Across the hospital staff were passionate about delivering patient centred care. In urgent and emergency care patients' parents expressed that the hospital was their preferred emergency department.
- Ward areas were visibly clean and tidy.
- Facilities and premises were appropriate for the services delivered. In urgent and emergency care a new 'quiet' room had been constructed in the emergency department to strengthen their ability to meet the needs of children with mental health needs.
- Across most areas of the hospital staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Where relevant, there were effective handovers and shift changes to ensure that staff can manage risks to people who use services.
- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and technologies.
- The paediatric urgent and emergency care department performed well against the national urgent care standards including the Department of Health standard (95%) for the percentage of patients admitted, transferred or discharged within four hours (monthly average 99% in 2017).
- Staff in the paediatric urgent and emergency care department had clear roles and responsibilities to support the governance systems. Regular governance meetings took place at department and directorate level to monitor and review the quality of care and risk management. The service took complaints seriously and responded to lessons learned, for example staff developed a leaflet to improve parents' understanding of the triggers for safeguarding referrals.
- In the paediatric urgent and emergency care service there was strong leadership and a positive, supportive culture amongst medical and nursing staff. Nursing and medical leads worked together with a focus on continuous learning and improvement supported by annual training days, the local audit programme, the appraisal process and mentorship to achieve competencies.

Urgent and emergency services

Good   

Key facts and figures

As part of the urgent care service, we inspected the children's emergency department located in Ormskirk and District General Hospital. The paediatric unit is open 24 hours a day, seven days a week and has been open since 2004. The unit comprises of a resuscitation area with two curtained bays, a minor injuries area with three curtained bays and an examination room. In addition there is a large children's playroom and a room specially designed to care for children with mental health needs. There is a six bedded assessment unit adjoining the unit that receives GP referrals and provides extended care up to 24 hours for patients seen in the emergency department. For longer stays in hospital, there is a children's ward also adjoining the emergency department. Staff refer any child aged 16 years or over to the adult emergency department at Southport and Formby District General Hospital.

There were 27,545 attendances during from April 2016 to March 2017 at the Paediatric A&E at Ormskirk and District General Hospital

We inspected the emergency department and adjoining assessment bay.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse. We inspected the hospital as part of an unannounced inspection between 20 and 23 November 2017.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Before the inspection visit, we reviewed information we held about these services and information requested from the trust.

During the inspection visit, the inspection team:

- Spoke with 8 parents whose children were using the service.
- Spoke with the clinical director, directorate manager and unit manager responsible for the paediatric emergency department
- Spoke with 12 other staff members including the assistant matron, consultant, GP trainee, sisters, staff nurses, health care assistants and ancillary staff
- Reviewed eleven patient records relating to safeguarding records
- Reviewed nine records related to risk assessments and observations

Summary of this service

Our overall rating of this service stayed the same. We rated it as good because:

- Patient safety and quality improvement were high priorities in the department. Management had identified lessons from incidents and the recent mortality review and were implementing changes to standardise nursing practice.
- All staff were trained to level three in child safeguarding and were confident in dealing with safeguarding issues.
- Mandatory training levels for nursing staff had improved since the last inspection
- Facilities and premises were appropriate for the services delivered. A new 'quiet' room had recently been constructed in the emergency department to strengthen their ability to meet the needs of children with mental health needs.

Urgent and emergency services

- Staff used evidence-based tools and the escalation process to manage clinical risk. They provided a consistent approach to frequent attenders with complex conditions by maintaining copies of their care plans for reference in the department.
- Feedback from children and parents confirmed that staff treated them well. Parents we spoke with were happy with the service and three told us that they preferred this emergency department to others for their children.
- The paediatric emergency department performed well against the national urgent care standards including the Department of Health standard (95%) for percentage of patients admitted, transferred or discharged within four hours (monthly average 99% in 2017).
- Staff had clear roles and responsibilities to support the governance systems. Regular governance meetings took place at department and directorate level to monitor and review the quality of care and risk management. The service took complaints seriously and responded to lessons learned, for example staff developed a leaflet to improve parents' understanding of the triggers for safeguarding referrals.
- There was strong leadership and a positive, supportive culture amongst medical and nursing staff. Nursing and medical leads worked together with a focus on continuous learning and improvement supported by annual training days, the local audit programme, the appraisal process and mentorship to achieve competencies.

