Care Quality Commission

Lancashire Teaching Hospitals NHS Foundation Trust

Chorley and South Ribble Hospital

Quality Report

Preston Road
Chorley
Lancashire
PR7 1PP address line 2 here>
Tel: 01257 261222
Website: www.lancsteachinghospitals.nhs.uk

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Chorley and South Ribble Hospital provides a full range of district general hospital services including urgent care centre, critical care, coronary care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, stroke rehabilitation, midwifery-led maternity care, and breast service.

The hospital has around 220 beds, large operating theatre complex, outpatient suites, and education facilities.

We inspected the hospital as a focused follow up to the inspection in July 2014 where the hospital was found to require improvement in the safe, responsive and well led domains and good in the effective and caring domains. We visited Chorley and South Ribble Hospital between 27 and 30 September 2016.

Following this inspection we have rated the hospital as requires improvement overall and the trust needs to make improvements. Staff were noted to be caring and patient focused and the caring domain was rated as good in all service areas.

We saw several areas of outstanding practice including:

- In outpatients the introduction in dermatology of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breeches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.
- In the urgent care centre the housekeeper helped make sure elderly patients being discharged home had basic groceries provided such as bread or milk.

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

Importantly, the trust must:

Urgent Care services

- Take action to help control risks associated with the room identified for mental health patients must be actioned and appropriately documented.
- Ensure records of controlled drug use in registers are kept in line with trust policy.
- Ensure mandatory training compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED.
- Ensure action plans following CEM audits target areas of poor performance and improve practice and that clinical staff are aware of and engaged with the process of clinical audit.
- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person and review dates included.
- Ensure major incident plans are updated to reflect the current use of the department.
- Improve communication and improve the negative culture centred on a lack of communication and feelings of mistrust amongst staff.

Medical Care (including older peoples care)

- The trust must ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- The trust must ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- The trust must ensure procedures in place around medicine management are robust and that policies are followed.

Summary of findings

- The trust must ensure the risk registers are consistent and demonstrate mitigating actions and review dates.

Surgery

- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.
- Take appropriate actions to improve staff training compliance in adult and children's safeguarding training.

Critical Care

- Improve the uptake of mandatory training particularly in safeguarding children and adults.

Maternity & Gynaecology

- The hospital must ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- The hospital must ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.
- The hospital must complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- The hospital must ensure that all staff receives medical devices training to ensure all equipment is used in a safe way

Outpatients and diagnostic imaging services

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not at risk.
- Ensure staff complete mandatory training as per the trust policy.

In addition the trust should:

Urgent Care services

- Have access to written information in languages other than English.
- Encourage staff to use an approved method of translation rather than relying on web based public translation tools.
- Improve access to regular teaching for medical staff.
- Ensure staff meetings are regularly held with minutes taken to record discussions.
- Introduce a mandatory daily handover between staff starting and finishing work, and document the details being discussed.
- Rotas should be stored in an organised and accessible to the right staff at all times.
- Improve root cause analysis to include the root cause of the incident.
- Improve the attendance of staff invited to safeguarding meetings
- Provide staff with results from hand hygiene and cleanliness audits for their department to help make sure they are able to monitor staff performance rather than results inclusive of multiple wards or directorates.

Medical Care (including older peoples care)

- The trust should ensure that patients are discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should ensure that patients have access to pressure relieving equipment at all times.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Summary of findings

Surgery

- Take appropriate actions to improve staff appraisal completion rates.
- Take appropriate actions so that emergency equipment is securely stored.

Critical Care

- Consider improving appraisal rates as these were lower than at the previous inspection.
- Consider improving the management of the followed up of audit action plans.
- Consider increasing the number of staff who had undertaken a post qualification course in critical care nursing in order to meet the Intensive Care Standards guidelines.
- Consider improving the access to specialist critical care trained pharmacist services on weekends.
- Consider increasing the monitoring of patient satisfaction as the service did not participate in the NHS friends and family test.
- Consider improving the level of Physiotherapy staffing to meet the minimum expected standards.

Maternity & Gynaecology

- The hospital should improve the recording of the review dates and version control of all policies and procedures.
- The hospital should improve attendance at governance meetings.
- The hospital should improve staff annual appraisal rates.
- The hospital should increase staff training uptake for Female Genital Mutilation (FGM) training.
- The hospital should work to better understand the variation inunplanned home birth rates to ensure safety of patients and babies.
- The hospital should strengthen the risk registers to support the management of risk.

Outpatients and diagnostic imaging services

- Consider monitoring and reviewing the procedures for caring for vulnerable patients attending for cancer therapy.
- Consider improving the environment in the Outpatients department to ensure privacy and dignity is maintained.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Requires improvement

Why have we given this rating?

In our previous inspection in July 2014, we gave Urgent and Emergency Services an overall rating of Good. Following this inspection, we have changed this rating to requires improvement. This is because:

- The daily recording of controlled drug use, stock and record checks was not done consistently.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Not all medical staff were aware of the need to obtain senior clinical review prior to discharging certain high risk patients such as those suffering chest pain.
- Attendance at monthly safeguarding meetings was poor.
- Processes were in place to manage risks to patients but these were not always followed. For example, doctors were unaware of the need to obtain a senior medical review prior to discharging certain patients and low levels of staff were compliant with advanced paediatric life support training.
- Trust major incident plans required the UCC to accept all emergency patients should a major incident be declared but no provision was in place for when the UCC closed at night.
- Whilst local guidance was in place and accessible, we found that review and update processes were not robust and some guidance appeared to be several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results. Instead staff relied on incidents of poor practice to help them identify issues. Staff were unaware of clinical audits being undertaken in the department.
- Medical staff told us teaching did not take place often enough in the UCC.
- Although services were in place for people living with dementia, staff gave vague responses when asked about care.

Summary of findings

- Reception staff were unable to locate approved phrase books to assist with language barriers which meant they used a public web based translation service if patients did not have written details with them. Although leaflets were available providing information following discharge from the UCC, none of these were displayed in languages other than English.
- Despite senior staff being aware of complaints through monthly governance meetings, we were less assured that this information was disseminated to staff as staff meetings were infrequent.
- Although risk registers were in place, these did not include enough information and were not specific to the ED. Some risks such as issues with meeting national targets were not included.
- Governance was in place in the department but this was not robust. For example, data was collected centrally but not broken down specifically to departmental level. This left us concerned that staff were unaware of basic governance matters such as overall cleanliness or record quality. Staff reported that staff meetings did not occur regularly.
- The culture was affected negatively by staff feeling unsure about plans for the future. They described an atmosphere of mistrust and suspicion. We also heard numerous staff tell us communication was not good which contributed to this.
- Staff engagement and communication was described as 'awful' by staff, particularly about the change from ED to UCC provision.

However:

- There was an open, no-blame culture of reporting and learning from incidents with the majority of incidents resulting in low or no harm.
- Staffing was adequate for both medical and nursing staff despite vacancies.
- Areas were visibly clean and tidy with cleaning staff available each day. Environments were pleasant light and airy.

Summary of findings

- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.
- Guidelines were based on national guidance.
- Pain was monitored and a range of pain relief was available should it be required.
- A range of food and refreshments were available for patients and loved ones visiting the department
- Staff competencies were maintained using information sharing and teaching. Revalidation was monitored regularly.
- Staff had access to the information they required to provide care for patents.
- Staff were aware of the need for consent and we saw evidence that consent was obtained appropriately.
- Patients told us staff caring for them were 'friendly' and 'supportive'.
- Patients completed surveys which showed 93% would recommend the service to friends and family members.
- We saw staff caring for patients in a kind and sensitive manner, taking account of their situations. The housekeeper described obtaining basic food items for some elderly patients who attended.

Medical care (including older people's care)

Requires improvement

We rated medical services at Chorley and South Ribble Hospital as requires improvement overall because:

- There were staff vacancies in most areas and there were occasions on wards when there had been a reliance on agency or bank nurses as well as locum doctors. Data provided showed there were occasions when the staffing levels were less than 80%.
- Overall compliance with mandatory training for all staff was below trust target. The trust target was 80%.
- There was a risk that personal information was accessible to members of the public as patient's records were not always stored securely.

Summary of findings

- There were systems for handling and disposing of medicines however incidents had occurred and we identified areas that required improvement.
- Clinical staff had access to information they required. However, patient's risks were not always being identified, monitored or addressed.
- There were ongoing issues with the access and flow of patients across the medical wards and there were occasions where there was insufficient bed capacity on the medical wards to meet the needs of people. However there were systems in place to ensure those patients on non-medical wards were reviewed by the medical team.
- There were occasions when patients experienced one or more moves during their hospital stay with some patients being moved during the night.
- There were governance structures in place which included a risk register. However there were inconsistencies across the divisional and trust risk register. Actions on the register had no additional mitigation action or timeframes for completion and it was unclear if these were being managed in an effective way to lower the risk.
- Policies and procedures were in place however we are not assured all of these reflected current practice as they were not always reviewed as planned.

However:

- The trust were monitoring and taking actions regarding staffing levels including rolling recruitment, including overseas and regular monitoring of staffing levels during the day to help mitigate the risk.
- Wards were visible clean and the majority of staff followed good hand hygiene practices.
- The majority of staff were aware of the trusts values and vision.
- Staff were proud of the work they did and well supported by their managers and worked collaboratively together to ensure patient were cared for.

Summary of findings

- Staff treated patients and their relatives with respect and dignity and communicated with them effectively. Patients were happy with their care, felt informed, and were involved in care planning.

Surgery

Good

The surgical services were previously rated as requires improvement for safe, responsive and well-led in July 2014 following our last inspection. This was because we had concerns around equipment management and poor compliance against 18 week referral to treatment standards. At this inspection we gave the surgical services at Chorley and South Ribble Hospital an overall rating of Good because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises.
- Medicines were stored safely and given to patients in a timely manner. Staff assessed and responded to patients risks and used an early warning score system. The theatre teams followed the five steps to safer surgery procedures and staff adherence to was monitored through routine audits.
- Equipment and consumable items were readily available for use by staff. The equipment we saw was appropriately checked, cleaned and serviced regularly under a planned maintenance schedule.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- The staffing levels and skills mix was sufficient to meet patients needs. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.
- There were systems in place to support vulnerable patients. Most complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Summary of findings

- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The hospitals values and objectives had been cascaded across the surgical services. There was effective teamwork and visible leadership across the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

However, we also found that: -

- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times between August 2015 and June 2016 for most surgical specialties. The surgical division RTT recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.
- Most staff had completed their annual appraisals and mandatory training; however the proportion of staff that had completed their appraisals and had completed adult and children's safeguarding training was below the hospitals expected levels.

Critical care

Good

We previously inspected the hospital in July 2014 and gave critical care services an overall rating of requires improvement. Following this inspection we have rated critical care services at Chorley and South Ribble Hospital overall as good because:

- The critical care services were well led and staff were aware of the trusts vision and values.
- We found that there were governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.

Summary of findings

- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated.
- Infection control was effectively managed and the department was visibly clean. Routine infection control audits were undertaken.
- Nurse and medical staffing was sufficient to meet patient's needs.
- Patients received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs.
- This care was delivered by competent and professional staff.
- The service participated in local and national audits.
- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.

However:

- Mandatory training uptake levels were low for some subjects, including safeguarding children and adult training.
- Appraisal rates were low at 62% and this was a deterioration from the previous inspection.
- Audits were not always followed up with action plans and a number of action plans had not been update for years in some cases.
- The service, as a whole, was not meeting the Intensive Care Standards guidelines for 50% of nursing staff to have undertaken a post qualification course in critical care nursing.
- There was limited monitoring of patient satisfaction.

Maternity and gynaecology

Requires improvement

At the previous inspection in July 2014 we rated the service as good overall. Following this inspection we rated have this service as requires improvement overall because:

Summary of findings

- All staff reported a shortfall in staffing and an increasing quantity of work and activity within the service. Management told us that the midwifery staffing levels had not been formally reviewed since 2011. This was also a concern raised at the time of the last CQC inspection in 2014. Although it was noted that since 2014, there had been an increase of 10 full time midwives.
- The maternity service was currently waiting for the Birthrate Plus (a national tool available for calculating midwifery staffing levels) review and report, which will calculate the number of clinically active midwives required to deliver a safe high quality service.
- Due to staffing issues and sickness absence rates, there was a heavy dependence on midwives working extra hours. The trust did not use agency staff but used their in-house bank staff on an ongoing basis. Midwives working over and above their normal working hours provided additional midwifery staffing. Community staff gave us examples of working a 24-hour shift and managers working a 60-hour week.
- All midwifery staffing, including community were flexed to meet the needs of the service user. Managers were aware of the staffing shortfall and recruitment was underway. Staff informed us that the current measures in place were not sustainable and insufficient to mitigate the risk of harm. Due to the pressures of work, staff morale was low but staff of all professions supported each other well to work as a team. There was a desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst midwives.
- Not all staff attended annual mandatory training or received their annual appraisal performance review in order to discuss and evaluate job performance and career development.

However:

- There was an integrated service between the community midwives and the two birth centres at RPH and CDH.

Summary of findings

- Care at the Chorley Birth Centre was provided in a calm, relaxed and spacious environment that had been specifically designed and equipped to support normal births. The centre comprised of spacious en-suite birthing rooms, each with a birthing pool, specialised birthing equipment and separate family rooms.
- There were clear systems for reporting incidents and managing identified risk within the service.
- Clear protocols and prompt cards were in place for all staff with relevant training in the management of obstetric emergencies. Regular training sessions were held with the ambulance service regarding transfers from the birthing centre at Chorley to the obstetric unit at RPH.
- CBC used a carbon fibre "Baby Pod" as a transport device for unwell babies who need transferring to RPH by ambulance. The unwell baby is comfortably secured in position by a vacuum mattress and soft positioning straps. The vacuum mattress is moulded around the baby and air is removed with the aid of a vacuum pump to hold the mattress in shape. All resuscitation procedures can be continued while the baby is securely positioned in the pod.
- Medicines were delivered, stored and dispensed safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.
- We found that committed and compassionate staff delivered maternity and gynaecology services. All staff treated patients with dignity and respect. People we spoke to were positive about the care they had received.
- Gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available.

Outpatients and diagnostic imaging

Requires improvement

We inspected the hospital in July 2014 and gave outpatient and diagnostic imaging services an overall rating of requires improvement. Following this inspection we have maintained the overall rating because:

Summary of findings

- The outpatients and diagnostics service was predominantly managed through the diagnostics and support services division. However key outpatient departments such as orthopaedics and ophthalmology were under a separate management structure. The recent changes in the divisional structure had led to some lack of clarity in terms of performance and governance.
- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- At our last inspection we found concerns within the ophthalmology department; clinics were sometimes cancelled at short notice and frequently ran late. At this inspection we found there were still issues regarding medical staffing and access to services in ophthalmology. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. The service had reported two serious incidents related to delays in accessing care and treatment.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Of the 16 separate specialties reported nine were below the England average.
- For incomplete pathways of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Although there was a clear process for reporting and investigating incidents, staff told us they had

Summary of findings

not received outcomes of incidents submitted. We found that improvements were required by the trust to ensure that staff received regular feedback on incidents.

- We found some areas did have significant vacancies such as radiology and ophthalmology. Staffing numbers and skill mix met the needs of the patients.
- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded. Patients were treated with dignity and respect by caring staff. However we observed patients having blood pressure monitoring in an open corridor. Patients spoke positively about staff and felt they had been involved in decisions about their care. Care provided was evidence based and followed national guidance. Across outpatients and imaging services we found there was good local leadership and staff were committed to meeting the needs of their patients. Overall staff worked well as a team and supported each other.

Chorley and South Ribble Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Chorley and South Ribble Hospital

Chorley and South Ribble Hospital is part of Lancashire Teaching Hospitals NHS Foundation Trust. General hospital services include an urgent care centre and a range of secondary care services including general medicine, surgery, critical care, maternity and gynaecology and outpatients services.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Consultant colorectal surgeon with 6 years' experience as a medical director

Acting Head of Hospital Inspections: Lorraine Bolam, Care Quality Commission

The team included eight CQC inspectors, a pharmacy inspector, two assistant inspectors, an inspection planner and a variety of specialists including an emergency department Consultant and nurse, Consultant Geriatrician/General Physician, medical nurse, theatre manager, consultant anaesthetist, Lead Nurse Acute Care Team and Hospital at Night team, Head of Midwifery/ General Manager, Matron Maternity, Nurse Consultant/ Advanced Paediatric Nurse Practitioner, Consultant in Clinical Oncology, Clinical Nurse Specialist Palliative Care, Urological and Surgical services nurse, Radiology General Manager, Senior Quality and Risk Manager, Director of Nursing, Equality and Diversity specialist, Specialist Community Paediatric Physiotherapist, gynaecology nurse and an expert by experience.

How we carried out this inspection

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

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

Detailed findings

The inspection team inspected the following eight core services at Lancashire Teaching Hospitals NHS Foundation Trust:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Outpatients

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment. We spoke with people who used the service and the people close to them and we also met with representatives of the Protect Chorley and South Ribble Hospital Campaign. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Lancashire Teaching Hospitals NHS Foundation Trust

Facts and data about Chorley and South Ribble Hospital

The trust serves a local population of 390,000 living in South Ribble, Chorley, and Preston boroughs.The health and deprivation of people in Lancashire as a county varies, with just over half of the health indicators worse than the England average, such as binge drinking adults and life expectancy.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

Urgent care services are provided at Chorley and South Ribble District General Hospital by the urgent care centre (UCC) under the trust's acute medicine division.

Previously an emergency department (ED), the trust temporarily changed the purpose of the centre to provide urgent rather than emergency care in April 2016, following staffing concerns. We inspected the service as an urgent care centre.

The UCC operates between 8am and 8pm, seven days a week. Between April 2015 and March 2016 (when the department was an ED) 49,869 patients attended, of which 9760 were children up to the age of 16 years. This was an average of 136 patients each day. However between April and July 2016, following the change to a UCC, 13,104 patients attended, of which 3356 were children. This was an average of 107 patients each day.

The UCC is staffed by a combination of consultants, nurse practitioners, GPs, nurses and healthcare assistants. It provides treatment for minor injury and illness such as minor burns, cuts, sprains and limb injuries.

Only certain patients arrive by ambulance via a designated entrance. These patients are triaged in one of two rapid assessment and treatment rooms. Ambulatory patients arrive through the main entrance and are assigned to the waiting area (children can wait in a separate waiting area) before being triaged in one of two rooms.

Following triage, patients receive care and treatment in three main areas: 'ambulatory' bays, 'consulting' rooms or the 'majors' area.

Patients with minor illnesses or injuries are treated in one of six ambulatory bays or six consulting rooms. People with more serious illness or injury are seen and treated in the 'majors' area which has four bays. Should patients arrive in the UCC requiring emergency care, they can be treated in one of two resuscitation bays.

In addition to these areas, the centre has one specialist room for treating eye problems, one room (with two trolleys) for plastering limbs, one treatment room and one decontamination room for patients following incidents with hazardous substances.

We visited the UCC during our inspection. We spoke with 13 patients and carers and 18 staff from different disciplines including clinical directors, doctors, matrons, nurses, emergency nurse practitioners, health care assistants, reception and domestic staff. We also reviewed five patient records and observed daily activity and clinical practice within the department. Prior to and following our inspection we analysed information about the service which was provided by the trust.

Urgent and emergency services

Summary of findings

In our previous inspection in July 2014, we gave Urgent and Emergency Services an overall rating of Good. Following this inspection, we have changed this rating to requires improvement. This is because:

- The daily recording of controlled drug use, stock and record checks was not done consistently.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Not all medical staff were aware of the need to obtain senior clinical review prior to discharging certain high risk patients such as those suffering chest pain.
- Attendance at monthly safeguarding meetings was poor.
- Processes were in place to manage risks to patients but these were not always followed. For example, doctors were unaware of the need to obtain a senior medical review prior to discharging certain patients and low levels of staff were compliant with advanced paediatric life support training.
- Trust major incident plans required the UCC to accept all emergency patients should a major incident be declared but no provision was in place for when the UCC closed at night.
- Whilst local guidance was in place and accessible, we found that review and update processes were not robust and some guidance appeared to be several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results. Instead staff relied on incidents of poor practice to help them identify issues. Staff were unaware of clinical audits being undertaken in the department.
- Medical staff told us teaching did not take place often enough in the UCC.
- Although services were in place for people living with dementia, staff gave vague responses when asked about care.
- Reception staff were unable to locate approved phrase books to assist with language barriers which meant they used a public web based translation service if patients did not have written details with them. Although leaflets were available providing information following discharge from the UCC, none of these were displayed in languages other than English.
- Despite senior staff being aware of complaints through monthly governance meetings, we were less assured that this information was disseminated to staff as staff meetings were infrequent.
- Although risk registers were in place, these did not include enough information and were not specific to the ED. Some risks such as issues with meeting national targets were not included.
- Governance was in place in the department but this was not robust. For example, data was collected centrally but not broken down specifically to departmental level. This left us concerned that staff were unaware of basic governance matters such as overall cleanliness or record quality. Staff reported that staff meetings did not occur regularly.
- The culture was affected negatively by staff feeling unsure about plans for the future. They described an atmosphere of mistrust and suspicion. We also heard numerous staff tell us communication was not good which contributed to this.
- Staff engagement and communication was described as 'awful' by staff, particularly about the change from ED to UCC provision.

However:

- There was an open, no-blame culture of reporting and learning from incidents with the majority of incidents resulting in low or no harm.
- Staffing was adequate for both medical and nursing staff despite vacancies.
- Areas were visibly clean and tidy with cleaning staff available each day. Environments were pleasant light and airy.
- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.
- Guidelines were based on national guidance.
- Pain was monitored and a range of pain relief was available should it be required.
- A range of food and refreshments were available for patients and loved ones visiting the department

Urgent and emergency services

- Staff competencies were maintained using information sharing and teaching. Revalidation was monitored regularly.
- Staff had access to the information they required to provide care for patents.
- Staff were aware of the need for consent and we saw evidence that consent was obtained appropriately.
- Patients told us staff caring for them were 'friendly' and 'supportive'.
- Patients completed surveys which showed 93% would recommend the service to friends and family members.
- We saw staff caring for patients in a kind and sensitive manner, taking account of their situations. The housekeeper described obtaining basic food items for some elderly patients who attended.

Are urgent and emergency services safe?

Requires improvement

In our previous inspection in July 2014 we rated safe as good however following this inspection we have changed this rating to requires improvement. This was because:

- The daily recording of controlled drug use, stock and record checks was not done consistently.
- Compliance with staff training was low with only 42% of doctors and nurses compliant overall.
- Attendance at monthly safeguarding meetings was poor.
- Processes were in place to manage risks to patients but these were not always followed. For example, doctors were unaware of the need to obtain a senior medical review prior to discharging certain patients and low levels of staff were compliant with advanced paediatric life support training.
- Trust major incident plans required the UCC to accept all emergency patients should a major incident be declared but no provision was in place for when the UCC closed at night.

However:

- There was an open, no-blame culture of reporting and learning from incidents with the majority of incidents resulting in low or no harm.
- Staffing was adequate for both medical and nursing staff despite vacancies.
- Areas were visibly clean and tidy with cleaning staff available each day. Environments were pleasant, light and airy.
- Safeguarding was managed centrally; with useful flow charts and support from lead nurses should staff have any queries.

Incidents

- There was a culture of reporting and learning from incidents and staff knew how to report incidents if needed.
- Incidents were reported electronically with the option to receive receipts on submission and feedback following investigation.
- Between April and July 2016, 39 incidents were reported in the department, all but one of which were reported as

low or no harm. The remaining incident was reported following the death of a patient, where upon review staff identified a possible failure to review an X-ray prior to discharge.

- Managers explained that root cause analysis was done following particular incidents and that debriefs took place if required. However, following review of one root cause analysis we saw that important details were not included such as the root cause itself. Additionally, when we asked for written evidence that a debrief had taken place we did not receive it. Instead the trust sent us minutes of a mortality meeting which did not reference any debriefs.
- Feedback following incidents was provided individually between staff and line managers, in newsletters and directorate meetings.
- Practice was changed following serious incidents. For example, the criteria for senior clinical review of children prior to discharge were changed following a serious incident.
- Mortality and morbidity meetings were held monthly. Consultants, nurses and physiotherapists were invited to attend. Here staff discussed both good and poor practice to aid improvement.
- Clinical staff that we spoke with were aware of the duty of candour. This is a legal duty to inform and apologise to patients if there have been mistakes in care that led to significant harm. We saw evidence that consideration of this duty was undertaken during investigations.

Cleanliness, infection control and hygiene

- All the areas we inspected were visibly clean and tidy, including reception and waiting areas, triage rooms, treatment bays, clean utility, sluice rooms and corridors.
- Gel dispensers were available for staff and visitors to disinfect hands safely.
- Cleaning staff worked daily between 7am and 3pm, completing scheduled tasks such as cleaning bays, toilets, corridors and examination or treatment rooms. Other tasks such as cleaning toys were done weekly. We saw evidence of this in cleaning records where staff could also record details of outstanding tasks if necessary.
- Cleaning cloths were colour coded to ensure they were not mixed. For example green cloths were for kitchen areas and red cloths were for bathroom areas.
- Cleaning staff helped reduce the risk of legionnaire's disease (a serious bacterial infection) in water supplies, by running water through taps each day and records seen for July 2016 confirmed this.
- Cleaning staff told us that supervisors visited the department each week to perform spot checks and identify areas requiring attention.
- The trust completed audited hand hygiene and mattress cleanliness. However the results provided by the trust included all wards and directorates, with no specific details for the UCC. Nevertheless, the results showed that in April 2016, 99% of mattresses passed checks against a target of 100% and staff scored 98% for hand hygiene against a target of 95%. In May the figures were 99% for hand hygiene and 96% for mattress cleanliness and in June; 98% for hand hygiene and 93% for mattress cleanliness. As we were unable to obtain findings specific to the UCC we remained concerned that staff in the department had no way of assessing their own levels of hygiene and cleanliness.

Environment and equipment

- Following refurbishment in October 2015, the department was light and spacious throughout.
- Access was via automatic doors between 8am and 8pm when doors were secured. After this time visitors pressed a call bell to summon assistance when the centre was closed.
- Diagnostic imaging equipment such as computerised tomography (CT) and X-ray machines were based next to the department and there was a plaster room with space to treat two patients at any time.
- There was a room assigned for patients with mental health needs. The room had dual exits. Managers confirmed that the room had been risk assessed to help minimise risks to mental health patients. However, despite the risk assessment stating risk to mental health patients in this room were 'not controlled using the room as it is' none of the actions to address this had been completed despite the assessment being six months old. Neither were there any updates to explain the reasons for this.
- Despite the fact that children were not ordinarily treated at the centre, one resuscitation bay was assigned for children should it be required.

- We checked a range of medical equipment in the department including paediatric items and devices such as defibrillators and oxygen cylinders. All these items were within expiry for portable electrical appliance tests and were clean and ready for use.
- We checked two resuscitation trolleys in the department. These contained the right equipment which was appropriately sealed, within expiry date and ready for use. Records showed that the trolleys were checked each day.
- Linen and extra supplies of equipment such as syringes were stored in an organised way. Items were checked by the department housekeeper and ordered via central stores. Staff also recorded items needed on a whiteboard as an additional measure. The housekeeper attended 'cost' meetings to help promote awareness of cost in the department. There was a fast-track option for items required at short notice.
- There was an area assigned for patients to provide samples. This unisex toilet had a hatch which allowed patients to leave their sample for staff without having to carry it anywhere. This was more convenient and reduced the risk of spillage.

Medicines

- A range of medicines and controlled drugs (prescription medicines which are controlled under legislation) were stored in the UCC.
- A range of staff (doctors, nurse prescribers (nurses authorised to prescribe) or other nurses) provided medicines and controlled drugs using Patient Group Directives (PGDs). PGDs are written instructions allowing specified healthcare professionals to supply or administer particular medicines under strict criteria without prescriptions.
- Pharmacy staff visited the department each week to check stock and top up medicines or drugs.
- We checked a range of medicines and controlled drugs in the UCC. Drug boxes stored medicines to treat particular conditions such as anaphylaxis (severe allergic reaction) and for intubation, allowed rapid access. These were appropriately sealed ready for use.
- Medicines requiring storage at low temperature were stored in fridges and those checked were within expiry date. We saw that fridge temperatures were checked daily.
- Medicines stored on resuscitation trolleys and the clean utility room were ready for use, sealed and within expiry date. Controlled drugs were in date and current stock numbers corresponded with written records (which are required by law).
- Despite this, when we examined the controlled drug register we found historical entries missing over several months in relation to morphine sulphate. Between 1 January and 24 February 2016, we found ten occasions when the drug had been removed for use, with no record of the amount used or authorising signature. This was against trust policy which stated 'both the staff administering the CD [controlled drug] and the approved witness must sign the record to indicate the CD has been administered. The record in the CD register must be made at the time of administration'. A senior nurse agreed this practice was unacceptable but confirmed that no action had been taken to address it.
- We also found checks of stock were not documented each day, despite there being a requirement to do so. Trust policy states 'the ward manager or a designated registered nurse/midwife must check the stock balance of CDs daily with an approved witness and record that this has been undertaken on the back pages of the CD register'. Between 29 January and 25 February 2016 ten dates of checks were missing.
- We raised our concerns with the matron who confirmed that an investigation would take place with learning shared in both the UCC and the trust's emergency department located in Royal Preston Hospital.

Records

- Patient records were paper based before being scanned onto an electronic patient information system.
- We reviewed five records of patients who attended the UCC. These were legible and included appropriate details including time of attendance and triage, medical history such as allergies, triage category, pain score and reason for attendance. Discharge plans were also included.
- Consultants told us the electronic system rarely failed but that when it did tasks such as ordering x-rays were done using paper forms, with results passed by telephone.

Urgent and emergency services

Safeguarding

- A consultant in the department acted as the safeguarding lead. Staff had access to the trust safeguarding team available during office hours or a link nurse (someone who staff can approach for specialist advice).
- Flow charts helped staff process concerns about vulnerable children and adults and refer concerning cases to other agencies appropriately. These were displayed in the department and contained clear instructions for staff to follow.
- Training in safeguarding was mandatory with a compliance target of 75%. Staff completed one of three levels of training based on the level of contact with patients. Nurses completed level two and senior nurses completed level three training which was in line with NHS England guidance.
- However, the figures for completed training were low. Only 38% of nurses had completed level two and 40% of senior nurses had completed level three training. Staff responsible for training explained that the figures were skewed due to recent changes in the levels of training required for staff. Efforts were being made to place staff onto training programmes. We saw weekly communication with course providers to identify spare places for staff and a number were scheduled to attend in coming weeks.
- Female Genital Mutilation (FGM) was covered in training and discussed at monthly safeguarding meetings.
- Monthly safeguarding meetings included discussion of recent referrals (including outcome), local processes, child sexual exploitation, domestic violence and training requirements. Representatives from other organisations were invited but rarely attended (only one had attended in the last six months). Attendance of trust staff was also poor. For example out of 27 people invited to meetings between January and June 2016; only eight attended in April, and six attended in May and July. No attendees were recorded for March or June and in February no meeting took place. The highest number of attendees (15) was recorded in January.
- Information systems in the department allowed staff to record details about safeguarding for particular patients, including previous attendances. However, details had to be accessed in a separate folder on the system rather than on the patient record itself.

Mandatory training

- Staff completed core training modules covering topics including; fire safety, fraud awareness and bribery awareness. Clinical staff completed additional training topics relevant to their roles.
- Training was delivered either face to face by trainers, or through e-learning on the trust intranet.
- The trust had various targets for the percentage of staff who should be compliant (up to date) with training. For example, the target for core information governance was 80% and conflict resolution it was 60%.
- Figures provided by the trust incorporated both the UCC and the ED together. This meant we were unable to break down the figures to see compliance solely for staff at the UCC. These showed that only 42% of medical staff across both sites were compliant with training overall. Whilst 83% were compliant in fire safety, fraud and bribery awareness training, figures were much lower for other topics. For example, only 27% were compliant with antimicrobial stewardship training, 30% with advanced basic life support and 18% with paediatric basic life support.
- For nursing staff, the overall compliance figure was also 42%. Whilst 80% were compliant with fire safety, fraud, bribery awareness and information governance, and 83% were compliant with conflict resolution training; compliance was much lower for other topics. For example, only 28% were trained in basic life support, 36% in advanced life support, 35% in moving and handling techniques and 59% in oral medication training.
- When training was due to be done, emails were sent to staff and line managers. This helped ensure staff were aware of training requirements.
- Practice educators confirmed actions were in place to improve areas of low compliance. We saw evidence that this was discussed during meetings before action such as further training was scheduled.

Assessing and responding to patient risk

- Processes helped staff manage potential risks to patients. For example, staff prioritised patients based on clinical need. This was done by obtaining medical history and baseline clinical observations (abnormal observations can indicate early deterioration in a patient's condition).