However:

- The patient group directive (PGD) documents did not evidence regular review and approval since 2009. Whilst pharmacy had provided interim approval for the current use of paediatric PGDs, this was recorded as a risk on the directorate risk register.
- The quality of documentation and approach to frequency of observations was inconsistent. Both issues were being addressed through repeated audit and the issue of a new protocol to standardise observations.
- Documented evidence that staff offered food and fluids, where appropriate, to children during their stay in the department was inconsistent.
- A potential risk to leadership capacity was developing following the recent transfer of bed managers from the Ormskirk site to Southport by trust management. Senior nurses across the paediatric department were required to support bed management duties on the site

Is the service safe?

Good ● → ←

Our rating of safe stayed the same. We rated it as good because:

- We saw evidence that the service investigated serious incidents thoroughly and monitored the impact of recommendations for improvement through audit.
- Lessons were learned and communicated through staff meetings and daily safety huddles.
- Staff understood and fulfilled their responsibilities to be open and transparent, raise concerns and report incidents.
- Staffing levels were planned and the skill mix improved by training advanced nurse practitioners to support the medical staff. There was very low use of agency nurses.
- The environment was visibly clean in all areas inspected and infection prevention and control practices were well-managed, including a paediatric sepsis pathway.

Urgent and emergency services

- Mandatory training levels for nursing staff had improved since the last inspection.
- There were clearly defined and embedded systems to manage child safeguarding.
- There was a clear triage and assessment process in place including use of a screening tool and escalation policy.
- Staff could access the information they needed to assess, plan and deliver care.
- Medicines were stored and disposed of safely and children received their medicines as prescribed.
- Safety performance showed a good track record and was displayed for staff to see in the department.
- There was a proactive approach to mortality review and department leads were working on implementing a recent mortality review action plan.

However:

- The patient group directive (PGD) documents did not evidence regular review and approval since 2009. Whilst pharmacy had approved the paediatric PGDs for use until December 2017, management had recorded this as a risk on the directorate risk register.
- The quality of documentation and approach to frequency of observations was inconsistent. Both issues were being addressed through repeated audit and the issue of a new protocol to standardise observations.

Is the service effective?

Good ● ➡ ➡

Our rating of effective stayed the same. We rated it as good because:

- The service participated in national and local audit to benchmark the quality of care. We saw that changes were made in response to Royal College of Emergency Medicine audit outcomes, for example taking blood sugars on children experiencing possible or actual fits.
- Staff worked collaboratively to understand and meet the complex needs of children in areas such as learning and physical disabilities, mental health and safeguarding.
- Staff gained a wide range of competencies by rotating through the areas of the paediatric unit including the emergency department. New emergency department staff received mentorship and support to achieve their competencies.
- All staff we spoke to had received an appraisal in the previous 12 months.
- The unplanned re-attendance rate within seven days was consistently better than the national standard of 5%, with an overall average of 2.5%.
- Staff obtained consent to care and treatment was in line with legislation and guidance.

However:

- Documented evidence that staff offered food and fluids, where appropriate, to children during their stay in the department was inconsistent.

Urgent and emergency services

Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- We saw nursing and medical staff engaging parents and children by using humour and a calm manner as they examined each child.
- The average Friends and Family Test performance was similar to the England average for emergency care at 86.5%; this was based on a low response rate of 2.8% compared to the England average for emergency departments of 12.6%.
- Parents we spoke to were happy with the service and told us they felt that staff were consistently caring and kind.
- We saw staff involve parents and children, where possible, in decisions about care.
- Parents told us they felt well-informed by staff and that they could ask questions at any point during the visit to the department.

Is the service responsive?