- The Manchester Triage System (MTS) and Early Warning Score (EWS) systems were used. The MTS is a clinical risk management tool used worldwide to prioritise patients based on how unwell they are and how quickly they need to be seen using categories green, yellow, orange and red. EWS systems analyse clinical observations within set parameters to determine how unwell a patient may be. When observations fall outside parameters they produce a higher score, requiring more urgent clinical care than others. We observed the process where medical history was discussed while a range of clinical observations were taken. Where required, pain relief was provided and treatment was initiated such as wound dressing.
- Reception staff told us they identified patients at risk of deterioration in the reception area. For example, when booking in patients with chest pain or shortness of breath staff contacted nurses and doctors via telephone to ensure they attended to them promptly.
- Ambulance staff brought patients (approximately six each day) under strict criteria to ensure only suitable patients were seen. As a further precaution, any ambulance patients arriving with an early warning score of more than six were re-directed to the trust's ED following approval by a doctor.
- Patients with particular needs were cared for where possible in assigned areas to reduce the risks associated with an ED environment. For example, mental health patients were assigned to a particular bay close to the nurses' station which had been risk assessed. However, when we asked for a copy of the risk assessment the trust did not provide it.
- Adult and paediatric waiting areas were partially visible to reception staff which helped them to identify deteriorating patients quickly and summon help via an emergency button. For areas which were not visible, they were close by to reception staff allowing them to provide immediate assistance if required.
- In line with Royal College of Emergency Medicine (RCEM) standards, the department worked to reduce the risk of incorrectly discharging patients by ensuring only senior doctors authorised the discharge of certain patients, for example, those with chest pain or repeat attenders within 72 hours. However not all doctors we spoke with were aware of this.
- Despite the fact that the UCC did not accept children, the risk of an unwell child being brought in was still managed. For example, some staff trained in paediatric life support techniques. Nurses told us all doctors and one emergency nurse practitioner underwent advanced paediatric life support training (APLS). However figures provided by the trust showed that only 17% of medical staff were compliant with APLS training. Senior nurses also told us they completed paediatric intermediate life support but the figure for nurses was only 20% against a target of 65%. This left us concerned that not enough staff could offer intermediate or advanced care for these children should it be required.
- Staff monitored the time taken to initially assess patients, which should be within 15 minutes of arrival. Between March and September 2016 the average time taken was seven minutes. These figures showed that the time reduced following the change to providing urgent rather than emergency care; (from 13 minutes in March, to five minutes in June through to September 2016).

Nursing staffing

- A range of nurses including staff nurses, sisters, matrons and nurse practitioners provided care for patients.
- Planned staffing included two nurses on both early and late shifts with an additional nurse during the day. A healthcare assistant was also assigned each day. We asked the trust to provide copies of rotas to corroborate but they did not provide this information.
- Senior nurses told us that 2.6 whole time equivalent nurses of pay band seven, 3.4 WTE nurses of pay band six (including emergency nurse practitioners), and 9.4 WTE staff nurses were employed in the UCC. We asked for written evidence of staffing levels to corroborate what we were told but the trust did not provide this.
- Managers did not use acuity tools to calculate staff requirements in the departments. However, they reviewed data over a two week period and used experience to make judgements.
- Senior nurses in the department said that nursing handovers took place each afternoon at 2pm where staff discussed each patient in the department as well as any incidents, alerts of other general information to be cascaded. However on the day we visited we did not see a handover take place and nurses we spoke with said handovers were rare.
- Staff sickness rates were monitored. Between April 2015 and March 2016, the sickness rate for nurses was 6.5%

and 4.6% for healthcare assistants (additional clinical services). This was higher than the average NHS sickness rate of 4.2% across England between April 2015 and March 2016.

Medical staffing

- Across the UCC and the trust's ED, 10.6 middle-grade doctors and 12.6 consultants (whole time equivalent) were employed. However, two middle grade doctors were absent and not expected to return to work. This meant there were only 8.6 working middle grade doctors available.
- A consultant was present between 9am and 6pm and a middle grade or junior doctor worked between 9am and 5pm each weekday. Middle grade doctors worked over the weekends where possible as well as two GPs. Junior doctors in their foundation years did not work at the centre due to being less experienced.
- The medical staffing rota was kept at the nurses' station. However, they were not stored in an organised way. Nurses were unable to locate the middle grade medical staff rota but instead found an old rota for GPs dating back to April and May 2016. Additionally, nurses said they did not have access to the rota for junior doctors.
- There were 5.4 whole time equivalent vacancies for medical staff across the trust's ED and the UCC (August 2016). This had led to the trust changing the ED to a UCC with daytime operating hours. Recruitment was in progress with vacancies advertised on the NHS jobs website on a rolling basis.
- Handovers between groups of medical staff did not take place. Instead doctors said medical handovers took place between individual doctors changing shift. This was because the centre was not open overnight which limited the need for details to be passed from one group of staff to the next.
- Despite asking for sickness rates for medical staff the trust did not provide it.

Major incident awareness and training

- There were policies to support staff in the event of a major incident or business continuity issues. These included a business continuity plan and individual plans for pandemics, adverse weather, fuel shortages or information system failures. However, these were not up to date. For example, review dates for the business continuity and major incident plans had expired (May and January 2016 respectively). Furthermore, the UCC was continually referred to as an ED throughout the policies.
- In the major incident policy the UCC was named as a receiving centre for 999 patients whilst the trust's ED would accept the major incident patients. We were concerned that following the change to a UCC, there may not be capacity to accept all 999 emergency patients and that staffing or opening times (daytime opening hours only) for the UCC would not allow for this change in purpose at short notice.
- An isolation room was available should patients require to attend following contact with hazardous substances or with an infectious disease. The room had an area for staff to put on and remove protective equipment prior to leaving or entering the room.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

In our previous inspection in July 2014 we did not have sufficient evidence to rate this domain. Following this inspection we have rated it as requires improvement. This was because:

- Whilst internal guidance for treating patients was in place and accessible, we found that review and update processes were not robust which posed a risk that guidance may not be checked and updated regularly. We also saw that some guidance appeared to be several years out of date.
- Although the department took part in national audit programmes, we saw little evidence of action to address poor results. Instead staff relied on incidents of poor practice to help them identify poor practice.
- Staff were unaware of local clinical audits being undertaken in the department.
- Medical staff told us teaching was irregular in the UCC.

However:

- Guidelines were based on national guidance.
- Pain was monitored and a range of pain relief was available should it be required.

- A range of food and refreshments were available for patients and loved ones visiting the department.
- Staff competencies were maintained using information sharing, and teaching. Revalidation was monitored regularly.
- Staff had access to the information they required to provide care for patients.
- Staff were aware of the need for consent and we saw evidence that consent was obtained appropriately.

Evidence-based care and treatment

- Staff provided evidence based care and treatment using national guidelines from the National Institute of Health and Care Excellence (NICE), the Royal College of Emergency Medicine (RCEM), National Poisons Information Service (ToxBase) and the Resuscitation Council UK.
- Guidelines formed the basis of local policies and pathways for treating conditions such as paracetamol overdose (using guidance from the National Poisons Information Service).
- Guidelines, policies and pathways were accessible via trust intranet systems and covered clinical care and treatment, referral to other places of care and equipment use. Nurses told us that when new guidelines or pathways were introduced, information was shared to ensure all staff were aware. Whilst we saw that a monthly newsletter was published, staff told us that meetings were irregular which left us concerned that opportunities to share information were limited.
- Senior medical staff told us guidelines were reviewed and updated regularly such as guidance for recording vital signs following a national audit (2015/16) to include reminders about repeating baseline observations. However other evidence indicated guidance was not reviewed regularly. For example, despite consultants assuring us the guideline for renal colic had been reviewed recently, the latest review date showing on the document was 2011. The review date of April 2015 had passed on guidelines for patients with cardiac chest pain and there was no review date on guidance for acute coronary syndrome. This left us concerned that guidance was not reviewed as often as it should be which posed a risk that staff were relying on outdated guidance.
- Some local audits such as use of early warning scores were done to confirm assurance about practice. Audits confirmed that between January 2015 and January 2016, staff scored 91% for recording an early warning score. Other audits showed that medicines and allergies were recorded in 100% of records between January 2015 and January 2016.

Pain relief

- Staff assessed pain using a scoring system between zero (indicating no pain) and ten (indicating significant pain). For children, staff used a pictorial chart, with a smiling face indicating no pain and a sad face indicating pain was present.
- Nurses provided pain relief such as paracetamol, codeine or ibuprofen if necessary during initial assessment, using Patient Group Directives (PGDs). PGDs permit the supply of certain medicines to some patients under strict criteria by healthcare professionals, without individual prescriptions. Other pain relief could be requested from medical staff if required.
- Line managers audited staff practice regarding pain management. In August 2016, staff scored 93% for asking about pain, recording details, responding with pain relief and seeing a reduction in pain. However, the audit had ceased since August 2016 because it related to elements of emergency care that the department no longer practised and was no longer appropriate.
- In the CQC Accident and Emergency (A&E) patient survey 2014, which reviewed emergency care across both the trust's emergency and urgent care departments, patients gave a score of seven out of ten for getting pain relief quickly after requesting it and eight out of ten for feeling staff did everything they could to control pain. These scores were about the same as other trusts surveyed in England.

Nutrition and hydration

- A housekeeper had responsibility for ensuring patients and loved ones were offered food and drinks where appropriate. However the housekeeper only worked four days each week. Outside of these times, nurses took responsibility.
- Toast, fruit, sandwiches and hot and cold drinks were provided for patients if required. Since becoming an UCC the department treated patients within an average 83 minutes which limited the need for patients to have meals provided.

- In the CQC A&E patient survey 2014, the trust (including the ED at Preston and the urgent care centre at Chorley) scored seven out of ten for providing suitable food and drinks for patients in the department. This was about the same as other trusts surveyed in England.

Patient outcomes

- The department contributed to mandatory national audits every three years by the Royal College of Emergency Medicine (RCEM). The latest audits for the Chorley site included: Asthma in Children (2013/14), Paracetamol Overdose (2013/14), Severe Sepsis and Septic Shock (2013/14) Mental Health in the ED (2014/15) and Assessing for Cognitive Impairment in Older People (2014/15).
- The audit for asthma in children found that staff did not document observations or provide treatment as quickly as they should. For example, out of 50 children, staff only documented a systolic blood pressure and peak flow reading in 4% of cases against targets of 100% (worse than the England average of 10%) and a specific treatment called Beta 2 agonist was given within ten minutes of arrival in 19% of cases against a target of 100% (better than the England average of 8%).
- The audit for paracetamol overdose found that out of 50 patients, none received a particular treatment drug (N-acetylcysteine) within the recommended hour of arrival against a target of 100% (comparable with than the England average). However, 84% of cases were deemed to have received recommended treatment generally which was better than the England average of 76%.
- In the audit of mental health, only 14% had a mental state examination, and 24% had a provisional diagnosis documented; both against targets of 100% (all worse than the England averages of 30% and 74% respectively).
- For assessing cognitive impairment in older people, none of the 50 cases reviewed showed that cognitive assessments had taken place (worse than the England average of 11%) or that assessment findings had been communicated to carers (same as the England average of 0%).
- Consultants told us outcomes for sepsis care were also monitored by a central team within the trust. However, when we asked for specific figures for the department, the trust were unable to provide them. This left us concerned that staff had no way of knowing how effectively they were identifying or treating this condition.
- Managers confirmed there were no specific action plans in place to address issues identified in audits.
- Managers told us that despite poor audit results they felt assured that the care provided was good. Instead of relying on audit outcomes, they based judgement on the belief that local clinical guidelines were good and that low levels of incidents relating to the audited elements of care were received. We remained concerned that indicators for the quality of care which benchmarked the department nationally were not being considered as thoroughly as they should be.
- Our concerns were heightened after we spoke with three medical and nursing staff who were not aware of any clinical audits being carried out. We were concerned that a lack of knowledge about what audits were being undertaken implied staff were not involved in monitoring outcomes to improve care.
- The trust monitored unplanned re-attendance to the UCC within seven days of discharge. Between March and August 2016, 4.7% of patients re-attended the department. This was lower (better) than the target of 5%.

Competent staff

- A practice educator facilitated training for UCC staff but was not based on site. One ED consultant was assigned to teach medical staff three to four times weekly. However differing comments from medical staff left us concerned that the teaching process was vague and not robust. We heard doctors say there was no training in the UCC, that they had not attended teaching sessions since April 2016, or that teaching was provided 'every other month'.
- Senior nurses managed nursing competencies by using workbooks which covered topics including patient triage, cannulation and venepuncture. This helped support staff to gain knowledge and experience in their roles.
- A process helped ensure staff received annual management appraisals. At the time of our inspection, only 60% of staff based in the UCC had received their

annual appraisal which was worse than the trust target of 85%. However, the trajectory for completion ran until April 2017 and managers expected that all staff would be up to date by then.
- Nurse revalidation was monitored centrally. Department leads received details of those approaching revalidation each quarter. Staff involved in the process told us that some nurses had completed revalidation with no problems.
- Competencies for Patient Group Directives (PGDs) were reviewed every two years to reflect new guidance.
- Staff rotated between the trust's UCC and ED if they wished to maintain skills with emergency as well as urgent care.
- In addition to mandatory training, extra training for nurses was provided in areas such as sepsis, bereavement and handover of patient details during induction.

Multidisciplinary working

- UCC staff worked with ambulance staff to ensure that patients attending the UCC did so appropriately. Following the introduction of criteria for bringing patients to the UCC, nurses told us ambulance staff often rang ahead to be sure staff could accept patients based on their clinical condition.
- Despite the UCC being closed after 8pm, reception staff and private ambulance staff worked together in the department overnight. This ensured there was always medical assistance available should a patient attend for urgent medical assistance out of hours.
- UCC and security staff worked closely together, helping ensure staff and visitors were kept safe.
- Staff worked with the Hospital Alcohol Liaison Service (HALS) and the Proactive Elderly Care Team (PECT) to ensure appropriate patients were referred for ongoing care if required. The PECT included geriatricians, physiotherapists and occupational therapists who assessed mobility, aid requirements or onward support for elderly patients. The HALT included specialist nurses providing assessment, interventions and advice to patients, family, caregivers and staff about alcohol-use. ED nurses told us both teams were responsive to the needs of patients.
- The trust bereavement team supported patients and loved ones should they be required. They were contactable via the hospital bleep system.
- Staff worked with mental health nurses and approved mental health professionals from a local NHS trust to provide care and support for mental health patients.
- The housekeeper worked closely with estates and canteen staff to ensure equipment was maintained and food and refreshments were available for visitors.

Seven-day services

- The UCC was open every day, 365 days a year to provide care for patients.
- The Proactive Elderly Care Team (PECT) and Hospital Alcohol Liaison Service (HALS) were available between 8:30am and 4:30pm, seven days a week.
- The trust bereavement team worked seven days a week (including bank holidays) between 9am and 5pm, and chaplaincy services were available 24 hours a day, seven days a week.

Access to information

- Staff we spoke with (including reception staff, nurses and doctors) said they had access to the information they needed to care for patients.
- We saw that information about patients who attended either of the trust's hospitals including previous visits, referrals, safeguarding concerns or particular clinical needs were available via the trust patient management system.
- Doctors said test results came though quickly for computerised tomography, X-ray and blood results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff worked on the principle of implied consent (consent implied by way of actions) when caring for patients able to make decisions. For those unable to make decisions about their care (for example, unconscious patients) decisions were made in line with best interests.
- For patients receiving care under the Mental Health Act, mental health liaison nurses were available to provide care 24 hours a day seven days a week. Staff also liaised with a local mental healthcare NHS trust who undertook assessments and initiated care plans for patients if necessary.
- We saw reception staff obtain verbal consent to share details with people who might ring to enquire about a loved one.

Urgent and emergency services

Are urgent and emergency services caring?

Good

In our previous inspection in July 2014 we rated caring as good and following this inspection the rating remains good. This was because:

- Patients told us staff caring for them were 'friendly' and 'supportive'.
- Patients completed surveys which showed 93% would recommend the service to friends and family members.
- In the CQC Accident and Emergency Survey 2014, patients said they were given enough time to discuss their problems with staff, had confidence in staff, felt they could summon staff if needed and felt involved in their own care. They also felt staff gave them enough privacy and dignity.
- We saw staff caring for patients in a kind and sensitive manner, taking account of their situations. The housekeeper described obtaining basic food items for some elderly patients who attended.

Compassionate care

- Patients rated their experience of the UCC in the NHS Friends and Family test. Between July and August 2016, 93% said they would recommend the service to friends and family members (better than the England average of 86%). The average response rate was 18% (also better than the England average of 13%).
- We spoke with 14 patients and visitors in the waiting area. They told us they were happy with the care provided and described staff as 'friendly' and 'supportive'. They told us they 'never had a problem' and that 'staff [were] respectful'. Reception staff were described as 'smashing'.
- In 2014 the CQC surveyed patients in Emergency Departments across England and provided scores out of ten for certain elements of care. Combined figures were provided for both the ED at the trust's other site in Preston and the urgent care centre site at Chorley which at the time was also an ED.
- In the survey, patients scored the departments nine out of ten for being given enough time to discuss their problem with staff (better than the England average). They also scored nine out of ten for feeling staff listened to them; having confidence and trust in staff and not feeling staff spoke to each other as if they were not present. Patients scored eight out of ten for feeling they could summon a member of staff if they needed attention and for feeling involved in their own care. These scores were all about the same as other trusts surveyed in England.
- In relation to privacy and dignity, patients gave the departments scores of nine out of ten for treating them with dignity and respect and giving them enough privacy during examination or treatment.
- We saw staff caring for patients sensitively, taking account of their injuries and responding sympathetically. Reception staff sourced details from patients in a polite and respectful manner.
- The housekeeper explained that in some cases requests were made to the canteen for basic groceries such as milk and bread to ensure elderly patients (who had often fallen on their way to purchase groceries) were provided with prior to leaving the UCC.

Understanding and involvement of patients and those close to them

- In the CQC A&E patient survey, patients scored the departments as eight out of ten for feeling staff explained why tests were required and nine out of ten for feeling staff explained test results in a way they could understand.
- The departments also scored six out of ten (better than the national average) for taking family or home situations into account and nine out of ten for providing enough information about their condition or treatment.
- Overall, patients gave a score of eight out of ten for feeling involved in decisions about care or treatment whilst in the departments.
- Patients told us medical staff gave them time to talk through their problem and explained everything, including the next stage of treatment. Only one patient out of 14 said that they had to ask staff to explain everything to them.

Emotional support

- The trust chaplaincy service was available 24 hours a day seven days a week to provide spiritual assessment and support for those experiencing loss or feeling isolated in the department.

Urgent and emergency services

- Bereavement services were also available every day to support patients nearing the end of life, and their families, as well as helping recently bereaved families of patients who have been cared for in the department.

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

(for example, to feedback?)

Good

At the previous inspection in July 2014 we rated responsive as good, following this inspection the rating remains unchanged following this inspection. This is because:

- Following our previous report where we highlighted the need to manage waiting times, we saw that following the change in purpose from an ED to a UCC, waiting times were now consistently meeting national targets.
- The number of patients seen within 4 hours was over 99% between May and September 2016 which was an improvement from when the department was an ED when the 95% target was not met with 77% in March and 85% in April 2016.
- The time to initial assessment had improved and was within 5 minutes between June and September 2016. This was well within the national target of 15 minutes.
- The total average time patients spent in the department between March and August 2016 was one hour 47 minutes. This was around half the length of time patients spent in the RPH ED.
- Between March and August 2016, the time taken to provide treatment ranged between 29 and 88 minutes with an average time of 45 minutes. This was an improving picture and from May 2016 the time to treatment was half that reported in March 2016.
- Despite the change to a UCC the department maintained processes for providing emergency care or transfer to the trust's main ED on an ad hoc basis should this be required.
- Staff were familiar with the needs of local people. There were toys for children, ample seating and a chaplaincy service covering a range of religious faiths. A hearing loop was available for patients with hearing problems and a process for identifying potentially vulnerable patients living with Dementia. Patients could be referred for specialised frailty care or support managing alcohol related problems.
- Complaints were managed through an established process.

However:

- Despite improved waiting times, some local people felt their needs were not being sufficiently met following the change in care provision and wanted the previous emergency care reinstating.
- Although services were in place for people living with dementia, staff gave vague responses when asked about care.
- Reception staff were unable to locate approved phrase books to assist with language barriers which meant they used a public web based translation service if patients did not have written details with them. Although leaflets were available providing information following discharge from the UCC, none of these were displayed in languages other than English.
- Despite senior staff being aware of complaints through monthly governance meetings, we were less assured that this information was disseminated to staff as staff meetings were infrequent.

Service planning and delivery to meet the needs of local people

- Staff were familiar with the needs of local people from a range of different backgrounds and cultures.
- Waiting areas for adults and children had ample seating, toys, television and magazines.
- As a number of patients were elderly, a Proactive Elderly Care Team (PECT) worked specifically to offer support with specific needs. This helped patients return home as soon as possible.
- The chaplaincy service had access to 32 different religious leaders and there were weekly prayers and services for patients and visitors of Christian and Muslim faiths.
- Following the change from providing emergency to urgent care in April 2016, some local people voiced disappointment, telling us they wanted emergency care reinstating. Managers acknowledged this but explained that safe staffing numbers remained their priority. They were working to reinstate emergency care once staffing levels improved. Managers also added that even as an

emergency department, several clinical conditions had always required care at the trust's main ED including paediatric, stroke, cardiac and trauma care. This element of care therefore remained unchanged. Managers explained that by temporarily changing the department the service was responding to the risk posed by inadequate staffing levels and providing safer more appropriate care to local people. In the meantime, the department ensured provision to deal with a medical emergency or ambulance transfer to the main ED was still available during and outside of opening times if necessary.

- Of the 14 patients and visitors we spoke with, two said the car park was problematic given that they had to pay a fee and could not park for more than three hours. However given the average time in the UCC of 83 minutes (between May and August 2016) we were satisfied that three hours was a suitable timeframe and ensured parking spaces were not used for longer than necessary.

Meeting people's individual needs

- Patients living with dementia were identified subtly through the use of a cut out flower shape on their wrist band. This ensured staff could see which patients had needs associated with dementia when providing care. However some nurses were vague when we asked about dementia. They told us there was a dementia policy but they did not know where it was.
- Nurses and reception staff were familiar with the use of 'hospital passports' which patients with learning disabilities or complex needs often carried with them to provide information about conditions, needs, likes and dislikes. Patients also had access to a particular room with a quieter environment which may be less stressful.
- Clinical staff could source telephone translation services if required. Face to face translation was also available but advance notice was required which was not always possible given the nature of urgent care. Reception staff told us that patients whose first language was not English often carried identification which allowed them to process details without difficulty. They told us they rarely used telephone translation for this reason. They told us they used a phrase book for visitors unable to speak English who arrived without identification, but could not locate this for us when we asked to see it.
- Services such as the Hospital Alcohol Liaison Service and the Proactive Elderly Care Team provided specialist care for patients with particular needs.
- Information leaflets were available for patients to take home following their visit to the ED. These covered aftercare for different conditions such as gastroenteritis in children and nose injury. However we noted that the leaflets were only in English. Nursing staff were not sure how to obtain leaflets in other languages.

Access and flow

- During our previous inspection we told the trust to improve mechanisms for achieving and maintaining performance to meet targets. Following the change in care provision from emergency to urgent care, the department had reduced waiting times for patients against all these targets.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. We reviewed data between March and August 2016 which showed that prior to changing the department from an ED to a UCC (March and up to 18 April 2016) the target was not met (77% in March and 85% in April). However, following the change, the centre had consistently met the target between May and September 2016 with an average of 99.7% of patients admitted, transferred or discharged within the four hour target. May 2016 was the first time since August 2015 that this target had been met.
- Other elements of care were also monitored by the trust and reported nationally. These included the average time taken to complete initial assessments, the percentage of patients waiting between four and 12 hours for admission following a decision to admit being made, the total time spent in the department, and time taken to provide treatment.
- Between March and August 2016, the average time taken to complete an initial assessment was seven minutes, which was within the national target of 15 minutes.
- Between March and April 2016, 80% of patients requiring admission waited between four and 12 hours from the point of decision to admit and actual admission. This figure decreased following the change of purpose from an ED to a UCC. For example between May and August 2016, the average rose to 97%.

Urgent and emergency services

- The total average time patients spent in the department between March and August 2016 was one hour 47 minutes.
- Between March and August 2016, the time taken to provide treatment ranged between 29 and 88 minutes with an average time of 45 minutes.
- Doctors we spoke to told us they had no problems with flow in the department in that patients were admitted or transferred without delay.
- In the wider hospital, bed meetings were held to focus on maintaining flow throughout the hospital. This helped ensure that beds were available for patients to move out of the UCC following admission.
- Some patients were referred to a co-located primary care GP service following triage if their condition did not require urgent care or treatment. Run by the local clinical commissioning group, managers were concerned that a recent change in service provider would impact on flow in the ED. This was because the current contract was due to cease two months prior to the new contract date. At the time of our inspection, the managers were unsure of arrangements to cover this shortfall.
- Patients requiring computerised tomography scans or X-rays experienced minimal delays, with an imaging area situated close by to the department. This made the process of investigation and formulation of care plans more efficient.
- We noted there were no formal procedures to help staff decide when pressures in the department required escalation to senior trust managers. Instead, experienced staff made decisions based on judgement. However managers explained that following visits to local NHS trusts, a new electronic system would be implemented which would act as a formal escalation tool for staff.

Learning from complaints and concerns

- Between 1 August 2015 and 31 July 2016, the ED received 18 complaints. Of these, 14 related to clinical care, two were about attitude of staff and the remainder were about discharge or transfer arrangements and communication.
- Advice to help patients and visitors make complaints was available in leaflets or via the trust's Patient Advice and Liaison Service (PALS). Complaints about nursing care were investigated by the Matron and medical care issues were investigated by the consultant on call at the time of the incident.
- One staff member acted as a link for complaints and compliments in the department. They compiled and monitored trends, and supported staff through the process. Another administrative member of staff acted as a central point of contact for complaints, distributing them to the appropriate managers for investigation.
- Nursing concerns were investigated by the Matron and consultants reviewed medical complaints.
- Information about the nature of, and outcome of complaints was shared at monthly governance meetings. Compliments were also discussed. However we were unsure how well details were disseminated to staff given that staff reported meetings were not held regularly. For example, staff told us this and minutes of meetings sent to us by the trust only related to the trust's ED with nothing included in relation to the UCC.

Are urgent and emergency services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good, following this inspection we have rated well led as requires improvement. This is because:

- Although risk registers were in place, these did not include enough information and were not specific to the ED. Some risks such as issues with meeting national targets were not included.
- Governance measures were in place but information was not broken down to department level which could result in staff being unaware of basic governance matters such as cleanliness or record keeping standards
- Staff reported that staff meetings did not occur regularly, which posed a risk that governance information may not be disseminated effectively
- Actions to mitigate risks were in place but we saw evidence that these were not always effective. Furthermore, the

- The culture was affected negatively by staff feeling unsure about plans for the future. They described an atmosphere of mistrust and suspicion. We also heard numerous staff tell us communication was not good which was a contributory factor.
- Staff engagement and communication was described as 'awful' by staff, particularly about the change from ED to UCC provision.

However:

- Staff spoke highly of their colleagues within the department.

Leadership of service

- Reception and cleaning staff told us they liked their line managers. Cleaning staff described being supported by the trust during difficult times.
- The situation was different amongst medical staff. Some only some consultants felt supported by senior leaders in the organisation particularly when introducing new ideas into practice. Some staff felt that trust leaders were not as visible as they were at the trust's ED in Preston. One doctor said their contact with senior managers was 'rare'.
- Nurses, medical and reception staff felt that not enough had been done to keep them informed about the change in service provision from emergency to urgent care.

Vision and strategy for this service

- The trust vision was to be recognised for providing acute and specialist services with high standards of compassionate, safe and research driven, innovative care. We saw that this vision partially formed the approach to care delivery for patients attending the UCC such as recognising and working to provide safe care and interacting with patients with care and compassion. However, teaching did not appear to be regular with medical staff reporting fewer teaching sessions than managers described (weekly).
- The trust strategy for 2014-2019 included elements specifically related to building an UCC. However the strategy stated that this would be in addition to operating the ED. Instead, the trust had taken the decision to change the current ED to an UCC. Whilst this was unforeseen at the time the strategy was published, no addition or adjustment had been made to ensure the strategy was aligned with the new service. The trust acknowledged that the change from an ED to an UCC was temporary and that the board remained 'committed to reinstating the emergency department as soon as [there were] enough doctors to provide a safe and sustainable service'. Despite this, we remained concerned that the trust strategy may not adequately reflect this change in service.

Governance, risk management and quality measurement

- Governance was in place, but we found information about important topics such as cleanliness and quality was only available at divisional level rather than being broken down to each department. This meant that staff could not identify the level of their own performance.
- Risks in the department were managed with process such as security staff and panic buttons in the reception area. However, we were concerned that these were not effective. When we asked reception staff to press the panic button, we saw no one responded. When we asked staff to press the button again, one member of staff walked over without urgency. Reception staff were not surprised by the response. This left us concerned that although processes to mitigate were in place they were not adequately actioned when implemented.
- The risk register was in place but incorporated risks for the division of medicine rather than specifically for the ED. The register did not include start dates, or any timeline or actions to mitigate the risk. We were concerned that without including important details for the department there may be a lower level of awareness of the risk.
- Nursing staff told us that staff meetings had not taken place since the department changed to a UCC in April 2016. When we asked for minutes of staff meetings the only documents sent to us related to the trust's ED and not the UCC. This left us concerned that staff were not provided with the opportunity to discuss issues, receive feedback or hear about outcomes, or new developments.

Culture within the service

- Doctors and nurses told us the culture was more positive following the change from an ED to a UCC, given that patients were now provided with safer care by the right number of staff.
- However, senior managers said the change from an ED to a UCC had affected their morale in other ways. Whilst

they felt strongly that they had made the right decision in influencing the change of the other service to providing urgent care, the local political and media responses had been difficult to cope with and left them feeling their reasoning had been misinterpreted.
- Reception staff described lowered morale brought about by uncertainty following the change from an ED to a UCC. They told us they did not know whether jobs would remain which was distressing given that many of them had worked for the department for a number of years. Supervisors were unable to allay anxieties due to being unsure as well.
- Cleaning staff confirmed this culture of uncertainty telling us 'no one knows what's happening'.
- One member of staff described vague information about plans for the department which fostered 'a culture of mistrust and suspicion'.
- Other feelings of uncertainty remained regarding changes to the co-located primary care service. A new organisation was due to provide this service in November 2016, following a tender bidding process but the current provider would cease work in September 2016. Senior managers were liaising with the local clinical commissioning group to ensure service provision continued between September and November.
- All the comments we received from staff led us to conclude that communication with staff was not as good as it should have been.
- More positively, staff spoke highly of each other with doctors describing the nurses as 'fantastic' and 'a credit to the hospital'.

Public engagement

- Patients were encouraged to complete the NHS Friends and Family survey following their visit to the ED.
- The department was involved in work to educate the public regarding the decision to temporarily change the ED to an UCC. Leaflets were available for the public in the reception area, and clinical managers met with a local Member of Parliament (MP) to discuss the change. The trust website displayed information, including answers to a range of queries and responses to suggestions made by the general public. Leaflets were also distributed via local doctors' surgeries and executive managers held public meetings as part of the process.
- Despite this, staff told us they did not think local GPs had been properly informed about the change in service provision because some patients were signposted there based on the incorrect assumption the department was still an ED.

Staff engagement

- Reception staff did not feel communication was adequate. This was because they felt unaware of future developments which made them feel anxious given the change from an ED to a UCC. They also described a lack of communication day to day. For example, they were not always aware of clinics running in the department, which led to confusion when doctors arrived to see patients.
- Other clinical staff described communication as 'awful', stating that staffing was being reduced without effective consultation with them. Another clinical staff member said that management had 'dealt badly with communication this year' and that management 'promised a weekly meeting which had only happened twice' since April 2016.
- Senior managers told us that executive (trust) managers liaised with and supported them through the change in service provision to urgent care only, which directly affected the department with staff changes and decreased attendances. This was done through staff forums and focus groups and visits from executives to the department itself.

Innovation, improvement and sustainability

- Sustainability issues had already led to the service being changed from a 24 hour ED to a UCC open during the daytime. The trust were hoping to move towards providing emergency care for patients in the future and liaised regularly with the local clinical commissioning group to ensure this could be done safely.
- Staff felt care had improved following the change to a UCC where now, care was provided more appropriately with a better patient to staff ratio.

Medical care (including older people's care)

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

Information about the service

Medical care services at Chorley and South Ribble Hospital provide care and treatment for patients with a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology.

There are a total of 130 medical beds at the hospital. The hospital provides medical care services to a population of 390,000 people living in South Ribble, Chorley, and Preston boroughs and between March 2015 and February 2016 there were 14,737 admissions.

We visited Chorley and South Ribble Hospital as part of our announced inspection on 29 September 2016 and carried out an unannounced visit on 14 October 2016.

As part of this inspection we visited the medical assessment unit (MAU), coronary care unit (CCU), Brindle ward (respiratory), Hazelwood ward (gastroenterology), Rockwood A (general medicine), Rockwood b ward (elderly care), the endoscopy unit and the dialysis unit.

We reviewed the environment and staffing levels and looked at 11 care records and 22 medication records. We spoke with one family member, 11 patients and 36 members of staff of different grades, including nurses, doctors, ward managers, matrons, ward clerks, discharge liaison officer, allied health professionals (such as physiotherapists and occupational therapists), and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience. We reviewed performance information about the trust and we observed how care and treatment was provided.

Medical care (including older people's care)

Summary of findings

We have previously inspected the hospital in July 2014 and gave medical services an overall rating of Requires Improvement.

Following this inspection we rated medical services at Chorley and South Ribble Hospital overall as requires improvement because:

- There were vacancies across medical services and there had been a reliance on agency or bank nurses as well as locum doctors to fil gaps in staffing.
- Nurse staffing levels on occasions were not always sufficient to meet the needs of patients and on these occasions care was prioritised however there were times when some staff felt staffing levels were unsafe.
- Clinical staff had access to information they required. However, we found standards in some record keeping required improvement and patient's records were not always stored securely.
- There were safe systems of the handling and disposing of medications. However we saw evidence these were not always followed and prescription record were stored at patient's bedside which meant they were accessible to patients and members of the public at all times.
- Compliance with mandatory training was below the trust target for all staff.
- There were ongoing issues with the access and flow of patients across the medical wards and there were occasions where there was insufficient bed capacity on the medical wards to meet the needs of people. However there were systems in place to ensure those patients on non-medical wards were reviewed by the medical team.
- There were a number of patients who did not stay in the same ward for the entirety of their time in hospital with some of those being moved during the night.
- There were governance structures in place which included the risk register however we are not assured of there was clear oversight or ownership of the risk register.

However :

- There were systems in place to keep people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.
- The hospital was clean and staff followed good hygiene practices.
- The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not booklets for people living with dementia or a cognitive impairment.
- We observed care and found this to be compassionate from all grades of support and clinical staff and patients were involved in their care and treatment.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to nurse staffing concerns, we have maintained this rating following this inspection because:

- Staffing across medical services was on the risk register and actions had been taken to help mitigate the risk, including ongoing monthly recruitment and regular monitoring of staffing levels during the day. However, there were occasions where the nurse staffing levels were not overall sufficient to meet the needs of patients and there was a reliance on most wards to use agency staff and staff to work extra shifts as part of the nurse bank to support ward areas.
- Compliance in Levels 2 and 3 in adults and children's safeguarding training were 61% and 54% which was below the trust target of 75%.
- Risk assessments were not always completed in a timely manner and records were not always completed, with one patient put at risk due to not having any pressure relieving equipment in place during their stay in hospital.
- An audit performed by the trust showed that there was lack of compliance with monitoring and escalating deteriorating patient's wards on the medical assessment unit at the hospital.
- There was no formal process for 'at risk' patients to be handed over between medical staff during out of hours however they did attend the meeting with the hospital at night team. This had been acknowledged by the senior managers who told us an action plan was to be submitted.
- During our inspection we observed on two occasions that staff were not wearing protective equipment when caring for patients.
- Prescription charts we looked at were not always completed thoroughly and we saw occasions where patient safety had been compromised, for example one patient was administered double the dose of medications on two occasions.
- Patient records were accessible to the public, as some records were left at the patient's bedside and some records trolleys were left unlocked.
- We found used sharps containers which had been left open in unlocked areas, which were accessible to patients and the public.

However:

- Incidents were reported by staff through effective systems and lessons were learnt and shared with staff. Although we were not always assured that all actions had been completed.
- Medical wards at the hospital were generally visibly clean and staff followed good hygiene practice,
- There were systems in place to protect people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse.

Incidents

- There were systems in place for reporting actual and near miss incidents across medical services. Staff were familiar with the process for reporting incidents and they understood their responsibilities to raise concerns and record safety incidents.
- All incidents were reviewed by the ward manager and the divisional governance or risk team, who ensured all appropriate measures had been taken and investigations carried out For example, when a fall had occurred, risk assessments and preventative measures were put in place and if injuries were sustained, this had been managed appropriately. The divisional governance and risk team also monitored themes and trends, which were shared with the safety and quality committee.
- From January 2016 to June 2016 there were 3106 incidents reported across the medical division, these were mainly in relation to unwitnessed falls, laboratory investigations/interpretations and inappropriate aggressive behaviour issues towards staff member. Of those, 731 (23%) resulted in harm to patients.
- Trust data showed there have been 15 serious incidents reported across medical services trust wide between June 2015 and July 2016, 12 of these were falls. A root cause analysis tool was used to investigate serious incidents and we saw that lessons were learned and where required an action plan was put in place to reduce the risk of the incident happening again. Two action plans we reviewed included a timescale, however, there was no evidence of completion, and therefore we were not assured that all the actions had been completed.

- Staff told us that learning from incidents was discussed during team meetings or at handover. One member of staff gave an example of an incident, which had occurred on another ward that had been shared with their team. We reviewed team meetings on one ward and found incidents were discussed.
- Staff shared with us examples of learning and changes to practice following an incident. For example, following an incident on the medical assessment unit (MAU): a patient was told they could go home by a doctor, but this was not recorded in the patient's records, which caused confusion and delayed discharge. Doctors and nurses now communicate more frequently with the nurse checking that all information has been documented in the patient's records.
- The trust had a policy for duty of candour and all staff we spoke with had an awareness and understanding. 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. Staff understood the principles of the duty of candour and gave examples of when this had been applied.
- The trust provided minutes from mortality and morbidity reviews for services across the medical division, which included surgery. We were unclear as to whether mortality and morbidity reviews where held across medical services, as the only data provided was the minutes from an audit meeting, which included a presentation of mortality review of patients on MAU from January to April 2016. However it did not stipulate whether this was at Chorley and South Ribble hospital or at the Royal Preston hospital. The results showed areas of improvement, for example input from the palliative care team and sharing results with the surgical team. Attendees were not documented and therefore we were not clear what representation there was from medical services. We requested further minutes from morbidity and mortality meetings for medical services but we did not receive these at the time of writing the report.

Safety thermometer

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- From August 2015 to August 2016 there were 5 pressure ulcers reported across medical services at the hospital. In the same period, there were 12 venous thromboembolisms, 10 catheter-acquired urinary tract infections and 5 falls which resulted in harm.
- The trust was participating in the 'NHS sign up to safety' campaign, with the goal to reduce avoidable harm by 50% and save 6,000 lives nationally. A safety improvement plan was developed by the trust, which identified key areas to focus on reducing avoidable falls with harm, reducing avoidable grade 3 pressure ulcers and eliminate grade 4 pressure ulcers and reduce avoidable healthcare infections. An action plan had been developed with actions, goals and timescales. We observed that some of the actions had already been implemented, with others ongoing.
- A falls improvement programme had been implemented, which included completion of SWARM which was a post fall rapid review following a fall, in addition to reporting the incident. Falls resulting in serious harm were reviewed by the case review group and learning from falls was shared in a quarterly newsletter. We reviewed a completed SWARM assessment following an unavoidable fall, however, it had not been documented whether there were any lessons learnt or whether the incident and findings had been fed back to staff.
- Staff on the wards were aware that there had been a high incidence of falls and they explained actions they would take to prevent patients falling, including nursing those at risk in enhanced bays, using alarm cushions and providing slipper socks. Link nurses for the patient safety group disseminated information and attend falls training. Data provided by the trust showed that staff who had attended falls training trust wide varied across medical services, with trained nurses ranging from 0% (neurology and diabetes) up to 50% (core therapy services).
- Senior managers told us that there had been a reduction in falls and pressure ulcers following the implementation of falls reduction strategies, including falls and pressure ulcer risk assessments being performed on all patients on admission, the use of falls alarms, falls prevention training and introduction of

repositioning charts and a tissue viability link nurse on wards. On reviewing the safety thermometer from the previous year, we noted that during August 2014 to August 2015 there were 28 falls resulting in harm and 76 pressure ulcers had been reported, compared to 12 falls and 35 pressure ulcers having been reported between August 2015 and August 2016.

Cleanliness, infection control and hygiene

- Data provided showed that between April 2015 and March 2016 there were 32 cases of Clostridium Difficile reported across medical services trust wide, which was below the target of 35.
- From September 2015 to September 2016 were 4 cases of methicillin-resistant staphylococcus aureus (MRSA) reported across medical services trust wide which was higher than the trust target of 0 and 20 incidents of methicillin-susceptible staphylococcus aureus (MSSA). We do not have the trust target for MSSA.
- Cleaning schedules were in place across the wards, with allocated responsibilities for housekeepers and ward staff, for cleaning the environment and equipment. We reviewed cleaning schedules on MAU and saw there were days when the tasks were not completed due to the housekeeper days off; in addition there was a period of 10 days in September where the housekeeper was on annual leave. The ward sister told us that there was no longer 7 days cover, as one of the housekeepers had moved to another ward. Cleaning schedules for ward staff were also not consistently completed and therefore we are not assured that all cleaning tasks were performed on a regular basis.
- The wards and areas we inspected were visibly clean and free from odour. All equipment we viewed was clean and we observed the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Hand hygiene audits were carried out monthly across medical wards. Results from hand hygiene audits between January 2016 and October 2016 showed that all the wards achieved above the 95% trust target, apart from July which reported 85% compliance. We requested action plans from the trust, but we had not received these at the time of report writing.
- There were sufficient hand washing basins and hand sanitising gels. Hand towel and soap dispensers were adequately stocked. All wards had antibacterial gel dispensers at the entrances, with appropriate signage, regarding hand washing for staff and visitors.
- Personal protective equipment (PPE), such as aprons and gloves, were readily available and in use in all areas. During our inspection we observed staff followed hand hygiene practice and 'bare below the elbow' guidance, however, we noted a phlebotomist taking blood without gloves on and a care assistant who only applied an apron and gloves part way through providing care. According to The World Health Organisation (2010) and National Institute for Health and Care Excellence guidelines 2 (2012) guidelines state that gloves should be worn if there is risk of exposure to blood.
- Side rooms were used as isolation rooms for patients identified as an increased infection risk (for example patients with MRSA). There was clear signage outside the rooms, so staff and visitors were aware of the increased precautions they had to take when entering and leaving the room.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance and sharps containers were signed and dated upon assembling them apart from two on Brindle ward. We also saw that sharps containers did not have the temporary closure in use and sharps on three of the wards we visited which meant that used cannulas and needles were accessible to patients and the public. We raised this with staff who immediately closed the containers.

Environment and equipment

- The wards and areas we visited were well maintained. There were systems in place to maintain and service equipment. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date.
- All clinical rooms were locked on the wards we visited apart from a room containing clinical waste on Hazelwood ward. We escalated this to the nurse in charge who closed it.
- Resuscitation equipment was available on all the wards we visited. The resuscitation trolleys were locked however we noted that intravenous fluids were accessible to members of the public within the trolleys. During our inspection this was reported to the trust and appropriate actions were taken to secure these.

- There were systems in place to ensure that emergency equipment was checked and ready for use on a daily basis. Records indicated that daily checks of resuscitation equipment had taken place on all the wards we visited, however, on the medical assessment unit they had not been completed in September 2016 on four occasions. Staff told us that in a recent resuscitation audit they had been rated 'red' due to failure to complete checklists. We have requested this from the trust however at the time of writing have not yet received this.
- During our inspection we observed that some of the oxygen cylinder valves on the resuscitation trolley had stickers in place to identify it had been checked and some did not. In addition we saw two stickers that indicated the valve check was overdue and we escalated these to the nurse in charge at the time of inspection. We requested the results of the most recent resus audit however at the time of writing the report we had not received it.
- Pressure relieving equipment was available from the stores department on site and staff told us that if it was not in stock, then equipment could be ordered and would be sent within 4 hours. However, if this occurred at the weekend, then patients would have to wait until Monday, although staff told us this rarely happened. Staff told us they would change the patient's position more frequently and monitor the patient closely.

Medicines

- There were suitable arrangements in place to store and administer controlled drugs (CD). All stock balances were correct on the wards, apart from Rockwood B ward, where we found that medication documented in the CD register was not present in the controlled drugs cupboard. This was escalated to the matron and it was identified that this was a transcription error and the medication had been returned to the patient, as documented in a previous CD book.
- Suitable cupboards and cabinets were in place to store medicines. This included a designated room on each ward to store medicines. All medicines we checked on the wards were found to be in date, indicating that there were good stock management systems in place.
- Staff on medication rounds wore red tabards to highlight to other staff that they were not to be disturbed when they administered medication to patients, thus reducing the risk of error.
- As a result of incidents reported on Rockwood A ward, where prescriptions charts had not been fully completed, an audit was performed on the ward from 1 to 30 May 2016.The audit concluded that there was a discrepancy between medications prescribed and the documentation of them being dispensed and an action plan was implemented. When we visited the ward, we saw that all the actions had been completed.
- We looked at 22 prescription records and observed that seven of those were not fully completed; reason for omitting a medication not recorded on six prescriptions and one prescription was not signed. We also identified that inhalers were not prescribed or recorded on the prescription chart as per trust policy of two patients who were self-administering inhalers. Ward staff told us they would assess the patient but not formally or complete any documentation. The chief pharmacist told us it was trust policy that patients could self-administer inhalers, as long as a risk assessment had been completed.
- During our review of prescriptions, we saw that a patient had received twice the prescribed dose on two consecutive nights; this was immediately escalated to the matron who discussed it with the medical team and told us they were going to report it as an incident.
- During our inspection staff shared with us an incident regarding a patient who had self-prescribed two controlled drugs, including an opiate. We viewed an RCA, which confirmed the patient had not taken one of the drugs but did not clarify about the other drug. It was documented that staff responded and took actions immediately, including removing the patients records from the bed side. An action plan was completed, however, we did not see any documentation regarding lessons learned.
- There was a process in place if medications were not available on the ward; staff could either access the intranet database to direct them to the ward with stock availability, access the emergency drug cupboard or contact the on call pharmacist. However, we were unsure if this process was being followed by all staff, as during inspection we noted two drugs had not been administered for three days due to availability, but when we asked a member of staff to check availability of the drugs on the intranet, we saw that the medications were available on other wards.
- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in

fridges. Records indicated that fridge temperatures were checked daily on the ones we looked at, apart from Hazelwood Ward, which had entries missing. On one occasion we noted that the temperature had gone out of range, however, staff had recorded the appropriate action taken.

- Data provided by the trust showed that there were 375 medication incidents reported across medical services, trust wide, from 4 January 2016 to 31 July 2016. However, we noted that there had been delays in reporting some of the incidents, with the earliest dated back to August 2015. Of the 375 medication incidents, 40 resulted in low harm, four resulted in moderate harm and the rest resulted in no harm. Medication incidents were discussed at the medicines safety group.
- We observed incidents reported and concerns were shared with us regarding unsafe discharges mainly around missing medication on discharge. One incident was regarding a patient who had been discharged without clear instructions for district nurses to crush medication prior to administering. We saw that lessons had been learned and this was shared with staff.

Records

- Patient records were completed electronically and on paper; two members of nursing staff acknowledged this potentially could cause a problem in consistency of care. Electronic records were accessible by inputting a personalised password, however, during the inspection, one member of nursing staff on a ward could not access the electronic records as their password did not work, which meant that they did not have access to all the information about their patients.
- On entering patient information, the electronic system prompted staff to follow an algorithm, which staff thought was helpful. For example, if staff entered 'yes' to a patient having a deprivation of liberties in place, this would prompt staff to report an incident, consider a care package, a mental capacity act review and input any identifiable characteristics such as tattoos should the patient go missing.
- In the 11 records we looked at, documentation was accurate, legible, signed and dated. They were easy to follow and medical staff had detailed information for patients' care and treatment.
- Patients had an individualised care plans that were regularly reviewed and updated in the records we reviewed.
- Patient medical records were stored in lockable trolleys, however, during our inspection we observed that trolleys were unlocked on MAU and the endoscopy unit and patients' records, including observational charts and prescription charts, were kept at the end of patients' beds on all the wards, which increased the potential for patient confidentiality to be breached.

Safeguarding

- The trust had a designated safeguarding team and there was a system in place for raising safeguarding concerns. Staff we spoke with were aware how to access the safeguarding team.
- Training statistics provided by the trust showed that compliance in Level 1 in adult safeguarding training trust wide and Level 1 children's safeguarding across the medical division was above the trust target of 90%.
- Compliance in Level 2 and Level 3 adult safeguarding training across the medical division trust wide, was 61 % and 54% respectively which was below the trust target of 75%.
- Compliance with Levels 2 and 3 children's safeguarding training across the medical division was 33% and 60% respectively which was also below the target of 90%.

Mandatory training

- Mandatory training, such as mental capacity act, health and safety, fire, manual
  - handling and infection control was available in group session format or via e-learning. Staff told us they would receive emails to alert them when training was due, however, some told us they struggled to complete training due to other work commitments.
- Mandatory training was on the divisional and trust risk register and it was noted that mandatory training had been cancelled to facilitate staffing levels. Senior managers told us staff had the opportunity to get paid and complete online training at home.
- Information provided by the trust showed that in August 2016, overall compliance rates with mandatory training for the medical division trust wide was 78%, which was below the trust target of 80%.
- Additional data provided by the trust showed various targets for individual courses, for example, consent was 40% and information governance was 80%. Compliance for nursing staff across the medical division was 47%, with staff achieving the trust target in seven of the

twenty eight courses, including consent, intravenous administration and conflict resolution. Medical staff across the medical division overall compliance was 52%, with four of the 24 courses achieving the trust target, including consent and information governance.

Assessing and responding to patient risk

- There was a policy in place for timely recognition and response for patients at risk of deterioration, for staff to refer to. In addition, staff had access and support from the critical outreach team, seven days a week, from 8am until 8pm and overnight from the hospital at night team.
- The National Early Warning Score (NEWS) - tool was used to identify deterioration in a patient's condition. There was evidence in patient notes of this tool being used. Staff were clear about procedures to follow when a patient was deteriorating, by alerting the on-call medic at the earliest opportunity, whilst continuing with vital sign observations.
- The ward manager on MAU told us that the critical care outreach team reviewed all patients presenting with acute kidney injury and a sticker was applied to patients' records to demonstrate they had been reviewed.
- Failure to recognise the deteriorating patient due to lack of compliance with accurate NEWS was on the risk register as a significant risk and audits were planned. However, it was unclear when this risk had been initially identified as it was not documented. Data from July 2016 indicated that the essentials of the care audit programme (ECAP) report showed non-compliance with NEWS on one medical ward (MAU) at the hospital due to inaccurate documentation including Early Warning Scores, fluid balance recordings and frequency of patient observations. Wards were required to submit an improvement plan. We have requested copies of the improvement plans; however, these had not been received at the time of report writing.
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place, to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (Malnutrition Universal Screening Tool or 'MUST'). However, we found one patient on Rockwood A ward was overdue their risk re-assessment by two days, which was clearly highlighted on the electronic system. This was brought to the attention of the nursing staff on the ward who said they would inform the nurse caring for that patient to action.
- To continually assess patient risk, intentional observation rounds were completed, every one to four hours, depending on patients' needs.
- Of the 11 records we reviewed, we saw that one patient in MAU did not have a wound assessment or care plan completed or any pressure relieving equipment put in place, despite having a Grade 3 pressure ulcer and bilateral leg dressings in place. In addition, there were no details regarding the pressure ulcer on the staff handover sheet and therefore staff caring for the patient were unaware of the current risk to this patient.
- We were told the equipment had been ordered, however, we could not see evidence of this in the ward's equipment request book. This was escalated to the ward manager and a mattress was immediately located from stores, a pressure relieving cushion was delivered within four hours and all wounds were redressed and wound care assessments completed.
- Patients with potential swallowing difficulties, and therefore at risk of aspiration, had an assessment by the speech and language therapist (SLT) and if required, a plan of care was documented in patients' records, with specific directions, for example a specific amount of thickener to be mixed with a set amount of fluid. However, we observed that staff did not record when and how much thickening product was added to fluids prepared for patients. Staff confirmed this and told us they would make add the amount stated to a jug of water and leave it at the patient's bedside. This increased the risk of patients not receiving the correct plan of care and therefore had the potential to increase risk, for example of aspiration.
- Patients at risk of venous thromboembolism(VTE) due to non-compliance with national guidelines was on the risk register dated 20/09/2016, however, it was not on the risk register submitted on 28/09/2016. No actions were updated and we were not clear as to when and why this was identified as a risk and we were not assured of any actions taken to mitigate the risk. Senior managers were unaware of why this was on the risk register when we asked them during our inspection.
- VTE assessments were mostly completed on electronic records. We reviewed 21 records and noted that one

patient had not had a VTE risk assessment since admission to hospital 14 days earlier. However it was documented in the patient's records that VTE prophylaxis was not required, as patient was mobile.

- Trust data from January 2016 to August 2016 showed compliance with VTE assessments across the trust was the same, or greater than the trust target of 95%, however, during the same period 54 incidents were reported for patients who have developed a VTE 48 hours post-admission or within 90 days of discharge, which all were found to be unavoidable. Recommendations including training around the importance of completing timely assessments in line with Trust policy was being provided to junior medical teams, who complete the electronic VTE assessments.
- Staff told us patients who were identified as being a higher risk, for example of falls, were either nursed in rooms adjacent to the nurses station or in enhanced bays, where a member of staff would be present at all times. We observed this practice on the wards we visited.
- Patient risks were discussed at staff handover and were also documented on the handover sheet, which was provided to every member of the nursing team at the beginning of each shift. However, there was nothing highlighted on the electronic record to easily alert staff to any risk, including specific information regarding the patient, for example if they had dementia.
- Staff on the cardiac unit monitored patients on the wards who had telemetry cardiac monitoring insitu and staff told us they would go directly to the ward or notify the ward if the patient experienced an abnormal rhythm.
- We reviewed a transfer of patient's policy version 2.3, which had been authorised in February 2013 and was due to be reviewed in June 2013. Information received from the trust states this was under review and was nearly complete, however, this did not provide us with assurance that all current processes were in place and were reflective of current practice and guidelines.

Nursing staffing

- The trust had used the National Institute for Health and Care Excellence (NICE) and National Quality Board approved 'Shelford tool' since 2015. This reviewed acuity and staffing levels, which the trust told us had helped to track the increases and decreases in dependency and acuity of patients and had led to an investment of over 100 nursing posts across wards trust wide.
- Ward managers told us they completed a dependency and acuity scoring system via the e-rostering system, along with professional judgement to identify staffing requirements and clinical competencies on a daily basis.
- Data provided in September 2016 by the trust shows there were nurse vacancies on the majority of medical wards with highest numbers of vacancies on Brindle Ward.
- 5.2wte) and MAU (6.2wte). However 47 Staff were currently being recruited into post across the trust and the recent safer staffing review showed that at the end of September 2016 there would be 65 staff (trained and untrained) vacancies across the medicine trust wide.
- The turnover rate of nursing staff for the past 12 months was variable between 5.6% (coronary care unit) and 36.1% (Rockwood A Ward) 10.69% and staff sickness for the last financial year was reported between 2.6% (coronary care unit) up to 13 % (Rockwood A Ward).
- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements and set key objectives though this work to support safer staffing. Data provided as part of this review dated November 2016 identified that for 2015/ 2016 the overall fil rate on the medical wards at the hospital was 95% and above and between 83.1% and 98.3% specifically for trained staff.
- The national benchmark of nursing shifts to be filled as planned during the day and night is 80%. We reviewed staffing figures across six medical wards from April 2016 to August 2016. We found most were above this benchmark during the day, apart from Brindle ward, which had a fill rate during this period ranging from 73.1% to 79.3%, Rockwood B ward fill rate was 79.2% (May 2016) and 76.9% (August 2016) and MAU was 76.5% (August 2016). During the night, all wards achieved higher than the 80% benchmark, apart from Brindle ward where staffing levels were 76.7% in April 2016 and 78.5% in May 2016.
- Staffing levels for unregistered staff from April 2016 and August 2016 ranged from 88% to 126.7% during the day.

Data provided during the night for July and August 2016 showed staffing levels ranged from 100 to 116%. Data provided during the night for the same period showed staffing levels ranged from 79.8 % to 116%.

- Each ward had a planned nurse staffing rota and managers reported on a regular basis if shifts had not been covered. Three methods of triangulation: the Professional Judgement tool', acuity and dependency scoring were used to determine their staffing needs.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the service were aware of the available staff and whether staffing levels were in line with the planned requirement.
- At the time of inspection, not all the shifts were filled as planned, despite agency and bank nurses being used to help fill staffing shortfalls, however, the matron felt the staffing levels were safe. The matron told us that staff were moved to support other wards at a week at a time to maintain familiarity and continuity of care for both the staff member and patient.
- Senior staff on the wards told us that staff would work overtime, or on the bank. Agency staff were requested and ward managers would try to use the same bank and agency staff to ensure that they had the required skills and continuity on the ward. We observed rotas which confirmed this, however, some shifts remained unfilled, which meant that there was a risk that patients did not receive the care they needed on these occasions.
- All ward staff we spoke with told us they ''were doing their best'' and ''pulling together'', however, four members of staff told us there were occasions when they felt that staffing levels were unsafe. Ward managers told us that they would escalate any concerns to the matron, prioritise care, and nurse at risk patients in enhanced bays, to maintain safety of all patients. Some ward managers told us they rarely managed to have 'management days', as they were required on the wards and had worked extra hours themselves. The ward manager on the medical assessment unit told us that since the Accident and Emergency (A&E) department in Chorley Hospital had closed, the acuity of patient had reduced, which had helped with maintaining safe staffing levels.
- From 4th January 2016 to 31st July 2016 we saw 30 incidents reported from staff regarding shortage in staffing levels on the ward.
- Nurse staffing levels was on the risk register. Senior managers told us there had been high levels of sickness, which was improving in addition to vacancies. Actions were being taken to mitigate risk, including reviewing recruitment processes and job adverts, facilitating recruitment events, recruiting abroad and maintaining a rolling recruitment programme for health care assistants and nursing staff. The trust had also commenced a pre-nursing apprenticeship programme and were working with the local university regarding placement of nurses on wards as part of preceptorship.
- However, senior managers told us that there had been no student nurse intake at the local university for the past 12 months and this has had an impact on recruitment and workforce planning.
- Matrons met with ward managers twice a day to discuss and monitor nurse staffing levels and ensure staff and skill mix were appropriately deployed and shared across all wards. The Nursing and Midwifery Director met with the Heads of Nursing weekly to manage and monitor the situation. Staffing was also monitored at monthly board meetings.
- We saw effective handover meetings between nursing staff and health care assistants, which were well-structured and highlighted key risks and plan of care for each patient. Each member of staff had a completed handover sheet, which had all relevant information documented including deteriorating patients, medical history and any requirements for the day.
- Safety huddles were held on MAU following each handover. We observed a safety huddle which was led by the co-coordinator, who discussed patients' risks, delegated duties and discussed actions for the day. This ensured that all staff were aware of their responsibilities in relation to patient care and promoted team work.

Medical staffing

- The percentage of consultants working at the trust was 39%, which was higher than the England average of 37%. The percentage of middle grade doctors (6%) and junior doctors (21%) was the same as the England average, however, registrars was 34% which was lower (worse) than the England average of 36%.
- Between April 2015 to April 2016 the turnover rate of medical staff was variable across the specialities, for example it was 0% for the diabetes department, 6.8% for respiratory, 22.2% for cardiology and 26.7% for MAU.

Medical care (including older people's care)

- Data provided by the trust showed that in July there were six medical vacancies at the hospital with two covered by trust locums. The data didn't stipulate what grade of doctor the vacancies were for. Senior managers told us they have been using the same locums on a regular basis to help fill the gaps. However, the trust were actively recruiting and were reviewing ways to increase recruitment, including overseas recruitment and looking at offering junior and middle grade rotational posts and combined posts for consultants.
- Medical staffing levels were on the divisional risk register and was discussed at the medicine divisional board meetings.
- Medical staff told us there was sufficient medical cover outside normal working hours and at weekends should patients need to see a doctor. We were told consultant cover was available on site from 9am to 8pm daily Monday to Friday and at weekends from 9am until 1pm. Outside these hours, a consultant was on call and was within 30 minutes travel time to of the hospital.
- Senior managers told us there were challenges in arranging cover for the gastro-intestinal (GI) bleed rota, to cover both Chorley Hospital and Preston Royal Hospital, due to staffing, however, ongoing recruitment had nearly been achieved. The surgical team covered the rota with support and access to an upper GI surgeon at all times. We were told there was ongoing monitoring of the situation and no incidents had occurred.
- There was no pathway or clear process for junior doctors to handover 'at risk' patients to the overnight on call team and two junior doctors told us it was down to 'good will' to contact the on call doctor and hand over patients. Senior managers told us they had visited two other trusts to look at ways of improving the process and were going to submit an action plan.
- However every night at 9pm, the onsite night manager, medical staff and the hospital at night team met to discuss issues, including bed capacity, medical outliers and deteriorating or potential deteriorating patients. The onsite manager would hand over to the day time onsite manager, who then attended the 9am meeting on MAU with the medical staff and matrons.

Major incident awareness and training

- The trust had a major incident plan in place, which listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of different types of major incidents.
- Staff we spoke with were aware of the major incident plan and how to access it.

Are medical care services effective?

Requires improvement

At the previous inspection in July 2014 we rated effective as requires improvement mainly due to improvements being needed in the management of patients with diabetes, especially with regard to foot risk assessments. We have maintained this rating following this inspection because:

- Medical services participated in the majority of clinical audits where they were eligible to take part. However recent national audits indicated further improvements were required in the care for people with diabetes.
- Diabetes care was not provided in line with national best practice.
- Staff had access to policies and procedures although these were not always reviewed or updated within the set timeframe
- We found that actions following local audit were not always clearly identified or monitored to measure improvement or impact.
- Most staff said they were supported effectively but the majority of staff who had received their annual appraisal was mainly below the trust target.
- The number of staff who had completed mental capacity act training was below the trust target however staff demonstrated a good understanding and awareness around mental capacity.
- Not all services provided a seven day service at the hospital.

However:

- The endoscopy unit had been formally recognised that it had competence to deliver against the measures in the endoscopy GRS standards and has received JAG accreditation in 2014.
- Nutrition and fluid intake were recorded correctly and support was provided for patient that needed assistance with eating and drinking.
- Patient's pain relief was monitored effectively.
- There was a focus on discharge planning and there was good multidisciplinary working to support this.

Medical care (including older people's care)

Evidence-based care and treatment

- Medical services were using national and best practice guidelines to care for and treat patients, for example with Chronic Obstructive Pulmonary Disease (COPD) to improve performance. We reviewed minutes from a diabetes meeting in March 2016, which stated that the recent diabetes survey showed that the trust were not adhering to NICE guidelines, as patients were not having their feet assessed on admission as there is no hospital based multidisciplinary team foot team for in-patients. We spoke with senior managers and requested a copy of the action plan, however, this had not been received at the time of writing our report.
- Staff told us policies and procedures reflected current best practice guidance and were available electronically on the trust's intranet. We reviewed a selection of policies and found that some, including transfer of patients and the escalation policy, had not been reviewed within the stated timelines, which therefore did not assure us that policies reflected the current guidance and needs of patients.
- The service participated in the majority of clinical audits they were eligible for through the advancing quality programme.
- Trust data showed examples of recent local audits that had been completed on the wards, including monthly medicines spot checks, documentation audits and compliance with the MUST tool.
- Staff told us about recent local audits that had been completed on the wards; these included clinical care indicators, such as nutrition and pain management. We observed minutes of a team meeting, where results of audit had been discussed along with lessons learned.
- We reviewed three audits undertaken within the last twelve months although one audit it was unclear as to which hospital this had been undertaken at. The audits identified areas of good practice and areas of improvement. Action plans were in place to improve standards, however, we observed on the audit of patients records that actions were either not actioned with no review date or responsible person We were therefore not assured that there was any improvement following this audit or if the results and recommendations were shared.
- The Trust had an essentials of care audit programme (ECAP), which measured care provided by individual wards in relation to nutrition, falls, medication, NEWS ,pain and tissue viability and results were demonstrated using a RAG (red , amber , green) rating. We viewed an audit report from July 2016, which gave overall trust wide scores of individual wards and we saw evidence that ward staff had attended a medicines safety group meeting, to present their action plan following amber and red ECAP results in relation to medication documentation.
- Safety crosses were completed and displayed on notice boards. A safety cross represented each calendar month and was completed daily to monitor avoidable harms such as falls, pressure ulcers, venous thromboembolism (preventing blood clots) and infections (MRSA and C-diff). These were visible to staff, patients and relatives. Staff told us the data was reported and discussed at staff handover and at team meetings. We observed this during our inspection.
- Medical services at the hospital participated in the joint advisory group (JAG) on gastro-intestinal endoscopy and had achieved JAG accreditation in September 2014. The JAG accreditation scheme ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy. Patients told us that they were asked about their pain and were supported to manage it.
- We saw completed pain assessments as part of the NEWS in patients' records.
- The trust told us that there was a specific pain assessment tool for use with patients living with dementia. However, three staff, including a ward manager, were unaware of this specific pain tool.

Nutrition and hydration

- Fluid balance charts were regularly completed and records showed that patients had an assessment of their nutritional needs using the malnutrition universal screening (MUST) tool. Patients were referred to a dietician where necessary.
- We saw there was a comprehensive selection of meals available from different menus, including halal, renal and high calorie diet, which was available for patients in addition to finger foods.
- Patients were offered toast and a hot or cold drink following their procedure in the endoscopy unit.

- Dieticians and speech and language therapists (SALT) were available on weekdays across the trust and staff knew how to access the services. A discreet sign was placed at the back of the patient's bed to state what type of diet is required, for example if a soft diet was required.
- During our inspection, we observed patients being offered and provided with drinks and food, including finger food, which supported nutritional intake**.** Drinks were within reach of patients**.** We saw staff assisting patients to eat and drink, whilst promoting compassion, dignity and independence. The majority of patients we spoke with said they were happy with the standard and choice of food available.
- Protected meal times were in place across the wards. The purpose of protected meal times is to allow patients to eat their meals without unnecessary interruption and to focus on providing assistance to those patients unable to eat independently.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2014/15 showed a high percentage of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI)), F were seen by a cardiologist prior to discharge with 96.2% , which was better than the national average of 94.8% and 44.6 % of patients were admitted to a cardiology ward, which was worse than the national average of 56.9%. When asked, senior managers were unaware as why the number of patients admitted to a cardiology ward was lower than the national average as there were no current issues. When asked senior managers regarding the results of patients admitted to a cardiology ward but told us they would look into it. We have requested the action plan but at the time of report this has not been received.
- The 2013/2014 heart failure audit showed the hospital performed better than the England average for ten out of the eleven clinical indicators.
- In the national diabetes inpatient audit 2015, the hospital was worse than the England average in 13 of the 17 indicators, this included patients receiving a foot assessment within 24 hours, medication errors, meal choice and staff knowledge. Senior managers told us they were looking at setting up an integrated service with primary care and that an action plan had been devised; we requested a copy of the action plan, however, at the time of inspection we had not yet received it.
- Data from the Lung Cancer Audit (2015) showed mixed performance in the quality of care at the trust. The trust achieved the expected or exceeded level in the process, imaging and nursing measures in two of the four indicators. Treatment measures achieved the expected or exceeded level in two indicators, and were significantly better than the national level in one. However they were below the expected level on two indicators and significantly worse on one treatment measure. The action plan following this audit has been requested however at the time of writing the report we had not yet received it.
- Between February 2015 to January 2016, Hospital Episode Statistics (HES) data showed the readmission rates for the hospital were was better than the England average for elective respiratory medicine and haematology, as well as non-elective general and respiratory medicine. Rates were similar to expected for other specialties.