Good  → ←

Our rating of responsive stayed the same. We rated it as good because:

- Since the last inspection, the trust had constructed a room in the department specifically designed for young patients with mental health needs.
- Facilities and premises were appropriate for the services delivered. There was adequate seating and space for parents and children including a large enclosed playroom adjoining the waiting area.
- The service supported patients' individual care needs by using play therapists and 'distraction' boxes. Staff managed a consistent approach to frequent attenders with complex conditions by maintaining copies of their care plans for reference in the department.
- The paediatric emergency department performed well against the national urgent care standards including the Department of Health standard for percentage of patients admitted, transferred or discharged within four hours (monthly average 99% in 2017) and the longest median time total time in the department (September 2017, 105 minutes).
- The service took concerns and complaints seriously, investigated them and learned lessons from the results which were shared with staff.

Is the service well-led?

Good  → ←

Our rating of well-led stayed the same. We rated it as good because:

Urgent and emergency services

- Leaders had the experience and capability to understand the challenges to and priorities for sustaining the paediatric emergency service. All levels of management were visible and approachable.
- There was no separate strategy for the paediatric emergency department but there were regular discussions of the performance of the unit and how to sustain this; improvement plans for urgent care were focussed on performance for the adult emergency department at Southport and Formby District General Hospital.
- The leadership encouraged staff empowerment to drive improvement and all staff we spoke to had received an appraisal in the twelve months prior to inspection.
- We saw positive relationships between staff and teams and all staff we spoke to were positive about their working experience in the emergency department.
- Governance structures, processes and systems of accountability were clearly set out in the paediatric unit and the specialist services directorate. Regular governance meetings took place at department and directorate level to monitor and review the quality of care and risk management.
- There was a focus on continuous learning and improvement supported by annual training days for all staff in paediatric emergency nursing.

However:

- A potential leadership capacity risk was developing following the recent removal of bed managers from the Ormskirk site by trust management. Senior nurses across the paediatric department were required to support bed management duties on the site.

Areas for improvement

Action the trust **SHOULD** take to improve

- The provider should review and approve pharmaceutical patient group directives on a regular basis.
- The provider should monitor and report the impact of removing bed management services on nursing leadership capacity at Ormskirk and District General Hospital.
- The paediatric emergency department should comply with the new protocol to standardise observations.
- The paediatric emergency department should display department quality and safety performance to people using the service.
- The paediatric emergency department should continue to audit and improve the standard of nursing and medical documentation.
- Staff in the paediatric emergency department should document food and drink offered and oral intake for children, when appropriate.

Surgery

Requires improvement   

Key facts and figures

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

Ormskirk and District General Hospital provides ophthalmology, dedicated arthroplasty and 24 hour surgical care for patients. Between July 2016 and June 2016 the trust had 17,095 surgical admissions. Of these admissions emergency admissions accounted for 3,657 (21.4%), 11,010 (64.4%) were day cases, and the remaining 2,428 (14.2%) were elective.

Ormskirk and District General Hospital has a 19 bed elective surgery unit, 12 bed dedicated arthroplasty ward and 5 bedded/ day case ophthalmology unit.

We visited:

- Ward F – Ophthalmology
- Ward H – Arthroplasty unit
- Ward G – 24 hour surgical unit
- Theatre suite
- Preoperative assessment clinic.

We plan our inspections based on everything we know about services including whether they appear to be getting better or worse.

We inspected the hospital as part of an unannounced inspection between 20 and 23 November 2017. During the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

- We reviewed 12 patients' records and other documentation about theatre checks, medicines administration and risk assessments.
- We spoke with nine patients, two relatives, and 26 staff of all grades including doctors, nurses, domestics, allied health professionals and senior managers.

Summary of this service

Surgical services had stayed the same since the last inspection. We rated it as requires improvement because:

- Staff did not always recognise incidents or report them appropriately.
- Staff were not clear about their role in relation to the duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).
- Unlocked doors to the dirty utility on all wards meant anyone could gain access. One ward had a fire door propped open on three consecutive days. Staff rectified this when highlighted by inspection staff.