Competent staff

- According to trust figures, at the end of July 2016 not all staff across medical services trust wide had received their annual appraisal, with compliance varying from 44% (additional professional scientific and technical staff) to 82.8% (medical and dental staff). The trust target was 80%. Staff we spoke to told us they had received an annual appraisal.
- Senior managers told us that clinical supervision for non-medical staff was not embedded across the trust. However, the charge nurse on Brindle ward told us that clinical supervision sessions were provided on the ward with the clinical educator. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- All new staff were required to complete a full day corporate induction and a local induction before undertaking their role with new nurses on the wards we visited were supernumerary up to four weeks.

- Doctors told us they received good clinical and educator supervision and attended teaching sessions every Friday lunch time.

Multidisciplinary working

- Multidisciplinary team (MDT) was well established across medical services, with patients having input from a range of allied healthcare professionals (AHPs), including occupational therapists, physiotherapists and speech and language therapists. However, staff on the MAU told us that therapists only saw patients who required review or support for discharge. Plans of care were available to staff to review patients goals and treatment plans.
- There was a cohesive and thorough approach to assessing the range of people's needs, setting individual goals and providing patient centred care.
- Nursing staff worked alongside other staff to provide a multidisciplinary approach and all staff we spoke to described good collaborative working practices. For example, a health care assistant on Rockwood A ward told us they worked with the therapist to facilitate activities, such as arm exercise classes with patients.
- Doctors told us they worked closely with ward staff, case managers and discharge liaison nurses, in preparation and planning for a complex discharge.
- There were specialist teams, including the tissue viability team and diabetes nurses who could be accessed for support, advice and provide joint patient care.
- Daily meetings, called board rounds, were attended by consultants, discharge planners, nurses and doctors. Board rounds were held Monday to Friday and we were told that the purpose was to review patients and complex discharges.
- The ward manager on MAU told us that they worked closely with the critical care outreach team and found them supportive and responsive. Following incidents which had been raised regarding poor management and documentation of patients with acute kidney injury (AKI) all patients with AKI are now reviewed by the team. Also it was identified more teaching was required and we were told that arrangements were being made for ward staff to shadow the critical care outreach team at the Royal Preston hospital.
- Senior nursing and medical staff would met twice a day at 9 am and 9 pm every day to handover patients including those at risk or deteriorating, determine priorities capacity and demand.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Not all services were providing seven-day services, including the endoscopy unit and the dialysis unit, which were both open Monday to Saturday. The endoscopy unit was utilised on a Sunday for emergencies only.
- There was a designated hospital at night clinician seven days a week who supported nurses and managed any issues including staffing at the hospital.
- Patients could be referred to the GP assessment area on MAU seven days a week. Staff told us that the consultant visited the MAU daily and reviewed all new patients and the senior registrar would discuss all other patients with the consultant.
- Pharmacists were available seven days a week and staff told us they could be contacted out of hours if there was a query regarding medication or discharge medication was required.
- The discharge team, including a social worker, was available seven days a week, from 9am to 5pm, which meant patients who were well could be discharged over the weekend.
- Patients who were competent to perform dialysis within their home environment had access to ongoing support which was available from 7am to 12pm and out of hours from the dialysis team at Royal Preston hospital.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There were computers available on the wards we visited, which provided staff access to patient and trust information.
- Policies and protocols were kept on the hospital's intranet, which meant all staff had access to them when required.

Medical care (including older people's care)

- On each ward there was an electronic patient board with details regarding each patient, including diagnosis, investigations /procedures required and discharge planning. However, when asked there was information on the board which staff did not understand.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Trust data confirmed that Mental Capacity Act 2005 (MCA) training was included in safeguarding training. Overall compliance across medical services trust wide was below the trust target of 75%, with 57% of medical staff, 59% of nursing staff and 68% of allied health professional having attended training in MCA.
- Staff we spoke with demonstrated awareness and understanding about the key principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to patient care. The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures.
- Compliance with consent training for qualified nursing staff was 100% across medical services.

Are medical care services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Patients told us staff were caring, kind and respected their wishes.
- We observed that staff interactions with people were person-centred and positive.
- Patients told us and we observed that they received compassionate care and their privacy and dignity was maintained at all times.
- Patients were complimentary about the staff that cared for them and told us they were involved in their care and were provided with appropriate emotional support.
- Provisions were made for carers and staff encouraged them to be integrated as part of the team.
- Chaplaincy services were available throughout the hospital for patients, relatives and staff.

Compassionate care

- During our inspection we observed patients being cared for with dignity, respect and kindness, with privacy maintained at all times. All patients who were at their bedside or in bed had access to call bells and staff responded promptly**.**
- All the patients we spoke with were positive about their care and treatment. Comments included ''I felt so poorly on admission, the nurse was so kind, I didn't want for anything''.
- Between June 2014 and July 2015, the NHS Friends and Family Test (FFT) overall response rate across the medical wards for this trust was 34%, which was better than the England average of 26%. The NHS Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. The scores from July 2015 to June 2016 were variable, with scores ranging from 67 % and 100%. However the coronary care unit scored 100% in five months, Rockwood B in two months and Rockwood A in one month which indicated that patients were positive about their experience.
- In the cancer patient experience survey 2015, the trust scored above average in 13 out of the 50 questions, whilst with the other questions the trust performed lower than expected.
- The trust performed about the same as similar trusts in all areas of the 2015 CQC inpatient survey. In response to the survey, the trust implemented an action plan with ongoing actions, including working with the research directorate to improve access to cancer research and the development and implementation of e-books to improve patient information.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they had received ongoing, clear information about their condition and treatment.

Medical care (including older people's care)

- Patients on the wards we visited did not have a named nurse and staff told us this was because they worked as a team, although during handover we noticed that nurses were assigned bays and side rooms.
- The trust were participating in 'John's campaign', which focused on caring and supporting carers to stay with their loved ones in hospital and have dementia. Badges were provided to carers of patients with learning disabilities or dementia; this ensured all staff were aware of who the carers were and staff told us they valued and liked to include carers to be part of the team. Staff told us they would arrange for subsidised parking at the hospital and offer carers a drink and a meal if there was any left over from the patients' meals trolley.
- Patients told us that clinical staff were approachable and noted that, although the staff were busy, they would always try to take the time to talk to them when they needed to. One patient told us that the doctor had explained their diagnosis and treatment simply and carefully and had provided ongoing reassurance during their stay.
- We observed in patients records that family members were kept informed regarding their loved ones plan of care. Two patients we spoke with told us their families were fully involved in planning their discharge and had attended case conferences.

Emotional support

- Visiting times met the needs of the relatives we spoke with. Open visiting times were available if patients needed support from relatives**.**
- On the endoscopy unit, family and friends could wait in the separate waiting area; however, staff were aware of the positive impact of having carers present for those with additional needs. Carers were allowed to stay with the patient throughout the process if this was the patient's choice.
- Staff on the endoscopy unit staff told us that for the past 12 years, there had been two volunteers who worked 2 mornings a week and would make drinks and toast and talk to patients following their procedure. During our inspection we observed a volunteer talking in a caring and cheerful manner to patients.
- At the hospital there was a chaplaincy team available 24 hours a day, seven days a week. The team consisted of chaplains and volunteers from all denominations. Staff would visits wards and offer support as required and would take patients to weekly prayer or services.

Are medical care services responsive?

Good

At the previous inspection in July 2014 we rated responsive as requires improvement, this was because bed occupancy for the trust was consistently higher than the England average, some of the escalation areas used were unsuitable and patients were transferred to another hospital to receive care. We have improved this rating to good following this inspection because:

- The hospital participated in number of schemes to help meet people's individual needs, such as the 'Quality Mark for Elder-Friendly hospital wards', 'John's campaign' and the 'Kings Fund' with patients from two wards having access to a dedicated nostalgia room and outside garden area.
- There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient who had dementia.
- Patients requiring dialysis had access to out of hour's appointments at the satellite clinic along with individual support and training in becoming independent in performing dialysis at home.
- The trust were working with local and social providers and CCG to address access and flow issues and had plans in place.
- There were on going issues with access and flow of patients across medical services mainly due to high occupancy rates and difficulties in discharging medically optimised patients. However the average length of stay at the hospital was similar to or less than the England average for all elective and non-elective specialties and there were low numbers of patients who were being cared for in non-speciality beds.
- People were supported to raise a concern or a complaint.
- There was access to translation services and leaflets available for patients about the services and the care they were receiving.

However;

- There was a number of patients who moved ward during the night and over half of patients experienced one or more moves during their stay.

- Medical services trust wide performed worse than the England average against the 18 week referral to treatment indicators in three specialities, with cardiology and gastroenterology treating 70% of patients within 18 weeks and 81.2% of patients within 18 weeks in general medicine

Service planning and delivery to meet the needs of local people

- The premises and facilities were appropriate for the services they planned and delivered.
- The hospital participated in the Quality Mark for Elder-Friendly Hospital Wards, with two wards (Rockwood A and Rockwood B) achieving the quality mark. The elder friendly quality mark is quality-improvement programme, which ensures a consistent quality care to patients over 65 years of age.
- The Proactive Elderly Care Team (PECT) provided patients and staff in identifying and assessing needs of older people and carried out dementia assessments for patients over the age of 75 years of age.
- There was a satellite clinic at the hospital, which provided haemodialysis for patients six days a week from 7am to 12 midnight. Staff told us this allowed for patients to attend at their preferred time of day, thus reducing the impact on their day-to-day life and other commitments they may have, for example work or childcare.
- The GP assessment area on MAU consisted of two bays, which were utilised as single sex bays. Each bay had chairs with curtains to maintain privacy along with a consultation room. Referrals would come via GP's and calls were triaged by a trained nurse, who remained in the area at all times.
- Escalation beds were opened in response to high levels of bed occupancy. Staffing was not increased when escalation beds were utilised, as senior managers told us that staffing was reviewed prior to opening the beds. Winstanley Ward was specifically used for escalation beds only and was staffed from other wards. In addition, the GP assessment bays on MAU were also utilised as required and accommodated up to seven patients. Staff told us they would move patients around to ensure patient acuity was taken into account and would try and keep the most mobile patients in this area. Any patients who had stayed in beds overnight in the bays were reviewed each morning and priority would be to de-escalate the patients to a ward area if they were not being discharged home. Staff told us that if patients could not be moved to a ward area, then they would move the patient's bed into the corridor and would provide the patient with a chair to allow more room. During our inspection we observed beds in the bay areas; each had a call bell within easy reach and curtains to each area to maintain privacy.

Access and flow

- Between November 2015 and June 2016 performance against national referral to treatment indicators (RTT) for 3 medical specialities trust wide, cardiology, gastroenterology and general medicine were below the national average. Board meeting papers confirmed that the trust worked with the Clinical Commissioning Group (CCG) and NHSI and an action plan with targets was implemented. We observed 'failure of 18 week compliance' was on the risk register, however, it was unclear whether this was for all specialities, although it did state a joint recovery plan had been developed with the CCG and a Neurology pathways group has been set up.
- Hospital episode statistics (HES) showed that the average length of stay was less than the England average for all elective and non-elective specialties apart from elective respiratory medicine which was the same.
- Between July 2015 and June 2016, the occupancy rate across the trust was between 94.9% and 97.3%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed that there were a number of patients being cared for in non-speciality beds, which may not have been best suited to meet their needs (also known as outliers).Trust data showed from July 2015 and July 2016 there was on average between 0 and 1 medical outliers per day at the hospital.
- The trust had an escalation policy, which included management of outliers. However the policy was dated 2014/2015, so we were not assured that this had been recently reviewed to reflect the current demands and needs of the hospital. Following our inspection, the trust provided a copy of a medical outlier's policy, version 1, which had been ratified in September 2016, however, we

were unsure if this was currently being followed, as there was no documentation to clarify which committee had ratified it and there was no review date or issue date.

- Bed management meetings were held daily Monday to Friday at 12:30pm and were attended by matrons, sisters and a representative from each ward. We attended a meeting and observed open and concise discussion regarding patients awaiting discharge, review of medical outliers and issues around discharges. The meeting also reviewed and updated the e-rostering for staffing across the wards for that day and over the weekend, with staff given information regarding who to contact if any issues. At weekends we were told there was no meeting, but the matron still reviewed staffing and patients on an ongoing basis.
- At the time of our inspection, senior staff said there were two beds escalated in the GP assessment area on MAU and two medical outliers. We reviewed the records for two medical patients who were outlying on a surgical ward and coronary care unit and found they had been seen daily by a member of the medical team. Staff told us that matrons would contact the ward each day to ensure the patients were reviewed by their medical team and they told us they had contact arrangements for the relevant speciality teams in and out of hours.
- Senior managers told us there were no mixed sex breaches at the hospital over the past twelve months. Single sex lists were performed on the endoscopy unit to prevent mixed sex breaches.
- In the period August 2015 to July 2016, 50% of patients experienced one ward move during their stay and a further 8% had 2 or 3 moves. This was slightly better than the previous year.
- Additional trust data showed that between January 2016 and July 2016, a number of patients on medical wards were transferred to another ward between 10 pm to 8 am, for example, a total of 24 patients had been transferred from Brindle Ward, 19 patients from Rockwood A Ward and 10 patients from Hazelwood Ward had been transferred during the night.
- Discharges were often delayed due to waiting for care packages (4.2%, which was better than the England average of 17.7%), awaiting a nursing home placement or availability (15.4% compared to the England average of 13.7%) and patient / family choice (52.4% compared to England average of 12%). Senior managers were aware of the high percentage due to patient or family choice, but did not have any plans in place to address the issue. Senior managers and matrons were emailed an update regarding patients who were medically fit for discharge and had actions and plans in place in order to facilitate the discharge.
- The discharge team manager met weekly with the social and community care providers, along with a member of the local clinical commission group, in order to discuss patients who were in hospital and required support for a length of time in the community. We were told this had not yet had an impact on discharges, however, they felt that the meetings had increased partnership working, along with increasing awareness to problems.
- The weekly Guardianship is a report that is distributed to matrons and case managers providing them with an overview of patients who had been in hospital for more than 21 days or for those patients who had multimoves during their in-patient stay. Senior managers told us to improve flow of patients this report would now be produced every five days instead of 21.
- Meetings on bed availability were held once a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff.
- Staff were focused on discharge planning for patients and wards. Staff discussed discharges at handovers, the daily board round and at the bed management meeting, with emphasis on 'golden discharges', where the aim was to get patients discharged from hospital before 10 am.
- The trust were rolling out an electronic system to allow discharge letters to send to GPs' via email however at the time of inspection this was not set up for all surgeries and therefore information was sent in the post. Referrals to other services for examples district nurses emailed and staff told us a receipt email would be obtained to prove it had been done.
- Patients received a printout report following their procedure on the endoscopy unit; this report would also be sent to their GP.
- The trust had commissioned and worked with 'Four Eyes Insight' to improve patient flow. This work included standardising practices on the wards, including daily board / ward rounds and review of the consultant's job plans to ensure capacity to support ward clinical work.

Medical care (including older people's care)

Meeting people's individual needs.

- Three wards were undergoing modifications as part of the King's Fund 'Enhancing the healing Environment' programme, to increase orientation for people with dementia, for example colour coded bays and unique artwork above beds. During our inspection we noted that Rockwood A and B Wards had undergone some modifications, including artwork above beds and staff on Brindle Ward told us that that the wards were being repainted to coloured bays.
- On Rockwood A Ward there was an outdoor garden area with seating for patients and their relatives to sit. In addition there was a nostalgia day room, which included a variety of equipment and activities for patients to reminisce, including board games. The room had been refurbished with comfortable chairs, dining table, TV and fire place for patients and their families to sit. Patients from Rockwood B Ward could also access these areas.
- The trust used the 'forget me not' and the 'hospital passport' documentation for carers, to record information about patients living with dementia or a learning disability. This ensured that staff knew the patients' likes, dislikes and ensured their needs were met. Trust data showed there were 32 dementia champions across medical services at the hospital.
- Translation services were available across the trust, which included face to face, telephone and written translation. However, one nurse we spoke to said that they had experienced a delay in care due to the process in booking a translator.
- During our inspection, we observed 'activity boxes' on some of the wards we visited, with games and books aimed at elderly patients to use, staff told us other wards had access to them when required. Patients with dementia had access to dolls and activity blankets, which were made by staff and sewing volunteers.
- Therapy staff regularly organised a luncheon club and themed tea parties on Rockwood A Ward. Staff told us that patients saw this as a social gathering and enjoyed eating their lunch at a dining table, which was laid out with a table cloth and mats 'just like home' and not by their bedside on a tray.
- There was a wide range of specialist nurses and teams, for example diabetes and renal nurses, who offered specialist advice to staff caring for people with these conditions. Staff told us they knew how to contact these specialists and felt supported by them.
- The team leader on the endoscopy unit told us that there was nothing formally in place for patients with learning disabilities or dementia; however, they would ensure that the same nurse stayed throughout their treatment, to maintain continuity and ongoing support and care.
- The home haemodialysis team provided one to one training and supported patients in achieving competences to become independent with performing dialysis. Staff on the unit showed us portable haemodialysis machines, which meant patients could have treatment at other locations, for example on holiday.
- On the dialysis unit, each patient had access to a television with headphones. However, none of the televisions worked and one patient told us it had been like this for weeks. The ward manager told us this had been escalated and managers were looking at funding.
- Information for patients about services and care they received could be accessed via information leaflets and the trust intranet, which could be translated into different languages, both in audio and written format.
- On MAU there was a prescribing pharmacist available Monday to Friday 9 am until 5 pm, who assisted with medications required for discharge. Staff told us the trust were looking at having a satellite pharmacy on the ward, so pharmacists could prescribe and dispense medications to patients immediately, thus expediting patient discharge.
- Pharmacists applied a sticker on patient's records to remind staff if the patient required a dossette or tablet organiser to be arranged prior to discharge. The medicines management dashboard in April showed a 92% turnaround of discharge prescriptions in average of 44 minutes (the target was 90 minutes).

Learning from complaints and concerns

- Trust data showed that between April 2015 and April 2016, there had been 193 complaints raised across medical services trust wide. The highest proportion of complaints related to all aspects of care and treatment. However, all patients we spoke with told us they were happy with the care and treatment they received.

Medical care (including older people's care)

- Patients and relatives could raise concerns in various ways, including email, in writing, in person or over the phone. We observed posters around the hospital with details about how to raise concerns and staff told us that members of the PALS team would visit the wards weekly and speak with staff and patients.
- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Complaints were risk assessed and delegated to the appropriate divisional governance team by the customer care team, with the chief executive having overall insight and overall responsibility. The trust also had the patient and advice liaison service (PALS) to support staff, patients and relatives through the process.
- Complaints were discussed at governance meetings across the trust including the safety and quality committee. The minutes stated that a report containing data regarding complaints including themes, trends and lessons learned were shared at the meetings.
- We reviewed a number of complaints and one complaint was regarding a patient who had been discharged from hospital with a cannula in place, because the correct discharge procedure and the check list had not been completed on MAU. On our inspection we viewed the records of a patient, who we were told was due to be discharged home, however, there was no discharge checklist in the patient's records. The ward manager confirmed this should have been in the patients records.
- During our inspection we spoke to one patient who had complained to the trust about equipment and was unhappy with the written response so met with the chief executive to discuss their concerns. The patient told us their problem had not yet been resolved, but had been assured by the chief executive that it would be in the near future.

Are medical care services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as requires improvement, this was because plans for the future of the service had not yet been finalised. We have maintained this rating following this inspection because:

- There was a governance structure in place, but there was limited evidence of actions being monitored within identified and agreed timelines.
- The medical division incorporated specialities trust wide and included accident and emergency, paediatric and medicine. Data wasn't always disaggregated to service level but reported as a division which meant it was difficult to monitor performance to speciality.
- Risk registers were in place, however, there were inconsistencies across the divisional and trust risk register including identification of risk and risk scores which did not give us assurance that medical services had full oversight of the risks or that risks were being monitored and actioned in a timely manner.
- Minutes from key divisional meetings discussed governance issues and although actions identified had a responsible person, there were no time lines, which did not assure us actions were being managed effectively or within an agreed time frame.
- The majority of governance meetings were held at the Royal Preston hospital and it wasn't clear on the minutes of the meeting whether there was representation from Chorley and South Ribble hospital.
- The 2015 NHS staff survey results showed that the trust scored worse than the national average in effective team working, organisation and management interest and action on staff health and well being. In addition the scores showed that 13 of 23 indicators were worse than the previous survey.

However;

- The majority of staff we asked were aware of the trust vision.
- The trust had participated in improvement programmes and worked alongside other services and were successful in reducing delayed transfers of care of patients.
- Staff felt supported and able to speak up if they had concerns and the number of staff who felt comfortable reporting unsafe clinical practice was similar to the England average.
- Staff and patients would recommend the hospital to friends or a relative.

Medical care (including older people's care)

Leadership of service

- The governance structure for medicine consisted of the Divisional Medical Director, Divisional Director and the Head of Nursing. Each of the three specialities had a clinical business manager and two speciality managers along with matrons representing each service.
- Staff were aware of who the matrons specific to their area were along with the executive team and senior managers. However three members of staff told us that the executive team were not visible at the hospital.
- All nursing staff spoke highly of ward managers and matrons and told us they were supportive regarding any issues on the ward. The ward managers told us they had access to leadership and management training.
- Doctors told us that senior medical staff were accessible and they received good support.
- During our inspection we observed positive working relationships within all teams.
- 31% of staff who participated in the NHS staff survey reported good communication from senior management to staff; this was the same as the 2014 national average.

Vision and strategy for this service

- The trust's vision is to be a leading provider of joined up healthcare that would support every patient who needed services, in addition to providing excellent care with compassion. The values were to be caring and compassionate, recognizing individuality, seeking to involve, team working and taking personal responsibility.
- The majority of staff we asked were aware of the vision and values and they were displayed on the notice boards on the wards we visited.
- The Medical division had a local strategy plan for 2016/2017, which outlined plans, priorities and areas of focus, including the provision of seven day cover and a review of the MAU function. The plans also identified opportunities and challenges in meeting the objectives.

Governance, risk management and quality measurement

- The medicine division had recently been restructured and covered 3 specialities; acute medicine, long term conditions and specialist medicine across two hospitals ; Royal Preston hospital and Chorley and South Ribble Hospital. Medical specialities along with emergency medicine, paediatrics and critical care were within the division. Some data provided by the trust was collated as a whole division and therefore it was difficult to monitor the performance of specific areas in for example training and reporting incidents.
- Monthly divisional safety and quality executive committee meetings were held at Royal Preston hospital and were attended by senior managers. Governance issues, including the safety and quality dashboard, divisional risk register, complaints and patient experience were discussed at each meeting, with actions assigned to individuals. However, no timelines were documented, which meant it was difficult to track progress.
- We reviewed the minutes of clinical governance meetings for individual services within the medical division trust wide, which were mainly held monthly, apart from the cardiology service, which was held quarterly. The majority of meetings were mostly held on the Royal Preston hospital site which meant staff had to travel to the other hospital to attend a meeting and it was difficult to identify on the attendees list whether there was staff representation and what proportion from each hospital. It was clear from the minutes we reviewed, that each service had different agenda's, with most services discussing performance and all services, apart from stroke services, respiratory services and diabetes services reviewing incidents. Actions from the meeting were identified in the minutes, along with the person responsible. However, there was no target date for the actions to be completed. It was therefore difficult to track progress against agreed actions.
- We reviewed three medicine divisional board minutes and found discrepancies with dates in two of the three minutes and therefore we were not clear exactly when the meeting or previous meeting had taken place. Safety and quality, along with staffing, was discussed in two of the meetings and discussion regarding the Accident and Emergency department's staffing crisis was discussed at the third meeting. All actions had an assigned person, but did not have a timescale and the minutes dated May 2016 had four outstanding actions with a question mark again them. This did not assure us that actions were being addressed or actioned in a timely manner.
- There were inconsistencies across the trust and medicine divisional risk registers, for example with details and risk scores, along with additional risks

reported on the trust wide risk registers, that had not been captured on the medical risk register. On requesting a copy of the risk register, inspectors received different versions and therefore we are not assured that risks were being managed and monitored consistently.

- The medicine divisional risk register was not specific to medical areas and included risks for the entire division of medicine, including outpatients and accident and emergency. Each risk was identified as trust wide, specific speciality and/or hospital. We were not assured actions were being managed as both risk registers did not clearly identify or manage risks as there was no current or additional mitigation action, a responsible person for each risk and on the trust wide register there were no time frames documented on the trust wide risk register which did not assure us that actions were being taken.
- There were conflicting opinions regarding the identification as to whether the beds on the GP assessment unit were escalation beds or extra beds; the ward manager and matrons told us that they were escalation beds, however, senior managers told us these were extra beds and not escalation beds. This did not give us assurance that there was a clear understanding regarding patient flow and management of the beds on MAU.

Culture within the service

- Staff said there was a positive, open and honest culture across at the hospital. Staff understood the need for openness and transparency and were knowledgeable about duty of candour.
- Staff said they felt supported and able to speak up to their immediate manager if they had concerns. They said that morale fluctuated from day to day due to staffing and workload pressures, but staff told us they felt proud of what they do.
- In the 2015 staff survey results showed that the number of staff who felt motivated at work was similar to national average score of 3.94 with a score of 3.89. The number of staff who felt secure when reporting unsafe clinical practice was 3.59 which was also similar than the national average score of 3.62.
- Results of the 2015 NHS Staff survey showed the trust scored worse than the national average for effective team working and organisation and management interest in and action on staff health and wellbeing. The trust scored in line with the national average for the majority of indicators and performed better than average for three indicators related to the levels of bullying from both staff and patients and staff working extra hours. The trust performed in line with the national average for 29 indicators. However it was noted 13 out of the 23 indicators were worse than the previous survey results.

Public engagement

- The trust had a public and engagement strategy 2013 to 2016, which was readily available on the trust website.
- The trust told us that governors would regularly attend events such as the Preston Health Mela and the University of Central Lancashire's (UCLan) Science festival and engage with the community, feeding back any issues or concerns.
- The trust had a magazine called 'Trust matters' for members of the trust, however, this could be accessed by all members of the public on the internet.
- Board meeting minutes were available on the trust's website, along with dates of future public board meetings.
- The hospital participated in the NHS friends and family test, giving people who used services the opportunity to provide feedback about care and treatment. At the time of the inspection, 90% of patients would recommend the wards at the hospital to friends or a relative.

Staff engagement

- The hospital participated in the NHS friends and family test, giving staff the opportunity to speak out about their place of work. From July 2016 to September 2016, 75% of staff would recommend this hospital to friends and family in need of care /treatment and 60% would recommend it as place to work to friends and family. Following the results a staff action and engagement plan 2016-2018 was devised.
- In February 2016 the trust engaged with staff at events called 'big discussions', to gain further clarity and identify improvements around the top three positive and negatives themes identified following the survey.
- The trust celebrated those members of staff who had worked in the NHS for 25 years at annual Long Service Awards.

- The trust celebrated the achievements of staff at an annual event. At the last event, the falls prevention team won the 'safe' award for the support they offer to those patients at risk of falling.

Innovation, improvement and sustainability

- Since March 2016, the trust participated in delayed transfer of care (DTOC) Improvement Programme. The trust worked with health and social care services, along with NHS improvement in a 90 day improvement programme and achieved a reduction in the DTOC from 6% to 3.8%. Senior managers told us this had resulted in several improvements, including the implementation of a check list to meet the agreed criteria for a continuing health care assessment, which has reduced the amount of assessments performed in hospital, thus expediting decisions around place of discharge.
- The trust were currently trialling a system where a recently recruited nurse reviewed delayed discharges and medical outliers on a daily basis, to identify any actions that can be taken the same day to facilitate discharge. Senior managers told us they felt this had contributed to the reduction in medical outliers trust wide.

Surgery

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

Information about the service

Chorley and South Ribble Hospital provides a range of surgical services including trauma and orthopaedics, urology, breast surgery, maxilla-facial surgery, ear, nose and throat (ENT) surgery and general surgery.

There were 14, 567 surgical procedures carried out at the hospital between March 2015 and February 2016 and approximately 80% of patients had day surgery, 18% had elective surgery and 2% were emergency surgical patients.

The hospital has six main theatres. The Longton unit (urology / ENT) and Rivington unit (maxilla-facial surgery) also have one operating theatre each and these are located separately to the main theatres.

The hospital also has a surgical inpatient unit (12 beds), an elective orthopaedic ward (25 inpatient beds) and a day case unit with capacity for up to 40 patients. The day case unit was separated into two areas; one for orthopaedic patients (Rawcliffe) and the other for general surgery (Winstanley).

We visited Chorley and South Ribble Hospital as part of our announced inspection during 27 to 30 September 2016. As part of the inspection, we visited the surgical wards, theatre areas and the day case areas.

We spoke with nine patients. We observed care and treatment and looked at seven care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, healthcare assistants, assistant practitioners, the matrons for elective surgery and theatres, theatres staff, the divisional medical director for surgery, the divisional head of nursing for surgery and the divisional directors for the surgical division and the diagnostics and clinical support division. We received comments from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Surgery

Summary of findings

The surgical services were previously rated as requires improvement for safe, responsive and well-led in July 2014 following our last inspection. This was because we had concerns around equipment management and poor compliance against 18 week referral to treatment standards.

At this inspection we gave the surgical services at Chorley and South Ribble Hospital an overall rating of Good because: -

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and appropriately maintained premises.
- Medicines were stored safely and given to patients in a timely manner. Staff assessed and responded to patients risks and used an early warning score system. The theatre teams followed the five steps to safer surgery procedures and staff adherence to was monitored through routine audits.
- Equipment and consumable items were readily available for use by staff. The equipment we saw was appropriately checked, cleaned and serviced regularly under a planned maintenance schedule.
- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with the England average for most safety and clinical performance measures.
- The staffing levels and skills mix was sufficient to meet patients needs. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.
- There were systems in place to support vulnerable patients. Most complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.
- Patients and their relatives spoke positively about the care and treatment they received. They told us they were kept fully involved in their care and the staff supported them with their emotional and spiritual needs. Patient feedback from the NHS Friends and Family Test showed that most patients were positive about recommending the surgical wards to friends and family.
- The hospitals values and objectives had been cascaded across the surgical services. There was effective teamwork and visible leadership across the services. Staff were positive about the culture within the surgical services and the level of support they received from their managers.

However, we also found that: -

- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times between August 2015 and June 2016 for most surgical specialties. The surgical division RTT recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.
- Most staff had completed their annual appraisals and mandatory training; however the proportion of staff that had completed their appraisals and had completed adult and children's safeguarding training was below the hospitals expected levels.

Surgery

Are surgery services safe?

Good

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to concerns around the management of patient records and the management of equipment, following this inspection we have rated safe as Good. This is because:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Staff were aware of the actions to take in the event of a major incident.
- The staffing levels and skill mix was sufficient to meet patients needs. There were minimal staff vacancies in the ward and theatre areas. Patient records were completed appropriately and stored securely.
- Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients. Medicines were stored safely and given to patients in a timely manner.
- Equipment and consumable items were readily available for use by staff. The equipment we saw was appropriately checked, cleaned and serviced regularly under a planned maintenance schedule.
- Staff assessed and responded to patients risks and used a national early warning score system (NEWS). The NEWS audit from May 2016 showed staff achieved high levels of compliance with the audit standards.
- The theatre teams followed the five steps to safer surgery procedures and staff adherence to this was monitored through routine audits. Audit records from January to June 2016 showed the theatre teams achieved 100% compliance.

However;

- Most staff had completed their mandatory training; however the proportion of staff that had completed adult and children's safeguarding training was below the hospitals expected levels.

Incidents

- There were no never events reported in relation to the surgical services at the hospital between August 2015 and August 2016. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- The Strategic Executive Information System (StEIS) data showed there were two serious patient safety incidents reported by the surgical services between August 2015 and August 2016. This included one instance of slips, trips and falls and an allegation of abuse of adult patient by a staff member.
- We saw evidence to show these incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by senior staff with the appropriate level of seniority. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matrons or clinical leads.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. Incidents and complaints were discussed during daily safety huddles and monthly staff meetings so shared learning could take place. Learning from incidents was also shared through hospital-wide newsletters.
- The incident reporting system provided prompts for staff to apply duty of candour. Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. 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.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed during monthly mortality and morbidity meetings and divisional clinical audit meetings every three months.