Surgery

- Due to staff shortages, urology and gynaecology patients were sometimes moved between the urology and gynaecology wards at short notice. This meant that patients recovering from gynaecology surgery could be moved to the urology ward shortly after treatment and vice versa.
- Approximately one third of staff had not completed mandatory training and dashboards were not up to date and therefore did not reflect current completion rates. However, completion levels of mandatory training had improved since the last inspection.
- Whilst staff completed emergency equipment checklists, we found equipment inside that was out of date or with damaged packaging.
- Staff recorded care and treatment provided. However, this was in multiple locations and was difficult to follow. Staff also did not consistently print their name or document their designation when completing records, as per best practice guidance.
- Surgical services had no current strategy in place and had several changes to senior managerial support.
- Staff stated they had appraisals annually however dashboards we reviewed did not reflect this.

However:

- The wards displayed the numbers of staff on duty and details of ward managers to show there were sufficient numbers of nursing staff to provide safe care and treatment.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Patients' had their needs assessed including their physical, mental health and nutritional needs. Staff identified expected outcomes and reviewed and updated them.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. This had significantly improved since the last inspection.
- Staff had infection control training and were aware of trust policies. Audits were completed and we observed appropriate hand washing and use of personal protective equipment (PPE).
- Medicines were stored, administered and recorded in line with best practice guidelines. Staff checked these drugs as per trust guidelines and random checks found that these had been completed appropriately.
- All areas we inspected appeared visibly clean and tidy. Wards displayed environmental audit results which were visible to staff, patients and visitors.

Is the service safe?

Requires improvement   

Our rating of safe stayed the same. We rated it as requires improvement because:

- Staff did not always recognise incidents or report them appropriately.
- Approximately one third of staff members had not completed mandatory training. Dashboards used to monitor performance were not up to date and therefore did not reflect current completion rates. However, mandatory training completion levels had improved since the last inspection.

Surgery

- Staff were not clear about their duties in relation to the duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person).
- Due to staff shortages, urology and gynaecology patients were frequently moved between the urology and gynaecology wards at short notice. This meant that patients recovering from gynaecology surgery could be moved to the urology ward shortly after treatment and vice versa.
- Unlocked doors to the dirty utility on all wards meant anyone could gain access, and hazardous liquids were not kept in locked cupboards. One ward had a fire door propped open on three consecutive days. Staff rectified this when highlighted by inspection staff.
- Staff kept records of patients' care and treatment. However; they were difficult to navigate and not stored securely. Staff completed notes, dated and signed them, however, they did not consistently include time, printed name or designation.
- Staff checked resuscitation trolleys as per guidelines, however despite this we found out of date or damaged items in each trolley, except in theatres.
- The wards had medicine trolleys that were kept secure, however one ward out of the three we visited had an unlocked and unattended medicine trolley, which was accessible by anyone on the ward.

However:

- When incidents were reported, the service investigated them and used information to improve the service. The service shared lessons learnt and these were discussed at ward team meetings.
- Staff recorded fridge and room temperatures and documented them including acceptable ranges.
- Medicines were stored, administered and recorded in line with best practice guidelines. Staff checked these drugs as per trust guidelines and we completed random checks on all wards and found all items were in date.
- All areas we inspected appeared visibly clean and tidy. Wards displayed environmental audit results which were visible to staff, patients and visitors.
- Staff had infection control training and were aware of trust policies. Audits were completed and we observed appropriate hand washing and use of personal protective equipment (PPE).
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. This has significantly improved since the last inspection.
- At the time of our inspection, the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment. However, staff vacancy (16.9%) and turnover (17.5%) rates were high.
- The service planned for emergencies and staff understood their roles if one should happen.
- The service had arrangements in place to recognise and respond appropriately to patient needs and risks.

Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

Surgery

- The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.
- Patients' had their needs assessed including their physical, mental health and nutritional needs. Staff identified expected outcomes and reviewed and updated them.
- Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLs) and knew the processes to ensure the protection of patients' rights.
- The service submitted data for internal and external audits in order to benchmark their performance.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service monitored competencies of staff in line with their job roles. Managers completed staff appraisals and held supervision meetings with them to provide support.
- Multi-disciplinary teams worked well across theatres and wards, working collaboratively to plan and provide care.
- Patients' consent was obtained and recorded in-line with guidance. Staff stated that capacity was assessed in clinic and reviewed on admission.

However:

Staff had access to information on patients' care and treatment; however, they needed to navigate multiple systems.

Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with respect and compassion. Feedback from patients was positive and confirmed that staff treated them with dignity and respect. Patients' we spoke with complimented the service and staff.
- Staff involved patients and those close to them in decisions about their care and treatment. We observed staff discussing care treatment options with patients' and their relatives.
- Staff provided emotional support to patients to minimise their distress. Staff promoted independence where appropriate and monitored their safety to do so.

However:

- Due to staff shortages, urology and gynaecology patients were sometimes moved between the urology and gynaecology wards at short notice. As a result patients recovering from gynaecology surgery could be moved to the urology ward shortly after surgery and vice versa. This could compromise patient privacy and dignity.

Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

Surgery

- The service assessed patients' and took account of their individual needs, planning and delivering care in-line with those needs. The service coordinated care and treatment with other services and providers.
- People could access the service when they needed it. The service managed waiting times, admissions and discharges well.
- The service ensured cancellations of surgery were re-scheduled within 28 days. Staff kept patients' informed of any disruption to their care and treatment.
- The service managed complaints well, investigated them and learned lessons from the results, which were shared with all staff.

However:

- The hospital did not always plan and provided services in a way that met the needs of local people.
- Due to staff shortages and challenges with access and flow, urology and gynaecology patients were sometimes moved between the urology and gynaecology wards at short notice. This meant that patients recovering from gynaecology surgery could be moved to the urology ward shortly after surgery and vice versa. This led to patients being cared for on a ward less suited to meet their needs.

Is the service well-led?

Requires improvement   

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service did not have a vision for what it wanted to achieve. Whilst there were plans for a strategy, it was not currently in place. Following the inspection a presentation of the surgical strategy was forwarded that highlighted plans for surgery on both sites including clear aims and dates for completion
- The service governance and performance management system did not operate effectively. Ward specific performance dashboards did not reflect correct information following several service moves. Senior managers stated that this had been addressed. However, dashboards we reviewed did not reflect this.
- The service managers told us they were committed to improving services by learning from when things go wrong. However, investigations or reviews following incidents did not always identify causative factors in order to prevent reoccurrence.
- The service had a limited approach to obtaining the views of patients and other stakeholders.

However:

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service completed audits and reported results at directorate and board level. Staff could tell us about audits they had actively completed.
- The service actively identified risks and was working to mitigate, eliminate or reduce them.
- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Areas for improvement

Action the trust **MUST** take to improve

- The provider must ensure that hazardous liquids are not accessible in dirty utility rooms.
- The provider must ensure that resuscitation trolleys are checked effectively and all medication and consumables are within date.
- The provider must ensure that clinical records are readily available to staff, are comprehensive and contemporaneous and maintained as per best practice guidelines and local policies and procedures. Records must be kept secure at all times.
- The provider must ensure that all staff complete mandatory training.
- The provider must ensure that duty of candour policies and processes are fully embedded across the service and that staff understand their responsibilities.

Action the trust **SHOULD** take to improve

- The provider should encourage patient feedback to drive improvement.
- The provider should develop a strategy and development plan for the future.

Maternity

Requires improvement



Key facts and figures

Maternity services at Ormskirk District General Hospital comprise of 42 beds; 12 on the maternal assessment unit, 22 on the maternity ward and eight labour beds on the consultant led unit including one pool room and one high dependency room.

There were two community midwife teams. One covered the West Lancashire area and the other the Southport area which included South Sefton and Formby.