Surgery

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- Safety Thermometer information between July 2015 and July 2016 showed there were 33 pressure ulcers, eight falls with harm and 26 catheter urinary tract infections reported across the surgical services.
- Patient records showed that appropriate risk assessments were carried out upon admission to the wards and patients identified at risk had the appropriate care plans and supporting equipment (e.g. increased observations, pressure relieving mattresses) in place to minimise the risk of patient harm.
- Staff monitored compliance against recognised quality standards by carrying out monthly audits as part of the hospitals essentials of care audit programme (ECAP). The ECAP audit results showed the hospitals internal target (95% compliance) for falls prevention and management was achieved each month between March 2016 and July 2016.
- The monthly ECAP audit results for tissue viability ranged between 91.2% and 97.8% during this period which meant the 95% target compliance was not consistently achieved. The surgical services launched the under pressure campaign in April 2016 to reduce pressure ulcers. The trust reported that the occurrence avoidable pressure ulcers had reduced by a third in the three months after the campaign commenced.
- We saw that notice boards near the entrance to ward areas displayed the number of patients with falls, pressure ulcers and CUTIs during the current month.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and 10 Clostridium difficile (C. diff) infections relating to surgery across the trust between April 2016 and October 2016. The rate of C.diff infections was within the surgery divisions internal target (12).
- We looked at the investigation report and actions plans for two C.diff incidents that occurred in April 2016 and July 2016. These were investigated appropriately and there was clear involvement from nursing and clinical staff, as well as the hospitals infection control team.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. However, we saw that clinical waste bags in the theatres were not clearly labelled in accordance with the Association for Perioperative Practice (AfPP) guidelines. The AfPP guidelines state that clinical waste bags should be labelled with the patients number, date of operation and theatre identity.
- There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Visitors were encouraged to wash their hands.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.
- Monthly hand hygiene audit was carried out across the wards and theatre areas. Audit results from April 2016 and September 2016 showed high levels of compliance by staff (97% to 100%) and the ward and theatre areas consistently scored above the hospitals internal target of 95% compliance.
- Infection control audits were also carried out every two weeks across the wards and theatre areas to check the cleanliness of the general environment and equipment. Audit results between January 2016 and August 2016 showed high levels of compliance (98%).

Environment and equipment

- The wards, day case and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- The general environment across the hospital was aged and worn but the wards we inspected were clean and in a good state of repair. The majority of clean utility rooms across the surgical wards had been recently refurbished.
- All the ward areas had sufficient shower and bathing facilities and separate male and female toilets were in place.

Surgery

- All the theatre areas were free from clutter and we saw that equipment and consumable items were stored appropriately.
- Equipment was appropriately checked and cleaned regularly and the majority of equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment needed for surgery was readily available and staff told us any faulty equipment could be replaced from the hospitals equipment store. Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit.
- Equipment was serviced by the trusts maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.
- The hospital may wish to note that none of the emergency (crash) trolleys we saw were securely locked even though they contained items such as intravenous fluid (saline) bags. There is a potential risk that these items could be tampered with. This was reported on inspection and appropriate action taken.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately.
- We saw that medicines that required storage at temperatures between 0C and 8C were appropriately stored in medicine fridges. Fridge temperatures were checked daily and medicines were stored at the correct temperatures.
- Ward staff told us they would notify the maintenance team and the pharmacy department if fridge temperatures exceeded the maximum temperature range.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for seven patients and found these to be complete, up to date and reviewed on a regular basis.
- The medication records also showed patients that received oxygen treatment had oxygen prescribed and appropriately documented.
- The ECAP audit results showed the hospitals internal target (95% compliance) for medication administration and prescribing was achieved each month between March 2016 and July 2016.

Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- Staff also used an electronic system for recording risk assessments, such as for falls, venous thromboembolism (VTE blood clots), pressure care and nutrition and these were reviewed and updated on a regular basis.
- We looked at the records for seven patients. These were structured, legible, complete and up to date.
- Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
- The ECAP audit results showed the hospitals internal target (95% compliance) for patient observations and completion of VTE risk assessments was achieved between March 2016 and July 2016.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children.
- Records showed 46% of staff across the surgical services had completed safeguarding adults (level 2) training and 49% had completed had completed safeguarding adults (level 3) training. This was below the hospitals internal target of 75% training completion.
- Records showed 94% of staff across the surgical services had completed child protection awareness training.

However, only 45% of staff had completed child protection (level 1) training and 79% had completed child protection (level 3) training. This was below the target of 90% training completion.

- The staff we spoke with were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and childrens safeguarding concerns was displayed in the areas we inspected. Each area also had safeguarding link nurses in place.
- Staff were aware they could seek advice and support from the trust-wide safeguarding team.
- Safeguarding incidents were reviewed by the departmental managers and also by the trust-wide safeguarding group, which held meetings every two months to review individual incidents and to look for trends.

Mandatory training

- Staff received mandatory training in key areas such as fire safety, health and safety, resuscitation, infection control, information governance, moving and handling, information governance and safeguarding of vulnerable adults and child protection.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. The training was delivered either face-to-face or via e-learning.
- Records up to July 2016 showed that overall mandatory training compliance for staff across the surgical services was 81% and the hospitals internal target of 80% had been achieved.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm.
- Patients at high risk were placed on care pathways and care plans were put in place so they received the right level of care. Staff carried out intentional rounding observations so any changes to the patients medical condition could be promptly identified.
- Staff used national early warning score systems (NEWS) and carried out routine monitoring based on patients individual needs to ensure any changes to their medical condition could be promptly identified.
- A NEWS audit was completed in May 2016 and the findings were based on a review 17 records across the surgical wards at the hospital. The audit showed good staff compliance in four of the five audit standards; all information completed (97%), monitoring plan completed and followed (69%), vital signs recorded correctly (100%) and NEWS calculated accurately (90%).
- There was an action plan in place to improve compliance, including raising awareness and training for staff and monitoring of staff compliance by the matron and ward managers.
- We observed four theatre teams undertaking the five steps to safer surgery procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the five steps to safer surgery procedures.
- The WHO checklist audit for the period between January and June 2016 involved a review of eight completed checklist records. The audit report showed high levels of staff compliance in the use of the checklist (100%).

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards, based on national NHS safe staffing guidelines. The nursing and midwifery staffing and skill mix report from November 2016 did not identify any significant staffing shortfalls in relation to surgical services at the hospital.
- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The theatre staffing levels were based on nationally recognised guidelines such as the Association for Perioperative Practice (AfPP). There were five whole time equivalent (wte) scrub nurse vacancies. These positions had been recruited to and were awaiting start dates.

- There were four theatre support worker vacancies. One of these posts had been recruited to and the remaining posts were covered through the use of agency staff.
- There was also one agency long-term agency theatre support worker in theatres that had undergone induction training and was familiar with the theatre departments policies and procedures.
- Staffing cover in the theatres was provided through existing staff working additional hours and cross-cover between theatre staff across both the trusts hospitals.
- The matron for elective surgery told us there were no nursing staff vacancies in the surgical wards and day case areas within the hospital. One vacant nursing post in the Leyland (orthopaedic) ward had been recruited to and was scheduled to commence employment in January 2017.
- There were two assistant practitioner vacancies across the surgical wards and the services were actively recruiting for these posts.
- The matron for elective surgery told us they rarely used agency staff. Staffing levels in the ward areas were maintained through the use of bank staff and by existing staff working additional hours.
- Nursing staff handovers took place during daily shift changes and these included discussions about patient needs and any staffing or capacity issues. Patients spoke positively about the staff and did not highlight any concerns relating to nurse staffing levels.

Surgical staffing

- The surgical services at the hospital had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants, middle career, registrar group and junior doctors was similar to the England average.
- The divisional medical director for surgery told us the majority of consultant and middle grade posts were fully recruited to. Records showed there were eight consultant vacancies (including two consultant posts in each of the orthopaedic, neurosurgery and ophthalmology specialties). There were also eight specialty and associate specialist (SAS) doctor posts vacant. Recruitment for these posts was on-going and six consultants had recently been appointed across the services with confirmed start dates confirmed between November 2016 and March 2017.
- Separate medical staffing rotas were in place for each surgical speciality. We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends.
- Patients admitted to the surgical wards or for day surgery were seen by a consultant surgeon prior to undergoing surgery. Patients on the surgical wards were reviewed daily by a consultant or registrar.
- Medical cover on the surgical wards and the day case unit was provided by a ward-based core trainee year 2 (CT2) doctor from Monday to Friday 7:45am to 5pm.
- Medical cover during the evenings and weekends was provided by resident medical officers (RMOs) that worked alternate shifts for two weeks. During their shift, one RMO was based at the hospital 24 hours per day for two weeks.
- During their shift, the CT2 doctor or RMO were responsible for monitoring of patients in the ward areas, prescribing medicines, cannulation and taking blood samples if needed.
- The ward-based doctors carried out medical handovers during shift changes and these included discussions about specific patient needs.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.

Major incident awareness and training

- There was a documented major incident plan in place and this listed key risks that could affect the provision of care and treatment. Surgical staff were aware of how to access this information when needed.
- There were clear instructions for staff to follow in the event of a fire or other major incident. Staff also had guidelines in place for dealing with medical emergencies such as a patient going into cardiac arrest.

Are surgery services effective?

Good

At the previous inspection in July 2014 we rated effective as good, we have maintained this rating following this inspection because:

- The services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.
- The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken to improve compliance in audits such as the national emergency laparotomy audit.
- The proportion of patients readmitted following discharge was 7.38% compared with the trust target of 7.39% and no clinical concerns had been raised relating to readmission rates.
- Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Most staff had completed their annual appraisals (95.6%) and the hospital's internal target for 90% appraisal completion was achieved.
- Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.

However,

- Most staff had completed their annual appraisals (71%); however the proportion of staff that had completed their appraisals was below the hospital's expected level (82%).

Evidence-based care and treatment

- Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE). Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- During 2015/16 the trust participated in all the national clinical audits and national confidential enquiries relating to surgical services for which it was eligible to participate in. The clinical audit and effectiveness forward programme (April 2016 to March 2017) listed all the local and national clinical audits the surgical services were currently involved in.
- Findings from clinical audits were reviewed during routine clinical audit and effectiveness meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a selection of the hospital's policies and procedures and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- The monthly essentials of care audit programme (ECAP) audit results for pain management average score was 99.6% between March 2016 and July 2016. This meant the hospital's 95% target for compliance was consistently achieved during this period.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort.
- Patients told us staff gave them pain relief medication when needed and their pain symptoms were managed appropriately.
- There was a dedicated pain team within the trust and staff knew how to contact them for advice and treatment when required.

Nutrition and hydration

- Patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- The monthly ECAP nutritional management audit average score was 97% between March 2016 and July 2016. The hospital's 95% target for compliance was consistently achieved during this period.
- Patient records showed fluid balance charts were in place and these were complete and up to date. The records also showed that there was regular dietician involvement with patients who were identified as being at risk.

- Patients with difficulties eating and drinking were placed on special diets. We also saw that the surgical wards used a coloured tray system so patients requiring assistance could be identified and supported by staff during mealtimes.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The hospital participated in national audit programmes such as performance reported outcomes measures (PROMs) and the National Joint Registry.
- The national joint registry (NJR) data between April 2003 and July 2015 showed that hip and knee mortality rates at the hospital were in line with national averages.
- Performance reported outcomes measures (PROMs) data between April 2015 and March 2016 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement and knee replacement was similar to the England average.
- The proportion of patients with improved outcomes following varicose vein procedures was much better than the England average during this period, with fewer patients reporting a worsening and more patients reporting an improvement after treatment, compared to the national average.
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was better than the expected range for all specialties except for elective urology and trauma and orthopaedic surgery.
- The trust reported that overall readmission rates were 7.38% compared with the internal trust target of 7.39% and no clinical concerns had been raised relating to readmission rates.
- The divisional medical director for surgery also told us a review was underway to determine if there was any data quality or coding issues in relation to the reporting of patient readmission rates.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised for up to four weeks. Agency and locum staff also had inductions before starting work.
- The theatres department had a practice educator that oversaw training processes and carried out competency assessments based on national competency guidelines.
- Staff told us they routinely received supervision and annual appraisals. Records up to July 2016 showed the majority of staff across the division of surgery (71%) had completed appraisals. However, this was below the hospital's internal target of 82% appraisal completion.
- Records showed most eligible medical staff in the surgical services that had reached their General Medical Council revalidation date had been reviewed within the recommended time scale or had a planned review date in place. There were only three overdue reviews from the 180 doctors in the surgical division.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, as well as diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the surgical wards by a ward-based resident medical officer (RMO) as well as on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant or registrar, and existing patients on the surgical wards were seen by the RMO.

- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The pharmacy was also open for a limited number of hours on Saturdays and Sundays.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- We saw that information such as audit results, performance information and internal correspondence were displayed in all the areas we inspected. Theatre staff used visual in-brief boards to aid planning. Ward staff also used visual boards to identify patients with specific needs, such as patients living with dementia or at risk of falls.
- Staff used pre-printed care pathway booklets for individual procedures and these were version-controlled and readily available.
- Staff could access information such as policies and procedures from the hospital's intranet. Staff told us they could access up to date national best practice guidelines and prescribing formularies when needed.
- The hospital used paper based patient records. The patient records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained from patients or their representatives and that planned care was delivered with their agreement.
- Consent records showed the risks and benefits of the specified surgical procedure were clearly documented and had been explained to the patient.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. We saw evidence of this in the patient records we looked at.
- There was a hospital-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.

Are surgery services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- We spoke with eight patients. They all spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Patients and their relatives were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patient feedback from the NHS Friends and Family Test between July 2015 and June 2016 showed the surgical wards consistently scored above 90% with a higher than average response rate. This showed that most patients were positive about recommending the surgical services to friends and family.
- The CQC's adult inpatient survey 2015 showed the trust was rated 'about the same' when compared with other trusts for all 10 sections, based on 501 responses received from patients.

Compassionate care

- We saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner in the wards and theatre areas.

- Patients' bed curtains were drawn when providing care and treatment and staff spoke with patients in private to maintain confidentiality.
- Patients could also be transferred to side rooms to provide privacy and to respect their dignity. The privacy and dignity of patients being transferred to the theatre areas was maintained and patients were provided with gowns and blankets.
- We spoke with eight patients. They all told us they thought staff were friendly and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "nurses are fantastic, treat you with respect", "staff are very helpful, can't fault them" and "everyone from the support staff to the doctors has been lovely".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between July 2015 and June 2016 showed the surgical wards consistently scored above 90%.
- The average scores across the surgical services were below the England average during this period. However, the survey showed the majority of patients were positive about recommending the hospital's surgical wards to friends and family.
- The average response rate (the percentage of patients that completed the survey out of all eligible patients) was better than the England average of 30% across all the surgical wards.
- The CQC's adult inpatient survey 2015 showed the trust was rated 'about the same' when compared with other trusts for all 10 sections, based on 501 responses received from patients.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences. Staff were respectful and sought permission from patients before they delivered care or treatment.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. The comments received included: "doctor seen daily, they explain everything" and "have had good communication from consultants".

Emotional support

- The staff we spoke with understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients.
- Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. Patients told us the anaesthetists and surgeons were calm and reassuring. One patient commented that the "staff lift you up and make you feel better".
- Staff were able to provide patients and their relatives with information and support about chaplaincy services and bereavement or counselling services.
- Staff told us they could contact the hospital's palliative (end of life care) team for support and advice during bereavement.

Are surgery services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement mainly due to concerns around the service's performance against 18 week referral to treatment standards. We have maintained this rating following this inspection because:

- During this inspection, we found that no significant improvements had been made and further improvement was still needed.
- The services performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted and non-admitted patients between August 2015 and June 2016 for most surgical specialties.

- There was a worsening trend in performance which meant the number of patients waiting longer than 18 weeks for treatment had steadily increased since the start of 2016.
- As part of the surgical division RTT recovery plan, a review identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists. The recovery plan included actions to improve 18 week wait times and to improve patient flow and efficiency in the wards and theatres by March 2017.

However,

- There were systems in place to support vulnerable patients. Most complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- Hospital episode statistics data showed 14, 567 surgical procedures took place at the hospital between March 2015 and February 2016. The data showed that approximately 80% of patients had day case procedures, 18% had elective surgery and 2% were emergency surgical patients.
- The hospital provided a range of elective and day case surgical services for the communities it served. This included trauma and orthopaedics, urology, breast surgery, maxilla-facial surgery, ear, nose and throat (ENT) surgery and general surgery (such as upper gastro-intestinal (GI) surgery).
- There were six theatres in the main theatres area, including three orthopaedic theatres. The Longton unit (urology / ENT) and Rivington unit (maxilla-facial surgery) had one operating theatre each and these units were located separately to the main theatres.
- The hospital only carried out a limited number of emergency surgical procedures and most patients requiring emergency surgery were transferred to Royal Preston Hospital.
- The ward and theatre areas we inspected were compliant with same-sex accommodation guidelines.
- There were daily meetings with the bed management team so patient flow could be maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Access and flow

- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- Patients undergoing day surgery were given morning and afternoon appointment times. Surgical specialties such as urology and ear, nose and throat surgery also operated all day lists. This meant that a patient arriving early in the morning could potentially wait for an extended period of time. Staff told us they prioritised patients based on risk so patients with greater dependency or medical needs were operated on earlier in the day.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Staff completed a discharge checklist, which covered areas such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.
- The average bed occupancy rate across the surgical division between April 2016 and July 2016 was 97.7%, compared with the trust target of 85%. This was reflected in the surgical wards we visited as we found that most available beds were occupied.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. Records showed that between January 2016 and July 2016 showed there were only four medical outlier patients across the two surgical-specialty wards. Staff told us any medical outlier patients admitted to the surgical wards would be assessed by medical specialty doctors.
- The average patient length of stay was better than the England average for all specialties except elective trauma and orthopaedics, which was only slightly worse than average (3.9 days compared with average of 3.4 days).

- Records between May 2016 and July 2016 showed the average theatre utilisation (efficiency) across the theatres was 88% and this was in line with the hospital's aspirational target of 85% utilisation.
- There were 174 operations cancelled between October 2015 and September 2016. The most frequent reasons for cancelled operations were 'overrun due to complications with previous patient' (22%) and 'other non-clinical reasons (14%).
- NHS England data showed the trust performed worse than the England average for 18 week referral to treatment (RTT) waiting times for admitted patients between August 2015 and June 2016 for all surgical specialties except trauma and orthopaedics (77.6% compared with the average of 69.9%).
- The incomplete referral to treatment waiting time standard is that at least 92% of patients should have to wait less than or equal to 18 weeks of referral for their treatment.
- Records showed that none of the specialties achieved the 92% standard during the period between February 2016 and August 2016.
- There was a worsening trend as overall compliance across the surgical specialties was 90% in September 2015 and this reduced month on month to 82% compliance in August 2016. This meant the number of patients waiting longer than 18 weeks for treatment had steadily increased during this period.
- As part of the surgical division RTT recovery plan, a review of the capability of services was carried out. This identified seven specialty areas with an imbalance in capacity and demand that would lead to increasing waiting lists.
- The recovery plan listed a broad range of actions to improve compliance with RTT standards. This included reducing the waiting list backlog, outsourcing or transferring services, recruitment of additional staff, a review of patient pathways and improving patient flow and efficiency in the wards and theatres.
- The recovery plan aimed to achieve compliance with RTT waiting times standards by April 2017. Progress against the proposed actions was scheduled to be monitored at specialty and divisional level meetings on a monthly basis.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- The areas we inspected had dementia link nurses in place. Staff also used a 'passport' document for patients admitted to the hospital with dementia or a learning disability. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes.
- The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Ward staff also told us they applied 'reasonable adjustment' principles for patients with learning disabilities.
- Staff could also contact the trust-wide safeguarding team for advice and support for caring for patients living with dementia or a learning disability.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the staff.
- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by a centralised complaints team, who notified individual managers when complaints were overdue.
- Staff told us that information about complaints was discussed during daily 'safety huddles' and at routine team meetings to aid future learning. We saw evidence of this in the meeting minutes we looked at.
- The hospital's complaints and concerns policy stated that complaints would be acknowledged within three

working days and responded to within 25 working days for routine formal complaints or within 40 working days for complex complaints that required detailed investigation.
- There were 15 complaints raised in relation to surgery at the hospital between August 2015 and July 2016. The most frequent reason for complaints was in relation to 'clinical treatment'.
- The average time taken to respond to these complaints was 50 days. This meant the majority of complaints about the surgical services were responded to in a timely manner, but not always within the timescales specified in the hospital's complaints policy.

Are surgery services well-led?

Good

At the previous inspection in July 2014 we rated well led as requires improvement mainly due to concerns that there was a lack of connection between theatre managers and managers of surgical specialties. Following this inspection we have rated the surgical services as Good because:

- The hospital's values and corporate objectives had been cascaded across the surgical services and staff had a clear understanding of what these involved.
- Key risks to the services, audit findings and quality and performance was monitored though routine departmental and divisional governance and quality and safety meetings.
- A new divisional structure had been in place since December 2015. Most surgical services formed part of the surgical division, whereas the theatres formed part of the diagnostics and clinical support division.
- The hospital provided a limited number of surgical services with a smaller team than the trust's main hospital site. The matron for elective surgery told us the smaller team meant it was easier to communicate with staff across the service. Staff were positive about the culture within the surgical services and the level of support they received from their managers.
- There was effective teamwork and clearly visible leadership within the services. There were daily discussions between the elective surgery and theatre matrons so that key risks and capacity issues could be identified and resolved or escalated.

Leadership of service

- The surgical services were incorporated across two divisions as part of a new divisional structure that had been in place since December 2015. The surgical specialties and ward areas formed part of the surgical division. The theatres formed part of the diagnostics and clinical support division. Each division was led by a divisional director, who was supported by a divisional medical director and a divisional head of nursing.
- The theatre matron was responsible for overseeing the theatres department. The wards and day case areas across the hospital were managed by the matron for elective surgery. The surgical wards were led by ward managers that reported to the matron.
- The hospital provided fewer surgical services with less staff and facilities than at Royal Preston Hospital. The matron for elective surgery told us the smaller team meant it was easier to communicate with staff across the service. There were daily discussions with the theatre matron so that key risks and capacity issues could be identified and resolved or escalated.
- The theatres and ward based staff told us they understood their departmental reporting structures clearly and described their line managers as approachable, visible and who provided good support.

Vision and strategy for this service

- The trust mission statement was; "Our purpose is to be recognised as the centre for acute and specialised hospital services in Lancashire and South Cumbria, providing the highest standards of compassionate, safe care that gives our patients a positive experience, excelling in research, innovation and teaching, developing our staff to reach their potential, and improving the health and wellbeing of our diverse communities."
- This was underpinned by a set of five values and behaviours; 'caring and compassionate', 'recognising individuality', 'seeking to involve', 'team working' and 'taking personal responsibility'.
- The division of surgery operational plan 2016/17 outlined the strategy for the surgical specialties and listed a number of key targets relating to quality and safety, IT, workforce and capacity and demand. This included recruitment and retention of nursing and

medical staff, developing nurse-led clinics and services, improving seven day services and review and improvement of patient pathways and capacity and demand.
- The mission statement, values and objectives had been cascaded to staff across the surgical services and staff had a good understanding of these.

Governance, risk management and quality measurement

- There were monthly divisional and specialty level governance and quality and safety meetings and monthly departmental staff meetings across the surgical services. There was a set agenda for these meetings with standing items, including the review of incidents, key risks, audit findings and monitoring of performance.
- The ward managers and matron for elective surgery attended routine divisional and trust-wide meetings held at Royal Preston hospital.
- Risks were documented and escalated by the service appropriately. The matron for elective surgery maintained an electronic departmental risk register. Key risks were escalated and recorded on the divisional risk register. The divisional risk register showed that key risks had been identified and these were regularly assessed and updated.
- In each area we inspected, the routine staff meetings were held at least monthly to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives (e.g. patient safety, staffing and training). This information was cascaded to the ward and theatre managers through performance dashboards.

Culture within the service

- The staff we spoke with were highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Records showed the average monthly staff turnover rate across the surgical division ranged between 10.44% and 10.85% between March 2016 and July 2016. This was slightly higher than the hospital's target of 10% turnover.
- During this period, the average monthly staff sickness rate across the surgical division ranged between 4.4% and 5.27%. This was higher than the hospital's target of 4.2% sickness.
- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of bank and agency staff as well as the existing staff working additional hours.

Public engagement

- Staff across the surgical services told us they routinely engaged with patients and their relatives to gain feedback from them. This was done informally through daily interactions and formally through participation in the NHS Friends and Family test.
- A number of ad hoc patient feedback surveys were carried out in a small number of surgical specialties. The services also received patient feedback from surveys conducted by external organisations such as Healthwatch.
- Public engagement was also conducted through patient focus groups and ad hoc events. For example, an orthopaedics event was held in March 2016 to provide information about the orthopaedic services delivered by the trust.

Staff engagement

- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards, theatres, and day case areas.
- The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The NHS staff survey of 2015 showed the trust had three positive findings out of the 34 indicators with 29 findings within expectations and only two negative findings. They were for 'effective team working' and 'organisation and management interest in and action on health and wellbeing'.
- The findings from the audit had been discussed with staff through focus groups across the surgical specialties and there were action plans in place to improve on the negative findings from the staff survey.

Surgery

Innovation, improvement and sustainability

- All the staff we spoke with were confident about the sustainability of the surgical services at the hospital. They felt the facilities and workforce enabled patients to receive a good standard of care and treatment.
- The matron for elective surgery told us there was scope to increase surgical services and activity at the hospital in order to meet the increased demand.
- The key risks to the services at the hospital were around maintaining staff levels and their ability to improve referral to treatment wait times and patient access and flow processes.

Critical care

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

Information about the service

The Critical Care Unit at Chorley District Hospital is located in the Medicine Division for the purposes of management and governance. The Medicine Division was further divided into Acute Medicine, Long-term Conditions and Specialist Medicine business units. Critical Care was in the Acute Medicine Business Unit with the Emergency Department; Assessment Units; Ambulatory Care and Paediatrics. A Clinical Business Manager, supported by two Speciality Business Managers, managed the Acute Medicine Business Unit. A Divisional Medical Director and Divisional Director, supported by the Head of Nursing managed the Medicine Division overall.

The Critical Care Unit had four level 2 inpatient beds. From April 2015 to March 2016, the Critical Care Unit accepted 135 admissions. The unit also provided a critical care outreach service between the hours of 8am and 8pm seven days a week.

We inspected the Critical Care Unit between 27 and 30 September 2016 as part of a comprehensive inspection of the trust. During our visit we spoke to one patient; two relatives and 10 staff. These included junior and senior nursing staff, junior and senior doctors and managers at both unit and divisional level. We observed care and treatment, the environment and equipment and examined one care record. We have also reviewed performance data about the Critical Care service.

Summary of findings

We previously inspected the hospital in July 2014 and gave critical care services an overall rating of requires improvement. Following this inspection we have rated critical care services at Chorley and South Ribble Hospital overall as good because:

- The critical care services were well led and staff were aware of the trusts vision and values.
- We found that there were governance frameworks in place and risks were appropriately identified and monitored.
- There was clear leadership throughout the service and staff spoke positively about their leaders.
- Staff were able to report incidents and were knowledgeable about the types of incident they should report.
- We saw evidence that learning from incidents and complaints was routine and this learning was disseminated.
- Infection control was effectively managed and the department was visibly clean. Routine infection control audits were undertaken.
- Nurse and medical staffing was sufficient to meet patient's needs.
- Patients received effective care and treatment that followed national clinical guidelines and was tailored to their individual needs.
- This care was delivered by competent and professional staff.
- The service participated in local and national audits.

Critical care

- Staff sought appropriate consent from patients before delivering treatment and care.
- Staff treated patients with kindness, dignity and respect and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.

However:

- Mandatory training uptake levels were low for some subjects, including safeguarding children and adult training.
- Appraisal rates were low at 62% and this was a deterioration from the previous inspection.
- Audits were not always followed up with action plans and a number of action plans had not been update for years in some cases.
- The service, as a whole, was not meeting the Intensive Care Standards guidelines for 50% of nursing staff to have undertaken a post qualification course in critical care nursing.
- There was limited monitoring of patient satisfaction.

Are critical care services safe?

Good

At the previous inspection in July 2014 we rated safe as good, we have maintained this rating following this inspection because:

- Staff were aware of how to report incidents and feedback from incidents was provided.
- There was a low rate of serious incidents in the service and the service had reported no never events.
- Lessons were learned from incidents and were distributed to facilitate learning.
- Safety performance was monitored and safety thermometer data showed that rates of avoidable harm were within national averages.
- Staff were aware of how to raise and manage safeguarding issues.
- Infection rates were low and staff observed appropriate measures to protect patients from avoidable infections.
- The environment was suitable for the delivery of patient care and equipment was well maintained.
- Staff managed medicines well and completed patient records correctly.
- Nurse staffing levels were sufficient to ensure safe patient care and senior managers had plans in place to fill existing vacancies.
- Medical staffing and skill mix was sufficient to ensure safe patient care.

However:

- Mandatory training uptake levels were low for some subjects including life support and safeguarding training.
- There was no specialist critical care trained pharmacist on weekends.

Incidents

- All staff had access to the trust wide electronic incident reporting system. Staff were able to demonstrate how they would report an incident or “near miss” using this system. Staff were aware of the types of incident they should report.
- Staff had access to a flowchart showing the reporting process and duty of candour process and this had been widely disseminated.

- Staff were aware of duty of candour. This 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. Staff gave examples of occasions when they had told patients something had not gone as planned and explained how they would exercise the duty of candour.
- Managers reviewed all incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents.
- Staff told us they received meaningful feedback relating to any incidents they raised. This feedback included what action had been taken.
- Staff reported six incidents in the critical care unit at Chorley district hospital for the 12 months prior to the inspection. Of these incidents, two were reported in relation to infusion pumps which were overdue for service, one report related to a patient fall, one related to the development of a pressure ulcer and two related to the potential mislabelling of blood samples. All six incidents had been categorised as low or no harm.
- If an incident was categorised as moderate or major these were reviewed and investigated by senior staff within the division and service.
- There had been no "Never Events" (very serious, wholly preventable patient safety incidents that should not occur if preventative measures are in place) reported in the twelve months before our inspection.
- Serious incidents were reported through the Strategic Executive Information System (STEIS).There were no serious incidents reported to STEIS in the 12 months prior to the inspection at the unit.
- Designated band 7 nursing sisters were assigned lead responsibilities for the investigation of specific areas when incidents were reported. For example, all tissue viability, staffing or blood sampling related incidents would be investigated by the band 7 designated to those incidents. A root cause analysis was undertaken for all tissue viability related incidents and they were reviewed together with the Head of Nursing.
- There were safety huddles before the start of a shift, during which wider trust incidents were discussed.
- There was mapping of incident trends and lessons were learned from these. These were discussed at team and weekly mortality and morbidity meetings. Managers also shared lessons learned from incidents with frontline staff through individual feedback.
- The unit at the Royal Preston Hospital held a weekly Mortality and Morbidity handover meeting on a Wednesday lunchtime which included patients at Chorley District Hospital. We attended this meeting during the inspection. It was attended by five Consultants; three Junior Doctors; nine Nurses; the Matron; the Governance Manager; three Critical Care Outreach workers, a medical student and a Discharge Co-ordinator.
- All deaths that occurred in both Critical Care Units were discussed at this meeting. There was an average of four deaths per week across both units. The Consultants used a mortality and morbidity review proforma that was completed for all dying patients and there was a central spreadsheet to collate all results. Each death was discussed at the meeting in detail and scores were given on the assessment of care; multidisciplinary working; the quality of records and documentation and engagement with relatives (such as in relation to organ donation and bereavement services offered). Things that could have been done better were discussed with staff at the earliest opportunity and there was an opportunity for open discussion on how improvements could be made.
- The meeting was in accordance with the Guidelines for the Provision of Intensive Care Services produced by the Faculty of Intensive Care Medicine and the Intensive care Society.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- The service were recording and monitoring data in line with this initiative. Information on performance in relation to this initiative was discussed at managerial and staff meetings. We reviewed information for 12

months prior to the inspection and this showed that the service and unit performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.
- Information relating to the Safety Thermometer performance was displayed on boards displayed in the critical care corridor. These showed current results in respect of falls with harm (levels 3 to 6); pressure ulcers graded at level 2 or above and catheter acquired urinary tract infections (C.UTIs) at level 3.
- From July 2015 to July 2016 there were no falls with harm; nine pressure ulcers of grade 2 and above and three recorded catheter associated urinary tract infections (C.UTIs) at level 3 (severe) across both units.

Cleanliness, infection control and hygiene

- The unit effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.
- We saw that the environment in the Critical Care Unit was clean and that staff adhered to good practice for the control and prevention of infection. Staff were bare below the elbows in clinical areas and washed their hands after dealing with a patient.
- Dated "I Am Clean" stickers were in use in the department to indicate when equipment had been cleaned.
- All areas of the unit were visibly clean and well maintained and staff were aware of current infection prevention and control guidelines.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons, and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'arms bare below the elbow' guidance.
- Equipment trolleys in the department carried a label that stated when they had been cleaned. The equipment was visibly clean.
- Sharps bins were labelled correctly, were not overfilled and were kept closed when not in use.
- The service undertook a monthly infection control and prevention audit which was compiled into a quarterly report. This report showed that the service met the 90% standard for three out of four quarters (2015/2016) in relation to isolation precautions and environmental factors. However the service failed to meet the 98% compliance standard for correct staff uniform factors. The report also showed that the service met the 100% standards for dealing with central venous catheters in all four quarters.
- The service also undertook quarterly audits in relation to preventing surgical site infections for patients who were admitted to the critical either pre or post-surgery. The audit looked at four key areas including pre-operative screening and post-operative care. Information provided by the service showed that the service met all four of these standards in 100% of cases audited against a target of 98% in the last three quarters of 2015 and the first quarter of 2016.
- The service audited compliance with the trust and service policy and process for dealing with suspected and diagnosed clostridium difficile infections. A report showed that the service met 100% of standards looked at for last three quarters of 2015 and the first quarter of 2016.
- There were two MRSA (methicillin-resistant staphylococcus aureus) acquisition cases across both units between July 2015 and July 2016 and four C. Difficile (Clostridium Difficile) cases in the same period. All the cases had been assessed as being unavoidable. There was a "Root Cause Analysis" report for each case.
- Hand hygiene audit data had not been disaggregated by the trust. Trust wide audit figures for July 2016 showed that overall compliance was 94% against a trust target of 95%. Doctors were seen to be 97% compliant, nurses were 92% compliant and healthcare assistants were 93% compliant.
- There was a side room off the main critical care unit where patients could be isolated if necessary.