Between July 2016 and June 2017 there were 2239 deliveries at the trust.

We plan our inspections based on everything we know about the trust including whether they appear to be getting better or worse. We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We inspected the hospital as part of an unannounced inspection between 20 and 23 November 2017. During the inspection we reviewed 16 women's records and other documentation about medicines administration and risk assessments.

We spoke with six doctors of all grades and 27 midwifery staff including managers, senior managers, midwives of all bands and health care assistants.

We spoke with seven women who used the service.

Summary of this service

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Staff did not complete Maternity Early Warning Scores (MEWS) assessments in accordance with trust policy in order to detect deterioration in a woman's condition. Women did not always receive a medical review when their assessment identified this was required.
- The World Health Organisations' surgical safety checklist was not always fully completed.
- Staff did not follow the trust schedule consistently for checking all equipment was present and in working order. This included the anaesthetic machine in theatre and resuscitation equipment available on the wards.
- Learning from incidents was not always disseminated in an effective way to staff. The trust reviewed every incident of postpartum haemorrhage from 1500mls and above but staff were unaware what learning had been gained from this.
- Records were not always up to date. We saw examples of delay in scanning records onto the online system meaning there were gaps in women's care records. Only one member of staff could open a particular patient record at a time which meant that records around caesarean sections were not always entered onto the system in a timely manner.
- Trust policies were not always reviewed in line with the schedule set out and there were some omissions within policies which made them difficult to follow. Staff were unaware if there was a review panel which had input into creating policies within the service.

Maternity

- There was no vision and strategy for the service which impacted on staff morale and hindered innovation and improvements within the service.
- Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Safeguarding supervision had been made part of mandatory training for all midwives and staff reported receiving good support from the safeguarding midwife.
- The service provided mandatory training in key skills to all staff and the majority had completed this. A practice development midwife had been appointed to ensure the training needs of staff were being met.
- Specialist midwives had been appointed since our last inspection to support midwives in the provision of care to women with complex needs. This had been well received by the midwives we spoke with.
- Staff we spoke with were passionate about providing good quality care to women and their families and some had been involved in initiatives to improve care.
- We found evidence of service planning to meet the needs of the local population.

Is the service safe?

Requires improvement



We rated it as requires improvement because:

- Learning from incidents was not consistently effectively shared as some staff we spoke to were unaware of recent learning from incidents.
- The service did not always store medicines well. There was no record of fridge temperatures being escalated when out of range and room temperatures were not consistently recorded where medicines were stored.
- Staff did not complete Maternity Early Warning Scores (MEWS) assessments in accordance with trust policy in order to detect deterioration in a woman's condition. Women did not always receive a medical review when their assessment identified this was required.
- The World Health Organisations' surgical safety checklist was not always fully completed.
- Staff did not follow the trust schedule consistently for checking all equipment was in working order. This included the anaesthetic machine in theatre and resuscitation equipment available on the wards.
- Records were not always up to date. We saw examples of delay in scanning records onto the online system meaning there were gaps in women's care records. Only one member of staff could open a particular patient record at a time which meant that records around caesarean sections were not always entered onto the system in a timely manner.
- There was a shortage in middle grade medical staffing and the trust had been unable to fill vacancies throughout the year.

However:

Maternity

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Safeguarding supervision had been made part of mandatory training for all midwives and staff reported receiving good support from the safeguarding midwife.
- The medical rota had been covered up to February 2018 through use of locum doctors and consultants.
- The service provided mandatory training in key skills to all staff and the majority had completed this. A practice development midwife had been appointed to ensure the training needs of staff were being met.
- Most staff recognised incidents and reported them appropriately. Managers investigated incidents.
- The service had suitable premises and equipment. There had been improvements since the last inspection.
- Pain relief was provided to women on request.

Is the service effective?