Environment and equipment

- The environment and equipment in the critical care unit was well maintained and spacious.
- The unit was tidy and free from clutter. Each patient bed area had an equipment trolley containing all the equipment required to treat the patient, including in an emergency situation.
- There was a sufficient quantity of specialist equipment available to treat patients. We found that two incidents

had been reported in relation to delayed servicing of infusion pumps on the unit. We were unable to confirm whether this situation had been resolved at the time of the inspection.

- Staff told us that all items of equipment were readily available and bed spaces were equipped with the right equipment needed to treat patients, such as ventilators and intubation equipment.
- Equipment was checked, cleaned and appropriately maintained on the unit. Resuscitation trolleys were stock-checked daily by the night shift and safety checklist were completed daily.
- The unit used a "six point of identification" syringe labelling system that arose from a Coroner's report and ensured that the ends of tubing were correctly labelled with what the tubes were for and connected to so that the right ends could be unplugged safely.
- Equipment conforming to relevant safety standards was regularly serviced and maintained by two Band 6 Technicians who were attached to the critical care units. The Technicians also assisted on future departmental planning and training staff on equipment use.
- They were supported by a Medical Engineering Department that were ISO 9001:2008 accredited for the management, maintenance and repair of medical devices.
- The trust policy for the management of medical devices was in date and published on the intranet.

Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. There were appropriate arrangements in place for the destruction of unwanted and expired medicines. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy.
- Emergency medicines and equipment were readily available and there was a procedure in place to ensure they were fit for use.
- Medicines fridges were secured and maximum and minimum temperatures had been recorded in accordance with national guidance.
- Controlled drugs were stored appropriately in locked cupboards in line with legislation on the management of controlled drugs. Records showed these medications were checked on a daily basis. Controlled drugs require additional checks and special storage arrangements because of their potential for abuse or addiction and also require clear and precise documentation of any wastage.
- There were appropriate processes in place for ordering medications and stock reconciliation and a designated pharmacist assisted the department with this. Staff also had 24 hour access to pharmacy support, if required.
- There was a permanent critical care unit Specialist Pharmacist in place who worked across both units. 0.3 WTE Pharmacists shared with other areas supported them. The Guidelines for the Provision of Intensive Care Services (GPICS) recommends that there should be 1.9 Pharmacists for 24 beds.
- An audit of GPICS compliance indicated that the shortfall in Pharmacists had been on the Departmental Risk register but had been removed to become part of a trust wide review; however this review had not progressed since then. Following a meeting between the Chief Pharmacist and Critical Care Governance Team, it was moved back to the Critical Care risk register and plans were being discussed around a seven-day service with an action for Pharmacy to review seven day staffing.
- Pharmacy deliveries to the critical care unit took place three times per week.
- A trained critical care unit pharmacist delivered prescribing services on weekdays. On-call non-specialist pharmacists delivered weekend services, although they had access to specialist advice if needed.
- The Specialist Pharmacist did not routinely attend the ward round but did attend all patients on the unit and communicated verbally and via the Quadramed electronic patient record system to Consultants. They were available during the ward round if required.
- There was a prescribing guide in place and this included guidance on auditing and recording all Pharmacist interventions. The threshold for recording interventions had been lowered so that there was an average of 200-250 per month across both units in 2016, compared to 60-100 per month in 2014 when the reporting threshold was lower. Interventions were recorded for four main reasons: to ensure patient safety and improve quality and continuity of patient care; to provide evidence to demonstrate the additional value of pharmacist input; to have an accurate record available for scrutiny where decisions could be challenged and for monitoring incidents or near misses in relation to

prescribing, dispensing or the administration of medicines. We were told that the intent was to discuss feedback monthly at the mortality and morbidity meetings to reduce prescribing and administration errors.
- The move towards using an electronic end-to-end E-prescribing and medicines administration system was in development with a view to this reducing prescribing and administration errors. It was thought that this system would be put on place when the department re-fit and expansion had been completed.
- Guidelines on the use and preparation of medication were readily available.

Records

- Since our last inspection the critical care unit had moved to an electronic paperlite patient record system and paper records had been replaced. This meant that all records were traceable and available.
- Appropriate risk assessments and prompts to specific care bundles was included in the system.
- We were satisfied that patient's individual care records were written and managed in a way that kept people safe.
- Treatment plans were documented on the system and visible to all relevant staff. Patient and relative conversations were documented and clearly labelled as such. Patient s were consulted on the ward round where possible.
- We reviewed one patient's records during our visit and found that records relating to patient treatment were legible and easy to follow. We found that patients' nursing records were kept up to date and fully completed.
- Record keeping was not listed on the yearly audit plan.

Safeguarding

- The trust had safeguarding policies and procedures in place which were readily available on the trust's intranet site.
- Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- At the time of our inspection 64% of all Critical Care staff requiring level two safeguarding vulnerable adults training had undertaken the course. This was lower than the trust target of 75%. However, 87% of all Critical Care staff requiring level three safeguarding vulnerable adults training had undertaken the course and this was higher than the trust target of 75%.
- Data showed that no Critical Care staff required level three safeguarding children training. The number of staff requiring level two safeguarding children training was 236. However only 15 staff (6%) had undertaken this training. This was below the trust target of 90%. We saw that 96% of Critical Care staff requiring level one safeguarding children had undertaken the course and this was above the trust target.
- All staff had to attend a child safeguarding session though there were no spaces on the courses at the time of our inspection for staff to be able to attend. The trust was intending to roll out an e-learning package for staff in addition to the sessions though this had not happened when we inspected.
- All staff had to undertake an e-learning package on child sexual exploitation and we were told by the Matron that there was an increased awareness of female genital mutilation (FGM) amongst staff.
- Staff told us they received feedback from all safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff and their managers.
- There was a system in place for raising safeguarding concerns. Staff were aware of the process and confident about making referrals.
- Safeguarding was part of the mandatory training programme for all staff. Staff on the unit at Band 6 or above had undertaken Level 3 Adult Safeguarding and staff below Band 6 were trained at Level 2.
- The nominated lead for safeguarding was the Associate Director for Patient Safety and Governance. This role was supported by a lead practitioner for adults and a named lead nurse for children. The rest of the safeguarding team comprised 2.6 whole time equivalent (WTE) band 6 staff and 1.6 WTE Band 3 Administrative Officer.
- The trust was represented on the subgroups of the Lancashire Adult Safeguarding Board and had established its own Safeguarding Board with a non-executive director as a member.

- Safeguarding concerns on the unit were discussed at the weekly mortality and morbidity meeting We were given examples of safeguarding concerns that had been raised by staff about two patients during the week of our inspection.

Mandatory training

- Mandatory training compliance was reviewed regularly by the service lead and matron.
- Uptake levels for mandatory training subjects were variable between subjects with some areas of high uptake which met the trusts target and some areas of low uptake which did not meet the trusts target.
- There were numerous mandatory training subjects which staff were required to undertake, some which required that they were undertaken on a yearly basis and others on a two yearly basis. Nursing staff were required to undertake mandatory training in aseptic no touch technique which was used to prepare infusions. The trust target for this training was 85% and 53% of nursing staff within the unit had undertaken this training.
- All nursing staff responsible for the administration of intravenous medications were required to undertake mandatory training in this subject. Records showed that 100% of staff had undertaken this training at the time of the inspection.
- The trust required that all staff involved with moving and handling patients undertook training in this subject. Records showed that 24% of nursing staff had undertaken this training against a target of 60%.
- The trust required that minimally 85% of staff undertook basic life support with training on how to use an automated external defibrillator. Records showed that only 17% of nursing staff and 52% of medical staff had up to date training in this subject. Some staff were also required to undertake a higher level of life support training (Advanced Life Support Training); the target for this training was 90%. Records showed that only 79% of nursing staff had undertaken up to date training in this subject.
- The critical care units had three WTE Nurse Educators who were employed in educational roles and were able to deliver training to Nursing and associated staff on the units and to offer additional clinical support on the unit. This was an increase in these roles since our last inspection and meant that recommended Nurse Educator ratios to number of Nurses had been achieved in accordance with the GPICS standards
- At the time of our inspection, 89% of nursing staff in Critical Care were up to date with mandatory training against a trust target of 90%.
- Staff told us they were encouraged to attend mandatory training and their manager reminded them when their mandatory training was due for renewal.

Assessing and responding to patient risk

- A weekly mortality and morbidity handover meeting was held within the service and discussed all patients who had been on the Critical Care Unit for more than 14 days. These were considered to be complex patients at higher risk of harm. Each patients' case was discussed in detail with a view to escalating care and treatment where required or moving the patient closer to a discharge date where there was evidence that the risk of the patient deteriorating was reducing.
- There was a trust National Early Warning Scores (NEWS) system in place for the early detection and escalation of the deteriorating patient.
- There was a clear escalation policy on the same sheet as the NEWS documentation. This linked clinical responses to the scores applied to physiological parameters.
- The trust carried out early Warning Score clinical audits to ascertain compliance and correct use of the National Early Warning Scores. In an audit in May 2016, wards and departments were visited and data collected on up to 10 patients triggering NEWS. Patient notes and vital chart signs were reviewed to gather evidence of compliance with the five elements of the audit. The Critical Care Outreach Team Practitioner made a judgment on whether the patient had been escalated appropriately according to the timely recognition and response policy. Each ward received feedback on the day of the audit and each ward manager received a hard copy of the audit proforma for his or her timely action.
- The data was collected on three patients in the Chorley Hospital Critical Care Unit who had triggered early warning scores. The audit results showed that all information had been completed in two out of the three cases; the monitoring plan was completed and followed in all cases; all vital signs were recorded to be able to

calculate a NEWS on all sets of observations in only one of the three cases. However, where the NEWS score was greater than 5 (in one of the three cases) the escalation policy was followed appropriately.

- Staff were required to carry out risk assessments to identify patients at risk of specific harm such as pressure ulcers and risk of falls. If staff identified patients susceptible to these risks, staff were required to place patients on the relevant care pathway and treatment plans. We found that, patients were placed on the pathway which related to the risks identified including pressure care.
- Staff carried out 'safety huddle' meetings once a day where specific patient needs were discussed.
- The critical care outreach team provided cover for the wards and theatre recovery areas across the hospital over seven days between 8am and 8pm. The team was enlarged in August 2015 and now included a Sepsis Nurse and an Acute Kidney Injury Service.
- Cover from 8pm to 8am was provided by the Hospital at Night Team that was managed by the Hospital at Night Nurse who was also the site manager.

Nursing staffing

- Acuity (the severity of illness in patients) and skill mix was determined by the Core Standards for Intensive Care Services (2013). There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty.
- Due to the low numbers of patients being admitted to the unit, nurse staffing was provided and planned on an on call rota basis from Preston Hospital. This ensured that there was always enough staff to staff the unit as needed. There was also a band 6 critical care nurse on site at Chorley District Hospital at all times to ensure that immediate critical nursing provision was available if a patient was admitted to the unit in an emergency.
- The staffing levels expected within the unit was minimally one nurse to one level 3 patient and one nurse to two level 2 patients, 24 hours a day.
- The staffing in the department was sufficient and we reviewed staffing rotas which showed staffing levels were within recommended guidelines for most shifts. On the shifts where the staffing figures fell below the recommended guidelines; this was due to short term and last minute absence. This was immediately rectified by obtaining staff form the Preston site. Managers had responded appropriately to try to address these staffing deficits.
- In accordance with the guidelines, there was a Band 8A Matron post, the identified Lead Nurse who was solely responsible for the critical care unit.
- Data relating to staffing was not disaggregated per site as the nursing staff cross covered between both sites. At the time of the inspection there were 3.5 nursing vacancies within the service. Senior
- The June 2016 turnover rate for nursing staff within the service was 9.12%. These meant that in one year 9.12% of the nursing employees left and were replaced by a new employee. A lower turnover rate indicates stability in the workforce and means that key skills and experience remain within a department. The rate was below the trust target of 10% or less staff turnover rate.
- Sickness rates for nursing staff working in the department were higher than the national average of approximately 4% at 9.5%.
- The service completed a yearly nurse staffing audit using a recognised workforce planning tool. The tool calculated the workforce and skill mix required to provide the nursing care needed in the department during the audit period.
- During our inspection we visited Brindle Ward where we were told, there were four high dependency Level 2 beds.
- However, we found that this ward was not routinely staffed with the numbers required for level 2 beds. The beds on the ward were used for patients with non-invasive ventilation and chest drains that would not usually be regarded as requiring high dependency. The normal staffing level on the ward was 1 Nurse and 1 Healthcare Assistant.
- We were told that staffing on the ward would increase if a patient's acuity rose to Level 2 but the ward staff were unable to tell us whether the beds were commissioned at level 2 and how often there were any high dependency patients on the ward.

Medical staffing

- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care. The medical staff also rotated through the unit at Chorley District Hospital, however

there was always a middle grade doctor on site who had training in the management of patient airways. In addition to this consultant cover was provided from the Royal Preston Hospital and was available 24 hours a day.

- The Intensive Care Standards state that there must be a designate Clinical Director and/or a Lead Consultant for Intensive Care. The department previously had a Lead Consultant and an Assistant Clinical Director. However, since moving from part of the Anaesthesia Directorate to part of the Acute Medicine Division, critical care now had its own Clinical Director.
- There were sixteen Critical Care Consultants working on the units. Critical Care Consultants were accessible 24 hours a day, 7 days a week. All were members of the Faculty of Intensive Care Medicine, Fellows of the Faculty of Intensive Care Medicine or Fellows of the Royal College of Anaesthetists (or both).
- Consultants covered a number of specialities within the critical care arena and were called upon for advice and training in their own specialities. Examples of areas of expertise among the consultants were: critical care anaesthesia; pain management; intensive care unit medicine; delirium and sedation; resuscitation; acute kidney injury; neuro intensive care; sepsis; cardiopulmonary exercise; liver failure; organ donation and end of life care.
- When patients were present in the unit, because of its small size, the staffing levels of consultants and doctors to patient ratio did not exceed 1:4 during weekdays or during out-of-hours service and this was well within ICS standards of 1:8 during weekdays and 1:15 during out-of-hours.
- The department had recently recruited a first Advanced Critical Care Practitioner (ACCP) and there were plans to recruit more.
- From August 2016, there had been an improvement to Consultant work patterns to deliver continuity of care. They had moved to a block-working pattern that involved three major changes of team per week where previously there had been six. Consultants now worked Monday to Wednesday, Wednesday to Friday or Friday to Sunday with a three-hour handover and grand round on Wednesday lunchtime. Consultants told us that they preferred block working and patients were receiving better continuity of care.
- Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- The unit was also participating in the Royal College of Anaesthetists Medical Training Initiative that allows a limited number of doctors from overseas to benefit from the opportunities of working in the NHS for a limited period, and receiving specialised training, before returning home.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handovers.

Major incident awareness and training

- The trust had a Major Incident plan that was available through the trust intranet pages.
- With regard to Critical Care, in the event of a major incident, lower risk patients would be moved within the hospital to other available and appropriate wards.
- The unit had been working with the Surgery division and another trust to plan what would happen in the event of a marauding terrorist attack and in the event of multiple burns victims. As a result of this the service had obtained stocks of double-flow oxygen meters to be used in the event of a terrorist attack.
- The service also had robust plans in place for the event of a disease epidemic.

Are critical care services effective?

Requires improvement

At the previous inspection in July 2014 we rated effective as good, following this inspection we have changed this rating to requires improvement because:

- The service was not meeting the Intensive Care Standards which states that at least 50% of nursing staff should complete a post qualification in critical care. Only 43% of nursing staff had completed such a qualification.
- There was a lack of a specialist critical care trained pharmacist on weekends

- Appraisal rates were low at 62% which was deterioration from the previous inspection.

However:

- Patients accessing critical care services received effective care and treatment that followed national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Intensive Care Society.
- Patient outcomes were better when compared with units of a similar size and nature.
- The service participated in local and national audits.
- The trust's policies and procedures reflected national guidelines and best practice.
- Patients' nutritional and hydration needs were identified and addressed appropriately.
- Patients received timely analgesia when they required it.
- Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team.
- Staff sought appropriate consent from patients before delivering treatment and care.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE) and National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations.
- Policies and procedures reflected current national guidelines and were easily accessible electronically and also in paper form in the department.
- We observed that patients were placed on evidence based care pathways when appropriate.
- The service used the NICE clinical guideline 83 on the rehabilitation after critical illness in adults. The trusts audited against aspects of this guideline, however these audits focused on areas outside of the critical care service. The service had an action plan to improve compliance with this clinical guideline but this action plan had not been updated since 2010 and there was no evidence that any of the actions listed had been carried out.
- Assessment of delirium acute confusion was routinely assessed by nursing staff, in accordance with CAM-ICU guidelines. If there were doubts, staff would involve a Psychologist to make an assessment of the patient.
- The critical care services participated in local and national quality audits and the service had a comprehensive audit plan. This plan included speciality audits including the use and utilisation of the critical care outreach team and the use of intravenous fluids in critically unwell patients.
- The service was part of the critical network of England, Wales and Northern Ireland. As a part of this network the service audited key areas of the service and units against standards set out by the Faculty of Intensive Care Medicine (FICM). A gap analysis undertaken in October 2015 showed that 16 out of 106 standards were partially met by the service; an example of this was the availability of endoscopy for urgent gastro intestinal bleeds 24 hours a day. There was an action assigned to this issue which was to develop a 24 hour rota for staff to respond to urgent gastro intestinal bleeds. However this action had not been updated since October 2015 and there was no evidence that the issue had been resolved. However 90 out of the 106 had been fully met by October 2015.
- The service provided a report on the audit of compliance against recommendations in relation out critical care outreach services. In 14 out of 67 of the standards audited the service were categorised as red which the trust defined as no action planned or in place. In 9 out of 67 of these standards the service was categorised as amber which the trust defined as action planned but not implemented and in 44 out of 67 standards the service was categorised as green which the trust defined as recommendation fully implemented. This report did not contain a date of specified location and we were unable to identify any evidence to support that action had been taken in response to the areas highlighted as requiring action.

Nutrition and hydration

- Staff identified patients who were not able to eat and drink and assistance was provided as they required. Fluid balances were checked and monitored and noted on patient records during the daily ward rounds.
- We found evidence in patient records that malnutrition risk assessments were completed appropriately in cases where patients were at risk of malnourishment.
- There was a full time Dietician for the critical care services. They were involved in the assessment,

implementation and management of appropriate nutrition support route. They did not routinely attend ward rounds though were available during the round if required.
- All patients with a tracheostomy should have communication and swallowing needs assessed when the decision to wean from the ventilator had been made and the sedation hold has started. There were difficulties in getting a speech and language team (SALT) assessment in a timely manner and this was often taking more than 24 hours.

Pain relief

- We observed that pain relief was routinely prescribed as part of sedation management and administered when required by patients who were conscious and able to ask for further pain relief.
- In all records we reviewed, which indicated patients required analgesia, this was prescribed appropriately.
- The critical care staff had guidance available about the medicines used for analgesia.

Patient outcomes

- The Intensive care national audit and research centre (ICNARC) between April 2015 and March 2016 showed that the service performed better than expected levels for all eight standards including blood unit acquired infections, high risk sepsis admissions, hospital mortality, non-clinical transfers and for unplanned readmissions.
- There were 26 patient deaths on the unit during this period which gave a crude mortality rate of 19.3%. This was within the expected range for similar units at 1.32 against an aggregate of 1.0.
- The average patient length of stay during this period was seven days, which was the same as units of a comparable size.
- Between April 2015 and March 2016, there were no unplanned readmissions to the unit within 48 hours of discharge and this was better than similar units where the average unplanned readmission rate was 1%.
- In the above period, there were no out-of-hours (post 10pm) discharges to the wards and this was better than similar units where there were an average of 2.1% out-of-hours discharges.
- Assessment of delirium acute confusion was routinely assessed by nursing staff, in accordance with Confusion Assessment Method for the Intensive Care Unit (CAM-ICU) guidelines. If there were doubts, staff would involve a Psychologist to make an assessment of the patient.

Competent staff

- Newly appointed staff were required to undertake an induction and their competency was assessed against practice based competencies prior to working unsupervised.
- The Medical Director was the responsible officer for medical workforce re-validation and appraisals. They were supported in this work by a deputy. The trust had a system for appraisals, training and revalidation. Staff were able to upload Continuous Professional Development and 3600 feedback documents. The datix incident reporting system fed into the appraisal and training system to highlight where more training may be required, for example, where staff were involved in repeated incidents or complaints.
- Staff told us they routinely received supervision and annual appraisals. Records showed the annual appraisal completion rate was 100% for medical staff and 62% for nursing staff against a trust target of 90%.
- Records showed that 81 out 179 of nursing staff across the critical care service which equated to 43% of staff had completed the post registration award in critical care nursing, which was lower than the Intensive Care Society (ICS) standard for at least 50% of staff to have completed this training. However a training plan was in place with a projected trajectory to meet this target by September 2017.
- Agency and bank staff received a local department induction on arrival to their shifts.
- The nursing and medical staff told us clinical supervision was available and were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- We saw evidence that there was effective communication and collaboration between multidisciplinary team members within the service and other specialities.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.

- Nursing staff told us they had good relationships with consultants and doctors of different disciplines.
- There was a twice daily Consultant Intensivist led ward round 365 days per year. There was direct nursing input to the ward round that was attended by the Band 6 leaders from each bed bay and the patient's nurse. Pharmacists and Physiotherapists did not usually attend the ward round directly but were available for input if required. At the Consultant shift change on Wednesday lunchtime, there was a three hour handover and grand round (where the medical problems of all patients were presented to the clinicians involved in the shift change). The handover also incorporated the Mortality and Morbidity meeting.
- There was also a twice weekly microbiology ward round and rapid access to telephone advice outside of this. Microbiological input to critical care is seen as essential to management of the septic patient.
- Safety huddles took place at the start of each shift during which specific patient needs were discussed and any incidents that had taken place were highlighted.

Seven-day services

- The unit was open 24 hours a day seven days a week.
- Staffing rotas showed that nurse staffing levels were sufficient to meet both the trusts and national guidelines during out-of-hours periods.
- Microbiology, imaging including CT scanning, physiotherapy and pharmacy support was available outside of normal working hours and at weekends. Physiotherapy support was available on the unit during the day on Saturdays and Sundays.
- Pharmacist services were delivered on weekdays by a trained critical care unit Pharmacist. On-call non-specialist Pharmacists delivered weekend services though they had access to specialist advice if needed.
- The lack of a specialist critical care trained Pharmacist on weekends had been re-added to the risk register by the Chief Pharmacist but given a low risk rating of 4. The Critical Care Governance Team had questioned the assessment and requested a meeting to review it. This had taken place just before our inspection. The risk rating was agreed at that meeting and reflected the level of harm and frequency of harm events from medication incidents captured in Datix reports.

Access to information

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- The records we reviewed were easy to locate and easy to follow. This meant staff could access all the information needed about patients easily.
- Information provided in handovers of patients from the unit to ward areas was accurate and detailed, which ensured the receiving staff had all the relevant information they needed.
- Staff were able to access trust policies and processes easily by using the trusts internal intranet pages.

Consent and Mental Capacity Act

- Staff sought consent from patients, who were conscious and able to give consent, prior to undertaking any treatment or procedures and documented this clearly in patient records.
- Staff had the appropriate skills and knowledge to seek consent from patients.
- Staff were able to articulate how they sought informed verbal and written consent before providing care or treatment.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals in "best interest" meetings at which all options were discussed before doing so.
- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- In response to cases where patients, who lacked capacity, were discharged to a ward and became agitated or suffered from delirium, staff routinely completed DoLS paperwork on discharge as security staff requested this.
- Staff were supported on the Mental Capacity Act and Deprivation of Liberty Safeguards by the Adult Safeguarding lead.

Are critical care services caring?

Critical care

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Staff treated patients with kindness, dignity and respect.
- Staff provided care to patients while maintaining their privacy, dignity and confidentiality.
- Patients spoke positively about the way staff treated them.
- Patients told us they were involved in decisions about their care and were informed about their plans of care.
- Staff took their time to support patients and ensure they knew what was happening.
- Staff showed that they understood the importance of providing emotional support for patients and their families.
- There were bereavement services `available for patients' relatives including chaplaincy and staff were aware of how to access these.

However:

- There was limited monitoring of patient satisfaction and the service did not participate in the NHS friends and family test.

Compassionate care

- The service did not participate in the NHS friends and family test (FFT). They undertook their own local satisfaction surveys; however there was no information available on any patients' satisfaction surveys for the unit at Chorley Hospital.
- We observed staff treating one patient who was present on the unit with kindness and compassion during all interactions. Staff took time to interact with this patient and treated them with dignity and respect.
- There were private rooms available where staff could speak to patients' relatives privately, if required, in order to maintain confidentiality.
- We spoke with one patient, who gave us positive feedback about how staff treated and interacted with them.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and felt fully informed about their care and treatment plan.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.
- Families were encouraged to keep patient diaries and we were told that many families took this up. This enabled patients to see and process their stay in the unit when they had recovered. The unit had a leaflet about what steps the patient may have gone through before discharge.
- The unit were looking into the legalities of keeping photos of patients throughout their treatment so that patients who later wanted to know and understand what had happened to them whilst on the unit could be shown more visually.
- Those patients that had been on the unit for four days or more were invited to a follow-up clinic. Clinics were held every week, seeing four or five patients per clinic. The patients met with a Band 6 Nurse from the Discharge Team and a Psychologist where any potential psychological or physical problems they may be experiencing post-discharge were discussed with referrals for further help and treatment where necessary. The patients were also brought back to the unit, shown their bed and staff talked through what had happened to them whilst they were there.

Emotional support

- Staff understood the importance of providing patients and their families with emotional support.
- We observed staff providing reassurance and comfort to patients and their relatives
- Patients told us that staff supported them with their emotional needs.
- Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.

Critical care

- The service had developed a support group for patients and their families following discharge form the unit. This group allowed patients and their relatives to share their experiences and gain support from others.
- Staff could also seek support from a palliative care team if a patient required end of life care. Patient and relative handbooks provided information about bereavement, counselling, chaplaincy and spiritual support services were available.
- There was a bereavement service in place to support patients, relatives or staff.
- Once a year, the critical care service held a remembrance service for relatives of patients who had died on the units. A local supermarket donated flowers for the service.

Are critical care services responsive?

Good

At the previous inspection in July 2014 we rated responsive as requires improvement, this was because the unit was underutilised; there was a lack of clarity around admission and referral to the unit and a partial critical care outreach service. We have increased this rating to good following this inspection because:

- There was sufficient capacity within the critical care service which meant patients were admitted promptly and received the right level of care.
- NHS England data showed bed occupancy levels between January 2016 and April 2016 were consistently better than the England average.
- Patient's individual needs were considered and accommodated.
- Complaints were well managed and there was a trusts wide approach to investigation of these complaints.
- The trust had an escalation plan in place and staff followed the steps set out in this policy in times of increased pressure.

However:

- Patients were not always discharged from critical care services in a timely manner. However ICNARC data showed that the unit at Chorley Hospital had consistently less delayed discharges when compared to similar units across England.
- There was insufficient Physiotherapy staffing to meet the minimum expected standards.

Service planning and delivery to meet the needs of local people

- The critical care services were provided for adults over the age of 16 years.
- There had been a recent downgrading of the Emergency Department at Chorley Hospital to an Urgent Care Centre which had resulted in fewer patients being admitted to the unit from the local area. However, GP medical admissions had increased to the hospital as a whole, although these admissions tended to be of a lower acuity.
- The planning of services delivered at the unit was also co-dependent on the provision of expansion plans at Preston Hospital. Four further Level 2 beds were due to open at Preston Hospital in November 2016 and it was though by senior staff that this was likely to involve increased patient transfers from Chorley and the redistribution of staff to facilitate the opening of these further beds.
- The trust had worked on a revised model of critical care services for Chorley Hospital, recognising its underutilisation. However, planning of the critical care service was on hold until a decision had been made about whether the Emergency Department would re-open as such.
- There was a visitors room available on the Unit at Chorley Hospital for patients relatives to utilise. This room was adequately sized and comfortable for the number of expected visitors based on bed numbers.

Meeting people's individual needs

- There were adequate facilities in the unit to allow access and use by disabled patients. Including wide corridors and rails in disabled bathrooms.
- Information leaflets about services available and discharge advice were readily available in the department. Leaflets could also be provided in different languages or other formats, such as audio, if requested.
- Staff told us that they could access a language interpreter if needed and were able to show us how they would do this. This was provided in a variety of methods including face to face and telephone interpreting and written translation.

Critical care

- Access to psychiatric support was readily available from the rapid assessment and interface discharge (RAID) team which was provided by a neighbouring trust.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).
- There was a pathway for patients living with dementia which guided staff on how best to treat and meet the needs of these patients. There was also a trust wide strategy to guide the care provided to patients living with dementia.
- Staff received mandatory training in dementia and how to care for patients living with dementia.
- Critical care standards recommend that patients receiving rehabilitation are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of five days a week, at a level that enables the patient to meet their rehabilitation goals. The unit was not compliant with this standard due to staffing and time constraints. There had been a 20% increase in referrals in the last two years. Respiratory physiotherapy was being prioritised over musculoskeletal therapy.

Access and flow

- There were 134 admissions to the Chorley Critical Care Unit from April 2015 to March 2016. During the same period there were 26 deaths on the unit.
- Patients could be admitted to the critical care services via the urgent care unit or from operating theatres, wards and departments across the hospital. Admission to critical care services was guided by the trusts admission and discharge policy with all admissions needing to be discussed between the referring team and the critical care consultant who was based at Preston Hospital.
- Intensive care standards determined that patients should be admitted to intensive care within 4 hours of the decision to admit. This was not formally audited by the trust but an audit of performance against the national standards stated that this was generally achieved.
- A Consultant reviewed patients within 12 hours of admission that was in accordance with national standards for intensive care services.
- Data showed bed occupancy levels were consistently lower than the England average of 85% at between 8-46%. When bed occupancy rates above 85% this can cause increased pressure within an inpatient area and can increase the risk of harm to patients in those areas.
- The intensive care national audit and research centre (ICNARC) collects and collates data relating to key areas of access and flow in relation to all critical care units in England. Data from these audit reports for 2015 and 2016 showed the number of patients transferred out of the critical care unit at Chorley Hospital for non-clinical reasons was within expected levels but was higher (worse than) than in other units of a similar size and nature at 1.5% against an average of 0.7% in similar units.
- Information from the 2015 and 2016 ICNARC audit reports also showed the number of reported delayed discharges and delayed discharges greater than eight hours was within the expected range and was better than other units of a similar size in 2016. Delayed discharges of between four and 24 hours were 38.5% against 36.1% for similar units. Delayed discharges exceeding 24 hours were higher than (worse than) figures for similar units with 22.9% of patients experiencing a delay of greater than 24 hours against 18.6% in similar units.
- Staff told us that there were no issues with obtaining critical care beds at Chorley Hospital and expressed that access and flow was managed effectively.
- There was a trust wide and hospital specific escalation policy and plan in place for use in times of increased pressure. This was available to staff via the trusts intranet site.

Learning from complaints and concerns

- Complaints were handled in line with trust policy and were resolved locally wherever possible.
- Information on how to raise a complaint and contact details for the Patient Advice and Liaison Service was displayed in visitor areas on the unit.
- Staff were aware of the complaints procedure and escalated any complaints received to the Matron to deal with at the earliest opportunity. Similarly, if a complaint was received through PALS (Patient Advice and Liaison Service), they would contact the Matron to see whether this could be resolved informally at a local level.
- The trust recorded complaints on the trust-wide system. Complaints were logged onto this system and

acknowledged by the trusts customer service team. The trust expected all complaints be acknowledged within three working days of receipt. In 2015/16 the trust met this standard in 98.5% of cases.
- A local complaints tracker was kept to monitor the progress of any investigations and responses against the timescales required in the policy and any liaison with PALS.
- In the four months before our inspection, no formal complaints had been received about the critical care unit. The few informal complaints received had been resolved by early face-to-face meetings.
- Feedback and lessons to be learnt from complaints was fed back to staff at the earliest opportunity and training needs for individual staff or groups of staff were identified from the complaints tracker.
- The Medical Director met with the Nursing Director on a weekly basis to examine any complaints that had been graded as most serious (level 3) formal complaints. They tracked how any investigations were progressing against timelines and ensured that lessons learnt were drawn up and disseminated appropriately.

Are critical care services well-led?

Good

At the previous inspection in July 2014 we rated well led as requires improvement, this was mainly because there was no clear or widely understood plan for the future utilisation of the unit. We have changed this rating to Good following this inspection because:

- The trust's vision and values were clear and staff were aware of these.
- There were good governance frameworks and managers were clear about their roles and responsibilities.
- Risks were identified, monitored and there was evidence of action taken, where appropriate.
- There was clear leadership in the service and staff spoke positively about their leaders.
- There were areas of innovation and leaders within the services were working to continually improve services.
- Staff were positive about the culture within the service and the level of support they received from their managers.

However:

- Staff did not think that the Executive Team were very visible at the Chorley site and that Middle Managers did not communicate important messages in a timely manner.