Good 

We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Women were encouraged to maintain a light diet during labour and were offered one to one support if they had chosen to breastfeed.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Midwives who assisted in theatre had the necessary training to undertake this role.
- The preceptorship package for newly qualified midwives had been reviewed so that they received sufficient time as a supernumerary member of staff and gained skills in each part of the service through rotation to different areas.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Since our last inspection, the trust had appointed a specialist perinatal mental health midwife who ran two clinics a week for women identified as needing this service. Staff told us that they received good support from the perinatal mental health midwife in meeting the needs of women with mental health concerns.

However:

- Staff did not always have access to up-to-date, accurate and comprehensive information on patients' care and treatment. Only one staff member could access online patient records at a time, this meant that information was not always recorded contemporaneously.
- Pain scores were not consistently recorded as part of Modified Early Warning Score assessments postoperatively.

Is the service caring?

We rated it as good because:

Maternity

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff treating women and their partners with dignity and respect and staff spoke respectfully of women during handovers of care.
- Staff involved women and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients to minimise their distress. This included counselling regarding antenatal screening and input from the bereavement midwife when required.

Is the service responsive?

Good 

We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people.
- People could access the service when they needed it. Processes were in place to ensure that women had timely access to multidisciplinary input when needed.
- The service took account of women's individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Is the service well-led?

Requires improvement 

We rated it as requires improvement because:

- The service did not always use a systematic approach to continually improving the quality of its services.
- Systems in place to assess, monitor and improve the quality of services were not always effective.
- The service was not always committed to improving services by learning from when things go well and when they go wrong.
- The service did not have a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Trust policies were not always reviewed in line with the schedule set out and there were some omissions within policies which made them difficult to follow. Staff were unaware if there was a review panel which had input into creating policies within the service.
- Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- The service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

Maternity

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborate with partner organisations effectively.
- The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Action the trust **MUST** take to improve

- The provider must ensure that Modified Early Warning Scores (MEWS) are completed and appropriately escalated in order to detect deterioration in condition.
- The provider must ensure that medicines are stored correctly in accordance with manufacturer's recommendations and that room and fridge temperatures which fall outside the normal parameters are escalated and actioned.
- The provider must carry out regular checks of medical equipment including the anaesthetic machine and resuscitation equipment to ensure this is safe for use.
- The provider must ensure that systems in place to assess, monitor and improve the quality of services are robust and effective.
- The provider must ensure that policies are reviewed within the specified timeframe and that robust systems are in place to identify policies past their review date.

Action the trust **SHOULD** take to improve

- The service should consider how all midwives can have timely access to patient information including any safeguarding concerns.
- The service should carry out a risk assessment in view of the storage of medical gases and equipment in the community.
- The service should consider how appropriate translation services are used to explain clinical decisions and gain consent for procedures from women who speak another language.
- The service should implement systems so that women are given individual times for antenatal clinic appointments and not booked into the same slot.
- The service should implement robust systems to ensure that test results such as blood results are reviewed and followed up so that women can receive the treatment needed in a timely way.
- The service should offer vaccination against seasonal flu to women at all stages of pregnancy including the postnatal period.
- The service should consider how to monitor that World Health Organisation surgical checklists are fully completed for every woman undergoing a surgical procedure.

Maternity

- The service should use audit results to drive improvement in consistency of documenting Fresh Eyes reviews for women in labour where applicable.
- The service should use results from the NHS Safety Thermometer to improve care for women and their families.
- The service should implement effective means of communication regarding referral to community midwifery following discharge from the maternity ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
Diagnostic and screening procedures	
Family planning services	
Management of supply of blood and blood derived products	
Maternity and midwifery services	
Surgical procedures	
Termination of pregnancies	
Transport services, triage and medical advice provided remotely	

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	
Management of supply of blood and blood derived products	
Maternity and midwifery services	
Surgical procedures	
Termination of pregnancies	
Transport services, triage and medical advice provided remotely	

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Diagnostic and screening procedures

Family planning services

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

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Our inspection team

Professor Iqbal Singh, Consultant Physician in medicine for older people chaired this inspection and Nicholas Smith, Head of Hospitals led it. The team included 14 inspectors, 12 specialist advisers, and 2 experts by experience. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.