Leadership of service

- The critical care unit (ICU) was part of the medical division which was split into three further divisions acute medicine, specialist medicine and long term conditions. The ICU was incorporated into the sub division of acute medicine. The service had only recently moved into this division following a reorganisation of the divisional services and structures.
- The Medical Division as a whole had a Medical Director; Associate Medical Directors who were responsible for horizon scanning (a systematic examination of information to identify potential threats, risks, emerging issues and opportunities), working with local GPs on the local health economy and Clinical Directors who were responsible for various hospital departments.
- The divisional structure had a divisional medical director, divisional director and a head of nursing. These three senior staff worked together to ensure the smooth running of the division across the medical, nursing and operational aspects. The division also had three business managers who were responsible for the operational aspects of the division.
- A matron with responsibility for the ICU based at Chorley and Preston Hospitals was also in place and reported directly to the head of nursing for the division. There were a number of senior and junior sisters who rotated through to the Chorley site but were predominantly based in the ICU at Preston Hospital. However a band 6 level sister was present at the Chorley site 24 hours a day, seven days a week.
- The Critical Care Units had a designated Clinical Director and a Lead Consultant for Intensive Care who were responsible for leading the medical staff and the service planning of the unit.
- The leadership in the division and unit at Chorley Hospital reflected the vision and values set out by the trust. Staff spoke positively about their managers and leaders.
- Leaders had clearly defined roles and were visible, respected and competent in their roles.
- The trust had an active leadership programme and we were told that candidates undertook projects as part of the course and the course was challenging.

- There were clearly defined and visible leadership roles in the department.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.
- The Medical Director worked in Critical Care for one day a week as a Consultant so did not lose touch with what was happening in their specialised area.
- The Chief Executive of the trust regularly undertook a "Back to the Floor" role where they worked with a different hospital team for a day, for example, Porters, Catering staff and Medical Device Technicians. They produced a Friday message for staff in the trust to keep them informed of headline news and there was a regular "Team Brief" for staff.
- However, staff in Focus Groups told us that they felt that there were communication issues with Middle managers not communicating important messages in a timely manner. The Executive Team told us that this had been recognised and a leadership course had been written specifically for middle managers.
- Staff also told us that the Executive Team were not very visible at the Chorley site, despite a member of the team working there on a daily basis on a rota system.

Vision and strategy for this service

- The trust had set of values based on five key areas, these were care and compassion, recognising individuality, seeking to involve, team working and taking personal responsibility.
- The trust has devised an acronym (a word formed as an abbreviation from the initial components in phrases or words) to help staff understand the values and apply them to their day to day working lives. The acronym was ALWAYS, reminding staff to "Ask your opinion"; "Listen to you and involve you in decisions about your care"; "Welcome you and show you respect"; "Assist and care for you"; "Treat you as you would like to be treated" and "Be sensitive to your individual needs".
- These values were displayed prominently around the hospital site and on the trusts intranet pages.
- Staff were aware of these values and embodied these values in the behaviour we observed during the inspection.

Governance, risk management and quality measurement

- There was a robust governance framework within the service and this extended to the Chorley ICU.
- Senior managers were clear on their roles in relation to governance and they identified, understood and appropriately managed quality, performance and risk.
- There was a risk register in place and there was a clear alignment of risks recorded with what staff told us was concerning them. Managers regularly reviewed, updated and escalated the risks on these registers, where appropriate. There were also action plans in place to address the identified risks.
- There was a system in place that allowed staff to escalate risks to divisional and trust board level through various meetings.
- Job planning for Consultants had improved so that from delivering a 38 week year on average from a planned 42 weeks, they were now delivering a 41.5 week year. This had saved the trust £800,000 in extra duty payments.
- All work streams throughout the trust concentrated on six key areas to report on and feed upwards through trust meetings. They had the acronym G-PRIME and this covered Governance; Performance; Revaluation; Improvement; Medical staffing and Education.
- Audit and monitoring of key processes took place across the service to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives through performance dashboards and meetings.
- There were monthly meetings held which included governance subjects and also a specific governance meeting and we saw minutes from these meetings.
- There were routine staff meetings for the staff working on the unit to discuss day-to-day issues and to share information on complaints, incidents and audit results.

Culture within the service

- There was an open, patient centred culture where staff were encouraged to raise any concerns about safety and staff were proud and positive about their work.
- Staff told us that both nursing and medical staff were approachable and able to provide them with good support.
- Staff told us there was a friendly and open culture.
- Records showed sickness rates for medical staff in the ICU at Chorley Hospital were low at around 1.7%. The sickness rates for nursing staff were higher at 9.5% on average for 2015/16. This was above trust acceptable

targets of 4.2% or less. We asked the senior managers in the division to explain why the sickness rates were high for nursing staff and they told us that this was due to a number of staff unfortunately having health problems at the same time. They told us that this was a sudden increase in the sickness rate and they were confident that this was now decreasing as staff returned to work. Nursing sickness rates were at around 5.61% at July 2016 and the rates were showing a downward trajectory. The sickness was not classed as work-related. An action plan had been written to improve sickness rates.

- The average staff turnover rate for nursing staff was 9.12% (at June 2016) and 8.1% for medical staff. This was below the trust target of 10%.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The critical care service did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment. Due to the complex nature of care provided in critical care meant that patients were either sedated or unable to communicate effectively with staff. This meant that staff were not able to directly gain feedback from patients in critical care. Patients would have been asked to participate in NHS Friends and Family Tests when they were discharged to a ward. However they did take part in a local satisfaction survey which allowed patients to provide feedback on their experiences after discharge or during follow-up appointments.
- The information from the surveys was used to look for improvements to the services.
- A review of data from the CQC's adult inpatient survey 2015 showed that the trust was about the same compared with other trusts for all 11 sections. The survey looked at the experiences of people who received care at an NHS hospital in July 2015. A questionnaire was sent to 1250 recent inpatients at the trust and 501 responses were received. The survey asked questions around a number of topics, such as waiting lists and planned admissions; waiting to get a bed on a ward; the environment of the ward; doctors and nurses; care and treatment; operations and procedures; leaving hospital and overall experiences. Sections received an overall score out of 10 and the survey showed that scores ranged from 5.4 out of 10 for overall views of care and services to 8.9 out of 10 for waiting lists and planned admissions. All scores were judged to be "About the same" (rather than better or worse) than other trusts.
- We were told that the trust had good connections with local 6th form colleges and the Manchester Medical School at Manchester University so they could attempt to "grow their own" future staff.
- We were told that in the near future, a "Virtual Hospital" would be online for the local colleges so that local students could study in an interactive hospital.
- The service had also developed a patient and family support group which gave patients and their families the opportunity to obtain support, share their experiences and talk about what they had been through. The support group held regular meetings and was initially set up with a former patient who suggested that patients may suffer flashbacks and feel the need to talk through what had happened to them whilst undergoing intensive care. Meetings were held every one to two months in the evenings or on a Saturday morning to allow as many former patients to access them as possible.

Staff engagement

- Staff participated in regular team meetings led by the service matron and managers.
- Staff told us they received support and regular communication from their managers in the form of emails, daily briefings and individual interactions.
- The trust board also engaged with staff via briefings and through the trusts internal intranet site.
- The trust performed about the same as other trusts surveyed across England in the 2016 GMC trainee doctor survey.
- The trust performed largely the same as other trusts in the 2015 NHS Staff Survey, however there were three positive findings which related to the percentage of staff working extra hours and two questions relating to harassment and bullying and two negative findings which related to effective team working and Organisation and management interest in and action on health and wellbeing. The trust had an action plan in place to address the areas identified for improvement in this survey.
- In addition to the overall staff survey, the Matron had also delivered a bespoke staff survey for critical care staff where they were invited to suggest what would

make things better for them specifically on the unit. Small requests, such as the addition of a staff microwave were said to have made a big difference and staff had commented that they felt able to make them without feeling that they were complaining.

Innovation, improvement and sustainability

- Staff and managers were continually striving to improve the care and treatment patients received. An example of this was the development of a patient and family support group for patients who had previously been discharged from the units in both Preston and Chorley Hospitals and their families.
- There was a realistic and comprehensive local strategy for the service and division, including a business plan with clear objectives.
- Staff were able to suggest improvements to managers and they considered and implemented them where possible.
- The unit had a running club for staff to help promote and improve their health and wellbeing.
- The service had also introduced a specialist discharge coordinator specifically for the critical care units. This was introduced to facilitate the often complex discharges from these areas and it was hoped that this would improve patients discharge experiences.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services are provided at the Chorley and South Ribble Hospital (CDH).

Maternity provision is provided in the Chorley Birth Centre (CBC) that is a freestanding birth centre, which includes three en-suite birthing rooms, two rooms having a birthing pool. It provides a homely environment, with one-to-one midwifery care, and is suitable for patients with low-risk pregnancies. The team is managed through the maternity services as part of the wider acute Lancashire Teaching Hospitals NHS Foundation Trust.

There is an integrated service between the community midwives and the two birth centres at Chorley District Hospital (CDH) and Royal Preston Hospital (RPH).

Between April 2015 and March 2016, the CBC delivered 276 babies, which was 6% of the total births across the acute Lancashire Teaching Hospital NHS Foundation Trust. The home birth rate for the same period was 87 births, 2% of the overall trust births.

Gynaecology services included outpatient clinics.

We visited the maternity and gynaecology departments on the Royal Preston and Chorley hospital sites during the announced inspection between 27 and 30 September 2016 and the unannounced inspection on the 14 October 2016.

During our visits, in total, we spoke with 43 staff, six patients and two family members across the Royal Preston and Chorley sites. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 22 patients and 18 medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

At the previous inspection in July 2014 we rated the service as good overall. Following this inspection we rated have this service as requires improvement overall because:

- All staff reported a shortfall in staffing and an increasing quantity of work and activity within the service. Management told us that the midwifery staffing levels had not been formally reviewed since 2011. This was also a concern raised at the time of the last CQC inspection in 2014 although it was noted that since 2014 there had been an increase of 10 full time midwives.
- The maternity service was currently waiting for the Birthrate Plus (a national tool available for calculating midwifery staffing levels) review and report, which will calculate the number of clinically active midwives required to deliver a safe high quality service.
- Due to staffing issues and sickness absence rates, there was a heavy dependence on midwives working extra hours. The trust did not use agency staff but used their in-house bank staff on an ongoing basis. Midwives working over and above their normal working hours provided additional midwifery staffing. Community staff gave us examples of working a 24-hour shift and managers working a 60-hour week.
- All midwifery staffing, including community were flexed to meet the needs of the service user. Managers were aware of the staffing shortfall and recruitment was underway. Staff informed us that the current measures in place were not sustainable and insufficient to mitigate the risk of harm. Due to the pressures of work, staff morale was low but staff of all professions supported each other well to work as a team. There was a desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst midwives.
- Not all staff attended annual mandatory training or received their annual appraisal performance review in order to discuss and evaluate job performance and career development.

However:

- There was an integrated service between the community midwives and the two birth centres at RPH and CDH.
- Care at the Chorley Birth Centre was provided in a calm, relaxed and spacious environment that had been specifically designed and equipped to support normal births. The centre comprised of spacious en-suite birthing rooms, each with a birthing pool, specialised birthing equipment and separate family rooms.
- There were clear systems for reporting incidents and managing identified risk within the service.
- Clear protocols and prompt cards were in place for all staff with relevant training in the management of obstetric emergencies. Regular training sessions were held with the ambulance service regarding transfers from the birthing centre at Chorley to the obstetric unit at RPH.
- CBC used a carbon fibre “Baby Pod” as a transport device for unwell babies who need transferring to RPH by ambulance. The unwell baby is comfortably secured in position by a vacuum mattress and soft positioning straps. The vacuum mattress is moulded around the baby and air is removed with the aid of a vacuum pump to hold the mattress in shape. All resuscitation procedures can be continued while the baby is securely positioned in the pod.
- Medicines were delivered, stored and dispensed safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.
- We found that committed and compassionate staff delivered maternity and gynaecology services. All staff treated patients with dignity and respect. People we spoke to were positive about the care they had received.
- Gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as good. Following this inspection we have rated safe as require improvement because:

- All staff, including management, reported a shortfall in staffing and an increasing quantity of work and activity within the service. The midwife to birth ratio was currently 1:31 (mean national ratio of 1:29.5 births, RCM 2011). The maternity service was currently waiting for the Birthrate Plus report, which would calculate the number of clinically active midwives required to deliver a safe high quality service. This was a concern raised during the previous CQC inspection in 2014.Although it was noted that since 2014, there had been an increase of 10 full time midwives.
- Staffing issues, combined with sickness absence rates of four to five percent, showed a heavy dependence on community midwives, extra hours being worked by staff and in-house bank staff being used on an ongoing basis. Midwives working over and above their normal working hours provided additional midwifery staffing. Community midwifery staff informed us that they were stretched to meet the needs of the service user and provide safe care. However, managers were aware of the staffing shortfall and recruitment was underway. Staff informed us that the current measures in place were not sustainable and insufficient to mitigate the risk of harm.
- Due to the pressures of work, staff told us morale was low but that staff of all professions supported each other well to work as a team. We observed a desire to provide the best care staff could to the patients and the inability to achieve this led to dissatisfaction amongst some midwives.
- Many staff were not up to date with mandatory training requirements. Staff reported that this was often due to increased clinical demands and staff shortages. Records showed that the maternity staff compliance rate in medical device training was 28%. The trust target was 75%.
- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.

However:

- There were clear systems for reporting incidents and managing identified risk within the service.
- All babies had security identification tags applied to ensure their safety.
- The wards were clean and infection rates were within expected ranges.
- Medicines were stored, dispensed and administered safely.
- The wards were adequately maintained and equipment was readily available and fit for immediate use. Resuscitation equipment was available and fit for use by suitably trained staff.

Incidents

- There were systems for reporting incidents across the maternity and gynaecology services. Staff informed us they reported incidents and were confident and competent in doing so. They told us that they knew what to report and were able to show us how they would report an incident through the electronic reporting system.
- Mortality and morbidity meetings were held regularly and all staff were invited to attend, with contributions valued and encouraged. The group was multidisciplinary and included colleagues from the paediatric team. Staff told us they were also aware of different forms of feedback, such as the risk meeting and regular newsletters.
- A weekly maternity incident review meeting took place every Friday morning at the RPH. A similar meeting took place on the gynaecology unit every Thursday. Staff who attended both meetings included nurses, midwives, medical staff, neonatal staff and anaesthetists and the Head of Midwifery. Staff informed us that they reviewed around 20 to 30 new incidents per week. All incidents and action plans were discussed and reviewed. However, some staff said the meetings were difficult to get to due to poor staffing levels.
- Staff we spoke to were aware of the process for the Duty of Candour.

- Lessons learnt and "Lessons of the week" were distributed to staff and discussed at all handovers and staff huddles. We also saw evidence of this in the trust magazine for women's health and notice board displays in the clinical areas.

Safety thermometer

- Information about harm free care was displayed in both the maternity and gynaecology clinical areas.
- The Head of Midwifery (HOM) informed us that the displayed information in the maternity areas was specific to maternity care and included the number of post-partum haemorrhages and infections. Staff were aware of this data collection and said it was discussed at the safety huddle to assess the performance of the ward.

Cleanliness, infection control and hygiene

- The Birth Centre appeared clean and tidy and each room was stocked with appropriate personal protective equipment. The gynaecology areas were clean but appeared old and tired.
- Community midwives were provided with personal protective equipment for home births.
- During our inspection, we observed good personal protective equipment practice, whereby staff were observed to be wearing gloves or washing their hands. Hand washing facilities and hand gel were widely available to staff and the public. However, we did observe one member of staff making a bed without using the correct protective items.
- We were provided with the most recent hand hygiene and uniform audit that had taken place in the department, in August 2016. Overall, the unit scored 100%, which indicated that staff had complied with best practice. This information was displayed on the performance board between the antenatal and postnatal wards.

Environment and equipment

- We found evidence of daily checking and recording of emergency resuscitation equipment in the Birth Centre.
- Equipment was clean and regularly checked. All the equipment we saw had service stickers displayed and these were within date.
- The trust's biomedical engineering team, under a planned preventive maintenance schedule, serviced equipment.
- The Birth Centre was bright, spacious, clean and well equipped. Equipment included Bradbury couches(unique shape which helps to obtain the most comfortable position during birthing), en-suite facilities, birthing mats, birthing balls, drop down beds for partners to stay, pools, projectors to play relaxing music and protract smoothing relaxing images onto the wall , Bluetooth speakers and aromatherapy oils.
- The maternity areas within the Birth Centre had rooms available for parent craft teaching sessions, breast feeding workshops, baby hearing screening and antenatal patients who needed a Glucose Tolerance Test (to test for diabetes).
- The community midwives home birth equipment box was well supplied with equipment such as protective aprons and gloves, blood taking packs, emergency bleeding packs, suturing packs and equipment to assist with the delivery of the placenta.
- Community midwives delivered a clinical waste box to patient's houses that were booked for a homebirth. All dirty clinical waste, following delivery, was securely packed into the clinical waste box and transported, back to the birth centres for disposal, in the community midwives car.
- During our inspection, medical devices maintenance list was provided by the trust. Overall, maternity staff competency and compliance was 28%. The trust target was 75%. This did not assure us that staff were competent to use equipment available in their ward and department.

Medicines

- The community midwives carried portable cylinders of medical gases in their cars, when attending a homebirth. These cylinders were in appropriate carrier bags, clearly labelled and in date. When not in use, we observed that cylinders were stored on the floor, in a key coded locked room in the actual birth centre and on the floor in a key coded locked staff changing room on the ground floor at the CBC. BOC (2011) recommend that cylinders are stored horizontally.
- The trust did not complete any risk assessment for midwives carrying medical gases in their cars and did not have a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car. Guidance on the security and storage of medical gas cylinders (NHS report 2014) states that a risk assessment should be undertaken to establish the physical security

requirements for the storage facility and that all of these systems and each step of the medical gas cylinder process should be written into a standard operating procedure.

- There were good systems in place for the recording, administration, storage and disposal of medicines in all areas.
- Staff had access to the policies and procedures for medicine administration on the hospital intranet.
- We observed that the records of fridge temperatures were recorded well in the maternity and gynaecology areas we visited.
- Community midwives did not routinely carry pethidine as pain relief for home births. There was no evidence or examples that patients had requested pethidine for a homebirth but staff were aware of controlled drugs trust policy and the safe dispensing and transportation, from delivery suite to the patients home, of a controlled drug if required. The trust policy was discussed with the community midwives, matron and CQC pharmacist at the time of inspection to ensure it was in line with national guidance on the secure dispensing of controlled drugs within a community setting. Between the announced and unannounced visits, the trust also enquired at other maternity units as to their policies. We were assured that a safe process was in place.

Records

- The Birth Centre used yellow hand written notes for their deliveries. However, at the acute trust, recording of labour and birth details were recorded electronically on the new K2 system.
- There were clear plans of care for patients in medical and nursing records. These included antenatal assessments, referrals to other centres for specialist consultations, discussions with patients and families, discharge notes to secondary care providers and communication notes from community midwives.
- Records were securely stored to protect their confidentiality for patients in the Birth Centre.
- During our inspection, we looked at 18 sets of patient records. Documentation in all the records was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Appropriate clinical risk assessments were in place within the patient's record. However, some prescription charts in the gynaecology ward were incomplete.
- The 'Child health record' (red book) was issued to mothers and advice was available on how to keep the record as the main record of a child's health, growth and development.

Safeguarding

- All babies had security identification tags applied to ensure their safety. Staff told us that the Birth Centre had a different tagging security system to RPH and reported no problems.
- Babies wearing security tags were checked and logged every morning by staff.
- Children and young people safeguarding training were available for all the midwives across the service. However, there was some discrepancy about what level the training was provided. Management informed us that the safeguarding training agenda consisted of level two training (required for non-clinical and clinical staff who have some degree of contact with children) but was considered by the service as equivalent to level three training (clinical staff working with children and young people (Safeguarding children and young people: intercollegiate document, 2014). Therefore, management considered all midwives to have level three safeguarding training but they recorded it as Level 2. This did not assure us that management had an understanding of the training requirements and that all midwives were appropriately trained. This was highlighted to management at the time of inspection.
- All the staff we spoke with were very positive about the support and advice from the safeguarding and vulnerable women's team and they felt well supported to manage safeguarding concerns.
- Staff informed us that patients who did not attend antenatal clinic or screening appointments were followed up by either the ANC midwives or community midwives, according to the trust missed appointments policy. If contact continued to be a concern, the midwives would contact the GP and enhanced vulnerable women's team. However, this was not stated as an action point in the policy.
- Safeguarding information was held in a designated file, which was separate from the patients hand held records. When the patient left the hospital in the

postnatal period, staff continued to undertake chronological records by accessing this file. A photocopy or scanned document of the chronology documentation was now routinely sent to the community midwifery office from the wards. After each visit, the community midwife updated the chronology on her return to base. Training was provided to community staff to ensure chronologies were updated appropriately and in a timely manner.

- Gynaecology staff informed us that they could access the safeguarding team online. Staff would notify the team regarding patients with learning difficulties. They would also inform the specialist vulnerable midwives team regarding patients involved with domestic abuse issues or Female Genital Mutilation (FGM). Staff completed a "DASH" checklist, to help identify high risk cases of domestic abuse, stalking and 'honour'- based violence.

Mandatory training

- Between September 2015 and August 2016, a variation of 65% and 91% of gynaecology staff had completed the trust mandatory training. No trust target was provided.
- For the same period, midwifery compliance for mental health training was variable between 88% and 92%.
- Antenatal screening was completed by between 93% and 98% of midwives. For post-operative interventions (curriculum not stipulated) between 94% and 98% of midwives had completed the training. There was no trust target provided.
- Training figures for maternity relating to October 2015 to September 2016 showed that 69% of staff had completed the Mandatory Study Day, 66% had completed the clinical study day and 63% had completed the professional study day. This three-day training included moving and handling, infant feeding and safeguarding level 2 update, risk management, Supervisor of midwives (SOM) update, screening, perineal care and suturing, CTG, intravenous fluids, VTE and research updates.
- Over the previous 12 months, 66% of midwives had completed the "PROMPT" (PRactical Obstetric Multi-ProfessionalTraining) programme which included shoulder dystocia, perineal mental health, neonatal resuscitation, breech birth and post-partum haemorrhage. No trust target was provided. No compliance figures were provided from the trust for the obstetric team.
- Over the previous 12 months, 76.19% of midwives had completed the AIMS (Association for Improvements in the Maternity Services) course. No trust target was provided. No compliance figures were provided from the trust for the obstetric team.
- From October 2015 to September 2016, CTG training completed by midwives varied from 55.4% compliance in August 2016 to 84.8% in December 2015. Between 93% and 98% of midwives had completed stop smoking training for this period. Breastfeeding training varied between 75.1% compliance in August 2016 to 91% in December 2015. Clinical moving and handling training completion rates varied from 88.8% to 92.5% of midwives for the same period.
- The trust provided us with data for three different target groups of staff who had completed Newborn Life support (NLS) training.
- Between September 2015 and August 2016, midwives who had completed NLS only training ranged from 78.6% in November and December 2015 to 43.4% in April 2016. For the same period, midwives who had completed the newborn resuscitation only training ranged from 85% in November 2015 to 61.7% in August 2016. Compliance figures for all midwives who had completed either one of the training between September 2015 and August 2016 ranged from the highest rate of 86.9% in November and December 2015 to the lowest rate of 57.3% in April 2016.
- From September 2015 to December 2015, between 70% and 81.2% of midwives had completed adult resuscitation training. However, figures provided by the trust showed that between January 2016 and August 2016, compliance rate was between 43.5% and 64.3%. It was unclear if training was monitored on a rolling programme, which was reset in April 2016 (start of new financial year) or it was based on the moment in time as to the percentage of staff trained who needed to be trained.
- A Simulation doll was available for resuscitation training.
- The trust informed us that no midwives were part of the trusts' conflict resolution target audience for training. The last midwife to have had any training was in 2012.
- Between August 2015 and August 2016, 85% of midwives were compliant in children's safeguarding training. The trust target was 90%. However, there was some discrepancy about what level the training was

provided. Management informed us that the safeguarding training agenda consisted of level two training but was considered by the service as equivalent to level three training.

- Adult safeguarding Level 1 training was completed by 86% of nursing and midwifery registered staff by the 31 August 2016. Trust target was 85%. Adult safeguarding Level 2 training was completed by 59% of nursing and midwifery registered staff by the 31 August 2016. Trust target was 75%.
- Mental Capacity Act training data received from the trust showed that 93% of nursing and midwifery staff had completed that training. However, there were no dates provided for when this initial training was completed.
- The trust informed us that 88% of midwifery staff had completed domestic violence training in the last 12 months. No trust target was stated.
- Some staff we spoke with confirmed that it was sometimes hard to access professional development days due to staffing levels. Staff told us they were encouraged to complete their mandatory training but clinical demands and staff shortages sometimes prevented staff from being released from the clinical areas.
- Gynaecology staff informed us that essential and mandatory training was completed annually but e-learning requirements were more difficult to complete due to staffing levels and clinical duties.

Assessing and responding to patient risk

- In the case of a deteriorating patient, staff at the CBC knew how to call the hospital emergency crash team. Staff told us that this has only occurred once in the last two years.
- If a deteriorating patient needed emergency transfer to the RPH, a 999 ambulance would be called. A midwife travelled in the ambulance with the patient. The staff worked flexibly across community and the two Birth Centres to ensure patients were transferred responsively and safely.
- CBC used a carbon fibre “Baby Pod” as a transport device for unwell babies who need transferring to PRH by ambulance. The unwell baby is comfortably secured in position by a vacuum mattress and soft positioning straps. The vacuum mattress is moulded around the baby and air is removed with the aid of a vacuum pump to hold the mattress in shape. All resuscitation procedures can be continued while the baby is securely positioned in the pod.
- Information provided by the trust showed that in December 2015 and January 2016, there were 35 births at the CBC and 17 transfer of patients to the delivery suite at the RPH. Reasons for transfers were all reviewed by management and deemed appropriate. These included maternal high blood pressure, undiagnosed breech presentation , static baby growth, , fetal bradycardia (slow heartbeat of baby), delay in 1st stage of labour (when contractions gradually open up the neck of your womb), delay in 2nd stage of labour (pushing stage when baby is born), epidural (pain relief) and baby passing meconium (baby faeces) before delivery. The majority of transfers occurred during the night shift. There were 2 occasions where staffing was reduced due to sickness where transfers occurred. Midwives working flexibly across from community resolved this to ensure all transfers occurred responsively and safely.
- An Early Warning Score (EWS) clinical audit took place in Feb 2016 to review compliance and correct use of the National Early Warning Score (NEWS) and escalation plan for patients at risk of deterioration. Five obstetric patient notes and vital signs charts were reviewed on delivery suite. Findings showed that 80% of all information was completed. One hundred percent of vital signs were completed to calculate NEWS. NEWS calculated accurately scored 80%. There were no triggers at the time of the audit. Ten gynaecology patients’ observation charts were reviewed. Findings showed that 60% of all information was completed. Ninety percent of monitoring plans were completed and followed. Ninety percent of vital signs were completed to calculate NEWS. NEWS calculated accurately scored 90%.
- A repeat EWS audit took place in May 2016. Ten gynaecology patients’ observation charts were reviewed. Findings showed that 70% of all information was completed. Ninety percent of monitoring plans were completed and followed. Sixty percent of vital signs were completed to calculate NEWS. If NEWS scored greater than five, escalation policy was followed in 100% of cases. Recommendations and an action plan were in place to improve practice. A repeat audit was due to take place in September 2016.

- There were protocols in place for the emergency transfer of patients from the either birth centres to the delivery suite at the RPH. This was facilitated using a blue light ambulance and informing the maternity emergency bleep holder at the hospital of the imminent transfer. A midwife from the birth centre would accompany the patient and handover their care giving all necessary information at the hospital.

Midwifery staffing

- The responsibility of both the Chorley Birth Centre and Preston Birth Centre was the role of one manager. She also managed the community midwifery team and the Enhanced Support Midwifery team. This managerial post was mainly based at RPH.
- The birth centre manager was also "Site Manager" three times per week at RPH. This involved managing areas outside her expertise, which could be time consuming.
- The CBC usually had two midwives and one Health Care Support Worker (HCSW) working on day shifts. If there were no patients on the birth centre during the day, one midwife would go out into the community to work.
- On night shifts, there was one midwife and one HCW working in the CBC.
- Out of hours, there were two community midwives on call for homebirths. If there were no planned homebirths, these staff rotated between the birth centres and the delivery unit at RPH.
- The birth centre manager told us that there was 55 whole time equivalent staff on her whole team. Sickness levels were equivalent to 4.7 full time staff. She also told us there was an ageing staff population and four staff had recently retired, some staff were retiring but coming back to work on the retire and return policy available to staff. None of her staff worked less than 3 days per week to ensure the service was adequately covered and continuity of care was provided as much as possible. At the time of or inspection, staff off on maternity leave was equal to four full time staff. We were told that these posts were back filled.
- A full time dedicated midwife was based at the antenatal clinic at the CDH. Three days per week, she worked on her own at the Chorley site, offering drop in appointments for patients, completing pregnancy booking appointments and managing phone calls. There were no dedicated clinics on these days. On Wednesday and Thursdays, a midwife and a health care support worker went to the Chorley site from the Preston site to assist with dedicated clinics.
- Staff told us that there were staff shortages in all areas due to sickness, maternity leave, retirement, posts waiting be filled through recruitment and an increase in births since the opening of the second birth centre in November 2014. The trust informed us that current midwifery staffing numbers were based on calculations performed in 2011. Since then, we were informed, there has been an increase in patients using the service, changes in the model of service and an increase in complexities of conditions that meant a need to increase the midwifery-staffing establishment.
- Managers told us they were also aware of the effect low staffing numbers was having on staff sickness and staff burnout and there was a potential increase in Patient Advice and Liaison Service (PALS) and formal complaints as well as damage to the service reputation.
- All the managers and staff described midwifery staffing as a day-to-day "challenge". The service did not use agency staff. It relied on their own staff working overtime or extra shifts. Staffing was highlighted as a concern in the previous inspection in 2014.
- Management informed us that over the past few months, the activity and acuity within the service had increased. This had been acknowledged by the increase in reported incidents relating to shortage of staff. Staff informed us that August 2016 and September 2016 had been particularly challenging months. The escalation process has been followed and a number of times the on-call community midwives have been called to attend and support the complex midwifery model. Community midwives told us that this affected their work schedule for the following day and occasionally had to rearrange home visits.
- Management informed us that since 2015, new senior staff had been appointed and at the time of our inspection, they were aware for the need to increase staffing levels. We were informed that the division had undertaken a review of staffing from June to August 2016 using the Birthrate Plus model. The final report was due soon after our inspection and management informed us that it was clear that further investment in midwifery staffing would be required.

- Gynaecology staff also reported issues with reduced staffing and an increased workload. One staff member told us "that the amount of work at times was a concern". On the unannounced visit, the gynaecology ward had the correct staff rostered on duty.
- Sickness absence rates were between 4-5% across the maternity services. This was slightly above the trust target.
- We saw examples of community staff covering the delivery unit. Community midwives and managers told us that this had negative effects on continuity of care to their patients in the community setting and that it was possible for postnatal patients to be seen by different midwives. Staff told us that they had managed to maintain 1:1 supervision for patients in labour, but that it had been very challenging. They also informed us that they have never had to cancel the home birth service due to staffing or increased workload within the maternity unit.
- Midwives told us that they were concerned that they were unable to work within their code of practice due to conflicting demands on their time and the care of patients with complex medical needs.
- Community midwives told us a lot of their extra work was done on "good will" and they often felt too tired to work due to the demands of being on call, called out during unsocial hours and working in the maternity unit. They worried about the safety of their own practice. Midwives said they had highlighted their concerns to senior management and were told to contact the supervisor on call if any concerns or worries. However, they said that most staff do not contact the supervisor or bleep holder and "they just get on with it".
- Staff reported they did not get their breaks and this left them exhausted. They told us the teamwork and desire to assist patients to have a good experience kept them coming to work; however, morale was low due to the shortages of staff. Examples were given to us about staff working over and beyond their contracted hours.
- The community midwives had a rota, which included rotating into the birth centres when they would also be the midwife on call for the community. There were two midwives and one midwifery assistant in the birth centre at night, which meant this staffing, was sufficient.
- The trust informed us that both Birth Centres achieved 100% 1:1 midwifery care in established labour but they had only just developed an acuity tool for those areas and had no evidence to demonstrate this at the time of inspection

Medical staffing

- Gynaecology nurse at CDH informed us that they had a good working relationship with the doctors and felt very supported in their specialist nursing roles.
- Midwifery staff at the Birth Centre also reported working well within their rotational role, with consultant and junior doctors.

Major incident awareness and training

- Managers and other staff we spoke with were aware there was a major incident policy however, some staff were unaware of any role they may have within it.

Are maternity and gynaecology services effective?

Requires improvement

At the previous inspection in July 2014 we rated effective as good. Following this inspection we have rated effective as requires improvement because:

- Staff annual appraisals were not always completed. Only 54% of maternity staff and 73% of gynaecology nurses had completed their annual appraisal between September 2015 and September 2016. The trust target was 90%.
- Data provided by the trust showed that maternity staff competency and compliance for medical devices training was 28%. The trust target was 75%.
- Trust data informed us that 49.1% of gynaecology staff had received Female Genital Mutilation (FGM) training; however, no specific training dates were specified by the trust for when this training occurred. The trust stated that staff who had not received full training due to ward pressures had been shown where the resources were and how to go about reporting FGM. FGM training was only available on mandatory study days held in 2015.
- Policies and guidelines were not robustly updated. Of the maternity polices and guidelines reviewed 30% were

out of date. However policies were easily accessible and in line with National Institute for Clinical Excellence (NICE) and other guidelines such as the Royal College of Obstetrics and Gynaecology (RCOG).
- The unplanned home birth rate was only recorded from January to June 2016 on the maternity dashboard. This ranged from 16.7% in February and April 2016 to 66.7% in January and March 2016. The wide variations and increased figures during certain months were discussed with management at the time of inspection. The trust informed us that there was some confusion in the trust about how this data was collected and recorded and it was not an accurate reflection of the true numbers of unplanned homebirths every month. This has not been audited by the trust.

However:

- The provision of the midwifery led birth centre offered patients a choice of a "normal" childbirth. Midwives attended the North West network for normality to share good practice and learn from others. This met with the Royal College of Midwives guidance on normality.
- There was an integrated service between the community midwives and the two birth centres at CDH and RPH.
- The Local Supervising Authority Audit took place in May 2016. The findings showed the supervisors of midwives were a strong, well-established and experienced team with a sound knowledge base. The team demonstrate an innovative and patient centred approach by improving care for all patients.
- There was evidence that research studies were used in the development of guidelines and practice, for example management of reduced baby movements.
- The Local Supervising Authority Audit took place in May 2016. The findings showed the supervisors of midwives were a strong, well-established and experienced team with a sound knowledge base.
- Audits took place to monitor the quality of the service provided. There was a comprehensive maternity information system in place for collecting and monitoring patient outcomes.
- Patients received timely pain relief.
- Systems were in place to offer good support for mothers who wished to breast and bottle-feed.
- There were examples of effective multi-disciplinary working in obstetrics and gynaecology services.

Evidence-based care and treatment

- Policies and procedures were in line with NICE/Royal College guidance. This included controlled drugs policy, post-operative nausea and vomiting in adult patients, Venous Thromboembolism (VTE) prevention and removal of Bartholin's cyst.
- A Preston Birth Centre Operational Policy and Chorley Birth Centre Operational Policy were provided by the trust, which included information about recommended staffing numbers for the birth centres as well as indications for transfer, management of obstetric emergencies, discharge home process and examination of the newborn.
- Staff in all areas knew how to access policies and procedures and they were available in both written form and on the intranet.
- The trust was taking part in the four elements of the 'Saving Babies Lives' (DOH 2016) programme, which included smoking cessation intervention, baby movement monitoring, better cardiotocography (CTG) understanding, and improved detection of growth restricted babies (GROW package). This provided standardised procedures, training and tools for assessment of baby growth and birthweight.
- The trust had developed customised individual growth charts and closer monitoring of reduced fetal growth through increased number of scans. This was in line with RCOG Green top guideline 2013.
- Midwives collected data for audits and did receive feedback following completion of audits.
- The provision of the midwifery led birth centre offered patients a choice of a "normal" childbirth. Midwives attended the North West network for normality to share good practice and learn from others. This met with the Royal College of Midwives guidance on normality of birth.
- There was evidence that research studies were used in the development of guidelines and practice such as induction of labour for patients over 35 years, self-hypnosis as pain relief in labour and prevention of pre-term labour.
- We observed research notice boards around the maternity and gynaecology areas that contained information about research projects. Some notice

boards contained clinical guidelines such as reduced baby movement's pathways. We also observed dedicated and up to date diabetic and Supervisor of Midwives notice boards.
- A place of birth risk assessment audit reviewed 32 sets of hospital notes from patients who delivered in May 2015. The aim was to look to see if patients delivered in the appropriate place. Data from the audit showed that all notes audited had a booking risk assessment fully completed and documentation of requested place of birth at booking documented. It also showed that all patients delivered in the most appropriate place in accordance to their clinical situation.

Pain relief

- The birth centre offered Entonox as a form of pain relief. Other alternative pain relief such as water, Tens machines, music and aromatherapy.
- Staff informed us that 82% of patients used water as a form of pain relief at the Birth Centres. Sixty percent of patients gave birth in water, which staff felt reduced the numbers of epidurals requested.
- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet individual need.

Nutrition and hydration

- There was a patients' kitchen where patients and partners could make hot and cold drinks and snacks. Staff if required also supplied food.
- The trust was not currently working towards the Baby friendly accreditation. The UNICEF UK Baby Friendly Initiative (BFI) provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method. However, the HOM had plans to implement the initiative again soon with the help of the infant feeding team.
- Breast feeding initiation rates, recorded on the maternity dashboard between July 2015 and June 2016, showed an average rate of 70%. (UK Infant Feeding Survey 2010 showed that 83% of patients in England breastfed their babies after birth).
- Assistant practitioners also provided post-natal support for infant feeding. They worked in both the hospital and community setting.

Patient outcomes

- Data from the trust maternity dashboard between July 2015 and June 2016 contained comprehensive information such as delivery rates, bookings performed, third and fourth degree tears, smoking and breast-feeding rates, stillbirth and blood loss rates. However, there was no trust or national targets on the dashboard. The rates were compared to the previous year's rates and coloured coded if rates had increased or decreased from the previous year.
- Data showed that between the 12 months recorded, the planned home birth rate was between 1% and 2%. This rate increased to 3.3% in December 2015. National home birth rate is 2.3% (Office of National Statistics 2014).
- The unplanned home birth rate was only recorded from January to June 2016 on the dashboard and this ranged from 16.7% in February and April 2016 to 66.7% in January and March 2016. This was discussed with management at the time of inspection, as these figures seemed high. Data provided by the trust informed us "there has been a bit of confusion over this. We did question this field last time we discussed the dashboard. What it actually means is that 66% of all the home births that month were unplanned. In reality, this is likely to mean that one was planned and two were born before arrival. This has not been audited by the trust"
- From December 2012 and April 2016, there were seven unplanned homebirths reported as incidents. All were reviewed and in six of the cases, staff took appropriate action at the time. The most recent incident in April 2016 was an unplanned home birth, with missed Small Gestational Age (SGA - smaller than normal growth of the baby). The importance of continuity of care and fundal height measurements (measureof the size of the uterus used to assess baby growth) as per guidelines were highlighted to staff. The severity of all unplanned home births was recorded as "no harm".
- Transfer of patients from the CBC to the delivery suite at RPH varied widely over the 12-month period recorded on the dashboard. January 2016 recorded a 3% transfer rate. However, for 6 months during this period the rate was between 10.5% and 20%. September 2015, December 2015 and February 2016 recorded rates between 30% and 32%.

- Midwifery led delivery rates had increased from 17.9% in the previous 12 months to 24.2% between July 2015 and June 2016. This was largely due to the opening of the PBC in November 2014.
- Booking patients before 12 weeks and 6 days was only above 90% in two of months between July 2015 and June 2016. NICE guidelines (2008) recommend that ideally patients should be booked around 10 weeks of pregnancy. This data was not provided on the dashboard.
- From April 2015 and March 2016, the total number of third degree perineal tears for CBC was 1.7%. There was no fourth degree perineal tears recorded. For the same period, the PBC had a 2.9% third degree tear rate. Fourth degree tears were recorded as 0.4%. This was within national recommended rates.
- Between July 2015 and June 2016, the stillbirth rate was 0.4%. This was down from 0.6% in the previous 12 months. This was below the national average for stillbirths in the UK.

Competent staff

- Maternity staff appraisal rates, up to the September 2015 to September 2016, showed that only 54% of staff had their annual appraisals completed.
- Ninety-two percent of rotational midwifery staff and 93% of specialist midwives had their appraisals completed, however; only 14% of CBC staff, 19% of PRH ward staff and 20% of the maternity support team had their annual appraisals completed. The trust target was 90%.
- One senior staff member told us that she had 14 staff members and that she had only completed two staff appraisal this year. An appraisal gives staff an opportunity to discuss their work progression, professional and personal development and future aspirations, objections and goals. This did not assure us that staff development was discussed and reviewed appropriately.
- From August 2015 to August 2016, there were 41 gynaecology nurses employed at the trust. Only 30 of these nurses had completed their annual appraisal, which was a compliance rate of 73%. One hundred percent of gynaecology specialist nurses at CDH had completed their annual appraisal; however, only 57% of specialist nurses at RPH had completed their annual appraisal.
- Data provided by the trust showed that maternity staff competency and compliance for medical devices training was 28%. The trust target was 75%.
- There was an integrated service between the community midwives and the two birth centres. Staff rotated between the different areas of work. Community midwives were rostered to work shifts on the births centres as well has provide community services. Some midwives felt this reduced the continuity of care within the community service.
- There were sufficient numbers of supervisors of midwives within the hospital. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure the mothers and babies receive good quality, safe care. As supervisors, they provide support, advice and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the Nursing and Midwifery Council. All midwives had an annual review by their allocated supervisor.
- The Local Supervising Authority Audit took place in May 2016. The findings showed the supervisors of midwives were a strong, well-established and experienced team with a sound knowledge base. The team demonstrate an innovative and patient centred approach by improving care for all patients. The team continued to build strong links with clinical governance and were appropriately reviewing serious incidents, conducting supervisory investigations and liaising appropriately with the LSA.
- Staff informed us that skills and drills training took place every Thursday at the CBC, which was run by the Birth Centre manager. All midwives could attend. Topics on the programme included bleeding after birth, pumps for administrating drugs, shoulder dystocia, breech delivery, cord prolapse, maternal collapse, high blood pressure, baby resuscitation and lessons learnt.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From discussions with members of the multidisciplinary teams, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.

- Maternity staff had been regularly asked to attend multi-agency meetings and contribute to pre-birth plans. There was good communication between the primary care and community health services.
- Staff were complimentary and respected the roles of the specialist midwives and consultant midwife.
- Midwives provided basic stop smoking advice and Carbo Monoxide testing to patients. Referrals to help patients quit smoking were referred to the local community stop smoking service.
- Gynaecology staff told us that many of their services were nurse led but the consultants were good to work with and they had a good rapport between them.
- Gynaecology staff also reported working closely with the McMillan Nurses and the adjourning cancer centre.
- Gynaecology staff told us they had good communication with GP and community midwives.
- Gynaecology staff informed us that they worked closely with the bereavement midwife and bereavement liaison officer. These specialist staff provided support and advice to staff and patients. They also provided pregnancy loss packs and resources to families. There was also a Chaplaincy service available to bereaved families.

Seven-day services

- The birth centre had 24 hours a day midwifery cover for patients to access.
- Community midwives provided on call cover 24 hours a day, 7 days per week.
- Weekly smear clinics were available weekly across the Preston and Chorley sites.
- Antenatal and postnatal services and visits were provided by the community midwives in various locations such as GP practices, Sure Start centres, high street shops such as Tesco's and Boots and patients homes.

Access to information

- Information notice boards were displayed in the clinic areas. This contained information such as audit outcomes, lessons of the week, IT issues and updates, incidents, complaints and claims.
- Staff accessed a closed Facebook page, where a lot of communication and information was shared safety.
- The maternity service used two different information technology (IT) systems and they were unable to communicate with each other. Individual staff had to input data separately onto both systems. The trust had recently introduced phase three of the new K2 IT system on delivery suite, which pulled information electronically from one system to the other. However, the old IT system was still being used in some areas. The introduction of the new computer system within the department was recorded on the risk register.
- Labour and birth details were being recorded electronically on the new K2 system on delivery unit at RPH. However, the Birth Centres still used yellow hand written notes for their deliveries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff, we spoke with, were aware of their role and responsibility regarding the care and support of any patient who lacked mental capacity.
- All staff we spoke to were aware of the consent procedure.
- Consent forms, we reviewed on the gynaecology unit, were completed.

Are maternity and gynaecology services caring?

Good

At the previous inspection in July 2014 we rated caring as good, we have maintained this rating following this inspection because:

- Midwives and nurses were respectful, caring and considerate to patients and their families.
- Patients were complimentary about staff and the care they had received. They described midwives and maternity support workers as very caring, considerate, helpful and kind. They recognised they were very busy but said the care they received was good despite this. There was recognition by staff of patients who may need additional emotional support and this was available from other specialists such as the bereavement midwife and Enhanced Team if required or through discussions and support at the "Births after Thoughts" clinic.
- There were facilities for partners to stay overnight at the Birth Centre, while their partner was in labour. There were also double bed family rooms for partners to stay.

- The Birth Centre Friends and Family Test (FFT) received positive comments; however, overall figures were low.

However;

- There was mixed feedback from the FFT for the gynaecology wards.

Compassionate care

- From June 2016 to August 2016, seven patients responded to the Friends and Family Test (FFT). Six patients stated that they were "extremely likely" to recommend the service; one response said they were "likely" to recommenced the service.
- The maternity FFT test from February 2016 to July 2016 showed that between 83% and 95% of patients would recommend the antenatal care. Between March 2016 and July 2016, between 94% and 98% of patients would recommend the trust for birth. Between 95% and 98% of patients said, they would recommend postnatal community service. Between 88% and 98% of patients would recommend postnatal community provision.
- Information provided by the trust showed that the FFT in the gynaecology department, up to August 2016, showed that there were 107 responses from patients. Of those, 71 patients said they were extremely likely to recommend gynaecology service.
- The trust did not have a formal home birth satisfaction survey although there were positive comments on the friends and family test results and the comments books on the birth centres, which were reviewed during the inspection.
- We spoke to a couple who had recently delivered at the Chorley Birth Centre, who praised the care they had received and spoke very positively about the staff.
- An audit of patient satisfaction in colposcopy clinic took place over a four-week period in November 2015. 40 patients from CDH and 40 patients from RPH completed the questionnaire. 86% of patients received written information prior to an appointment. This was down from 97% in the previous audit. 86% of patients said they received an explanation about the risks and benefits in a way that they understood. Ninety six percent said they were treated with respect and dignity and 97% said the care they received in the outpatients department was excellent, very good or good.

Understanding and involvement of patients and those close to them

- There were facilities for partners to stay overnight at the Birth Centre.
- There were also double bed family rooms for partners to stay.
- A partner, we spoke to, was very happy about the care his partner had received at the Birth Centre and was also complimentary about how he was treated and involved in the labour by staff.

Emotional support

- Midwifery staff told us that advice and support for antenatal complications were managed sensitively.
- Staff we spoke with understood the need to provide emotional support for mothers, and carried out assessments for anxiety and depression. Women who had complications during or following birth were offered a postnatal listening service. Information about how to contact the "Birth after Thoughts" service was provided in leaflets available to patients. The service had a maternity bereavement midwife to support patients and their partners following the loss of their baby.
- The dedicated bereavement midwife and bereavement liaison officer provided staff and patients support and advice on both the maternity and gynaecology wards. Resources such as support contact numbers and items such as memory boxes, pictures, handprints were all accessible to bereaved families in a sensitive and dignified manner, taking into consideration different cultural and religious needs. A chaplaincy service was also available to families.
- An Enhanced Support Team worked across both the maternity and gynaecology areas. This team included specialist staff in perinatal mental health, drugs and alcohol misuse, and a safeguarding midwife to provide advice and support to vulnerable patients. This team was well respected and valued across all areas and were involved with supporting staff also.
- The dedicated specialist Mental Health midwife worked within a multidisciplinary team providing support and care. A special mental health clinic ran regularly.
- Gynaecology staff told us that all local gynaecology oncology patients were assigned a key worker for support. However, staff told us that patients based at Chorley might not always see a key worker.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Good

At the previous inspection in July 2014 we rated responsive as good, we have maintained this rating following this inspection because:

- Specialist midwives such as the bereavement midwife and Enhanced Support Team and specialist nurse clinics in the gynaecology service cared for individual needs and patients with complex needs.
- There had been no closures of the maternity services between January 2015 and June 2016.
- Gynaecology referral to treatment times met the national recommendations with rapid access to clinics available.
- Services were planned to facilitate access for patients from a wide geographical area.
- There were services to meet the needs of patients from differing social and cultural backgrounds and many examples of specialist services and adaptations.

However:

- Community midwives told us that they were struggling to provide continuity of care to patients in the community when they were required work in the maternity unit when it was busy and short staffed.

Service planning and delivery to meet the needs of local people

- A full time dedicated midwife was based at the antenatal clinic at the Chorley District General hospital. Three days per week, she worked on her own at the Chorley site, offering drop in appointments for patients, completing pregnancy booking appointments and managing phone calls. There were no dedicated clinics on these days. For the other two days, a midwife and a health care support worker went to the Chorley site from the Preston site to assist with dedicated clinics.
- Gynaecology services included many nurse led clinics and consultant clinics such as smear test clinics, colposcopy clinics, infertility clinics, pre-operative clinics, third degree tear perineal tear clinics that was midwife led and endocrine clinics.
- Community midwives told us that they were struggling to provide continuity of care to patients in the community when they were required to work in the maternity unit when it was busy and short staffed. They told us that management were aware.
- Community midwives told us about providing care in various geographical areas to help patient's access services easily. Examples such as Sure start clinic at health centres, Boots pharmacy and Tesco's supermarket
- Health Care Assistants ranphenylketonuria(PKU) and baby weight clinics weakly at local health centres. The PKU test is done to check whether a baby has the enzyme needed to use phenylalanine in his or her body. Phenylalanine is an amino acid that is needed for normal growth and development.

Access and flow

- Data obtained from the trust showed that there was an 18% transfer rate from both the PBC and CBC to the delivery suite. Staff informed us that these had all been reviewed, there were no themes or trends established, and all that transfers were appropriate at the time.
- Data received from the trust and gynaecology staff informed us that referral to treatment times met the national recommendations, with rapid access to clinics available. Between September 2015 and August 2016, administration compliance was above 95% for nine of the 12 months. The remaining three months had a compliance rate between 93% and 94%. For the same 12 months, pathway compliance was between 98% and 100%.
- The trust reported that there were no maternity unit closures between January 2015 and June 2016.
- The use of a safety huddle in the mornings on the labour ward involved all areas of the unit. They discussed patients, number of caesarean sections and inductions, staffing, safeguarding, all clinical areas including Chorley services, community services, antenatal clinic and support of staff for which they looked at a 24-hour period including gynaecological beds.
- We were informed that patients were able to self-refer to the maternity service and were able to choose where they wanted to give birth in discussion with the midwife.

Maternity and gynaecology

Meeting people's individual needs

- The maternity service offered patients and their families' four different choices of place of birth. This included the two birth centres, a community homebirth service and the delivery suite at the Preston site.
- A sitting room and familyroom provided additional facilities for new patients and their birth partners.
- Senior midwives informed us that they worked closely with patients who requested care outside of national guidance. Specific cases were discussed at operative and obstetrician levels and a variety of evidence was gathered by staff to discuss at multidisciplinary meetings. Midwives and Supervisor of midwives (SOM) worked closely with patients to create a suitable and safe patient care plan. This was saved and stored on the IT database for easy access for all staff. Staff gave examples where this had occurred with positive outcomes. Leaflets were available for mothers to help them decide where to have their baby. The leaflets outlined the choices available for patients, including the difference between midwifery-led care, consultant-led care and options for home births or attending the birthing centre. Other leaflets were available on the unit or from the midwives on the antenatal unit.
- We saw that information was available for people whose first language was not English.
- Staff were able to describe how they would access translation services.
- After caring for a deaf patient, a member of staff set up group for deaf patients.
- Birth option appointments for patients and their partners who have had a previous traumatic experience and for patients who had had a previous caesarean section were available. Patients were referred for an appointment with the consultant midwife to discuss anxieties and options and agree a plan of care. These appointments were supported by the specialist midwife for perinatal mental health with the option to refer to other health professionals if required.
- A team of specialist midwives and rotational staff provided a vulnerable patients service with responsibility for coordinating care for patients with complex social needs, including safeguarding and domestic violence.
- The role of the Public Health Specialist midwife, who was also a SOM, included public health issues such as smoking, breast-feeding, flu and whooping cough vaccinations.
- The consultant midwife ran the Vaginal Birth after Caesarean (VBAC) clinic to discuss birth options after previous having a caesarean section.
- We found that breastfeeding support was available across the service. The service had two part time designated infant feeding specialist midwives available to provide information and support about breastfeeding.
- The endometriosis service ran a telephone helpline, once a week, for patient follow up and support service.
- All the patients who had sustained a third or fourth degree perineal tear during birth attended a pelvic floor clinic, with appropriate follow-up in place.
- Gynaecology staff ran a "Health and Wellbeing" clinic where patient were able to access many different care providers such as specialist nurses, complimentary therapies, fatigue management, counselling, return to work advice and benefits advise.
- The gynaecology service offered patients interactive books developed especially for gynaecology patients.
- Gynaecology staff gave an example of support and care given to transgender patients, which included pre-planning meetings to accommodate specific requirements, while an inpatient.
- Gynaecology staff informed us that interpreter services were available via the Big Word telephone system.
- Gynaecology staff told us that they catered for a variety of different religious beliefs and had recently employed a band 3 bereavement liaison officer to support different religious customs and traditions.
- Gynaecology staff informed us about using a "passport" to assist patients with learning difficulties. Passports were designed to give hospital staff helpful information that is about not only illness and health. It can include lists of what the person likes or dislikes, from the amount of physical contact to their favouritetype of drink, as well as their interests. This will help all the hospital staff know how to make them feel comfortable.
- Gynaecology staff were involved with the "Forget Me Not" programme for patients with dementia. This helps staff to understand and improve the environment and well-being of people with dementia

Maternity and gynaecology

Learning from complaints and concerns

- Staff we spoke to were aware of the trust's complaints system and discussed with patients and relatives how to make a complaint, if they wished to do so.
- We found that leaflets were freely available with information on how to complain or raise concerns about the services.
- We found that the service was proactive in learning from complaints and concerns. A checklist had been developed that was sent to families after a serious incident to seek feedback from patients and their families on what happened and how the service could improve. This showed that the service was very open in responding to learning from complaints and concerns.
- Patient Advice and Liaison Service (PALS) leaflets and posters were available and visible in all the clinical areas.
- Information about supervisors of midwives and how to contact them was freely available on the unit.
- Complaints were discussed at the monthly meetings of the quality and governance committee safety huddles at shift handover.

Are maternity and gynaecology services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good. Following this inspection we rated well-led as requires improvement because:

- Morale was low due to the pressures of work and staffing levels. However, staff of all professions supported each other well to work as a team. There was an overwhelming desire to provide the best care they could to the patients and the inability to achieve this led to dissatisfaction amongst the midwives.
- Poor staffing was a cause for concern in the last CQC inspection in 2014 and remained the same issues during this inspection.
- Clinical governance and risk meetings were established but the attendance by clinical grade staff was limited and so it appeared that clinical governance was not integral to the management of safety within the service.
- The risk register was not as robust as expected with some expected parameters not included meaning that the process was not auditable.
- Leadership in maternity although improved was reported to lack visibility in some areas and that executive leads were not visible and communication from the executive felt remote.
- Community lead midwives were allocated one management day per week however; this was not protected time and was often hard to take due to busy workloads and staff shortages.

However:

- There was an obstetric strategic plan for 2016/17, which most maternity staff were aware of. There was also an obstetric business plan 2016 to 2018.
- Maternity and gynaecology clinical governance and risk meetings took place monthly where risks were discussed and reviewed.
- The service had just re-introduced the Maternity Services Liaison Committee which enables maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local patients, parents and families.
- There was good evidence of collaborative work with external networks and organisations with regards to evidence based practice and promoting "normality"

Leadership of service

- The Birth Centre manager divided her management role and time between the Preston and Chorley birth centres but told us realistically she only spent one day per week at the CBC.
- She told us she was more visible at the PBC as that was her main office base and was where most of her meetings were held. Therefore she was not as visible at the CBC to support staff as much as she would have liked to.
- The consultant midwife told us that she also split her time between the two birth centres but again felt she spent more time at the RPH site. She gave many examples of her proactive work locally, nationally and internationally supporting normal childbirth and promoting midwifery led units. All levels of multidisciplinary staff throughout the trust also were

keen to praise the work of the consultant midwife during our inspection. However, she told us that she was soon to leave the trust. Management told us that they were planning to advertise her post.

- In most areas band five and six midwives told us the managers were supportive but there was only so much the managers could do due to the poor staffing levels.
- Staff told us the leadership of the service in most areas had improved and that senior midwifery managers were more visible now than previously.
- However, other staff informed us while the midwifery matrons were visible, the HOM was only sometimes visible in the clinical areas and they never saw the divisional nursing and midwifery lead or the Chief Executive Officer(CEO).
- There was conflicting opinion amongst the senior midwives we spoke with about the midwifery management team. Whilst some described them as "proactive" and "research focussed" with a good mix of clinical and personnel management skills, others stated there was "a lack of managerial appreciation of what is safe and what is not". Management informed us that they were proud of the way the midwives worked and repeatedly told us that even though the staffing levels were "stretched" the hospital was safe for patients. This meant there was inconsistency in the way the leadership and safety aspect of the service was viewed by staff and management.
- Staff told us they felt "stretched and stretched" and "sad and unhappy" at times". They felt "frustrated with the way things were run" but passionate about the care they gave their patients. Staff told us that peer support among the teams was good but even though management were approachable and had an "open door" policy, they felt that senior managers had "priorities elsewhere".
- Staff highlighted that support from the SOM was good.
- Gynaecology staff informed us that matrons and senior management were approachable and visible. They reported an open door policy and a no blame culture. Staff felt respected, valued and care was patient centred. Staff reported, "loving their job".
- Community lead midwives told us that they are usually allocated one management day per week however; this was not protected time and was often hard to take due to busy workloads and staff shortages.

Vision and strategy for this service

- An overview of the obstetric strategic plan for 2016/17 stated the need for the development of the perinatal mental health service including external agencies, acknowledge the growing needs of vulnerable patients and families i.e. safeguarding and Female Genital Mutilation (FGM),the development of a high dependency unit (HDU) and Triage.
- Senior management were keen to continue to develop the two Birth Centres on both hospital sites.
- The majority of staff we spoke to were aware of future plans for the service. Senior managers informed us that they were in conversation with the local CCG regarding funding to move toward the "Patient Knows Best" initiative by the Perinatal Institute. This involves the introduction of the "MiApp" online records system that offers mothers and healthcare professionals full access to the clinical record of the pregnancy, birth and postnatal period. MiApp puts the mother in control of her own health record and is accessible on her mobile phone, tablet or home computer. The information can be shared instantly with primary and secondary care providers and links to GP and hospital based information systems, thereby avoiding double entry of data. MiApp promotes effective communication between the mother and her carers and ensures that patients have the opportunity to be fully informed and engaged in decision-making.
- The trust informed us that the provision of MiApp would enhance the recording of safeguarding issues and sharing of this information between relevant staff. A business plan had been completed and discussions were ongoing with the CCG regarding funding for a pilot project of MiApp.
- Senior management informed us that they were worried about midwifery staffing levels, staff morale and staff sickness rates. Currently sickness rates were between four and five percent, which was slightly above the trust target. Management were also aware of their ageing staff population and told us they were working with the local university to recruit their own students once qualified.

Governance, risk management and quality measurement

- There was a clinical governance and risk lead midwife, a governance facilitator, an obstetric consultant lead for governance and a consultant lead for gynaecology in the service.
- All maternity risks were managed and monitored by the clinical governance and risk management process at the weekly incident and risk meeting and reported to the clinical governance and risk management group monthly. All new significant and high risks were approved through the directorate processes in accordance with the Divisional Risk Strategy before being placed on the risk register.
- Between November 2015 and July 2016, monthly governance and risk meetings were well attended by the Clinical Governance and Risk Lead, Clinical and Medical Director and the HOM. However, there was poor monthly representation from clinical managers, team leaders, matrons, consultant midwife, SOM, gynaecology leads, vulnerable midwifery team, audit lead and Birth Centre representatives. Topics discussed included risk register, high-level investigations, lessons learnt, implementation new computer system (K2), maternity dashboard and thermometer and safeguarding.
- Gynaecology governance meetings took place every second month. Between January 2015 and May 2016 (10 meetings), the gynaecology ward manager attended nine of the 10 meetings. However, there was poor attendance from other senior nursing and medical clinical leads. Topics discussed included risk management issues, guidelines, patient information leaflets, training issues, gynaecology dashboard and service development.
- The trust provided a risk management report for the period between March 2016 and August 2016. There were no high risks reported.
- Any new risks were identified by all levels of staff and this was encouraged through directorate and team meetings. The trust told us they were proactive in the identification and management of risks. However, poor staffing, reduced consultant hours and baby security were all mentioned in the last CQC inspection in 2014 and still remained the same issues during this inspection.
- The gynaecology risk register provided by the trust, had only two items recorded on it. The risk register did not have any start or review dates, actions plans, timelines for completion of any actions or a named member of staff to lead and take ownership. The rating scores were not explained nor what the previous rating was at last review.
- As part of our inspection, we were able to observe the weekly risk meeting and saw evidence of how incidents were reported and appropriate follow-up actions identified, such as a formal review or root cause analysis if required.
- The trust produced a twice yearly Maternity Service Governance Magazine which included topics such as supervision, incidents, lessons learnt, risk register, patient case summaries, audit, safety and quality updates and research.

Culture within the service

- Staff acknowledged the challenges about staffing shortages. They felt that managers were aware of the issues and were trying to recruit more staff. However, staff generally felt there was low morale amongst the staff and some staff told us they felt exhausted and worried once they went home at the end of a shift. There was a similar acknowledgement in the last inspection report in 2014 where staff acknowledged the same challenges about staffing levels.
- Many staff across the service spoke enthusiastically about their work and were proud of the care they delivered as a whole team. They described that there was a culture of 'good will' within the service, but staff were worried about how far that good will could sustain the provision of good patient care.
- Staff we spoke to were aware of the Duty of Candour policy.

Public engagement

- The service had just re-introduced the Maternity Services Liaison Committee (MSLC) meeting in February 2016. This forum enables maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local patients, parents and families. Representation at these meetings included CCG, trust, NCT, GP and Public Health. Items on the agenda included service user engagement group feedback, performance update, MSLC Facebook page, UNICEF BFI, MiApp update, birth centre updates and complaints.

Maternity and gynaecology

Staff engagement

- Staff told us that they did not always feel engaged as part of the trust and felt that the senior managers were aware of the issues within the services but it did not always filter down to them. This was a change since the last inspection report in 2014, where staff did feel engaged.
- Staff told us that the CEO communicated through emails to staff, encouraging the staff to ask questions to the CEO, however, they told us that there were no staff meetings held in the trust for staff to attend to be "heard" or "voice" opinions. However, we were told by the trust that there was a "Valuing your Voice" intranet page which allowed staff to directly access senior leadership with issues.
- Community management informed us that they held a monthly team meeting but also encouraged the teams to have their own regular meeting. However, staff said this was sometimes impossible due to clinical and staffing demands.
- A new initiative by the community manager was to hold a "share the air" half hour booked time slot on alternative months, for staff to come to discuss anything. At the time of our inspection, only one meeting had been held where no staff turned up.
- Staff informed us about some student midwives who undertook some funding events to raise money for equipment for the CBC.
- A band 7 specialist midwife was trained in counselling skills and provided support and counselling to staff. The trust also had a support agency that staff could self refer too.
- Gynaecology staff told us that staff engagement and communication was mainly through team meetings, memos or by emails.

Innovation, improvement and sustainability

- There was a 2016 to 2018 maternity obstetric business plan. In this were the aims, objectives and challenges for the next five years of the service. These were both clinical and quality objectives and challenges with an action plan of how to achieve the improvements identified.
- Managers informed us that the midwifery service has been a stretched service; however, ensuring safety of mothers and babies was paramount. Patient safety was provided by monitoring incidents, outcomes and complaints relating to staffing. However, management acknowledged that midwives were working extremely hard to continue to provide an excellent service to mothers, babies and families which was a testament to them and but it was recognised that this was not sustainable.
- During our inspection, managers were waiting for the Birthrate Plus report in order to assess and recruit more staff. The report findings were to be presented within the Surgical Division and then to the Trust Board in November 2016, when an increase in investment for midwives would be requested.
- The consultant midwife received a COST European funding (COST is a European framework supporting trans-national cooperation among researchers, engineers and scholars across Europe) as part of a research project to work closely with midwives in Bulgaria to improve and implement Midwifery Led Care. Bulgarian midwives were planning to visit the Birth Centres in November 2016.
- The role of the consultant midwife included service innovation, research, education and clinical roles. However, she did inform us that she was soon to leave the trust. Her post was to be advertised.
- In some areas, individual staff members had been supported and encouraged to be innovative and develop practice ideas; however, they agreed that this had become difficult due to poor staffing levels, which meant their workload had increased.
- We saw several examples of research projects the service were involved with, including projects looking at inductions and reducing the risk of stillbirth. The consultant midwife worked closely with a large local university to review and set up new research studies.
- The maternity service had developed an information booklet called "your.choice where to have your baby". This provided planning and choosing where to birth information to healthy patients who had a straightforward pregnancy. The consultant midwife informed us that this booklet was to be used by NICE on their website for national use.
- The consultant midwife was also involved with national NICE guideline initiatives such as intrapartum guidelines, continuity of care guidelines and normalising birth in medical settings – supporting delivery suite staff. She was also participated in the intrapartum high-risk guideline group and was part of the national task force for supervision.

Maternity and gynaecology

- The consultant midwife informed us that the trust was waiting to hear if they became a site for the national Midwifery Unit Network. In collaboration with the Royal College of Midwives, the Maternity Network Unit offers support to those wishing to develop midwifery units (birth centres), and to those already established midwifery units. The network acts as a hub to share good practice and information resources, and be a community of practice with a shared philosophy essential to offer consistent, excellent and safe care for patients and their families.
- A "Maternity Unit Network Celebrating Maternity Units in Lancashire" event took place at RPH in July 2016. National leads, senior RCM representatives, consultant midwives and HOMs attended as well as a presentation from a local service user.
- In June 2016, local service users nominated midwives for the "Lancashire Health Hero's" Award.
- The consultant midwife won the RCM national award for "Evidence into Practice" in 2015.
- Gynaecology staff were shortlisted for the RCNI Nurse Awards 2016 for their telephone follow-up service for patients with endometrial cancer.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided by Lancashire teaching NHS Foundation Trust at the Royal Preston Hospital and Chorley and South Ribble Hospital.

The Chorley and South Ribble Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities, including: dermatology, cardiology, ear nose and throat (ENT), diabetic, orthopaedic and fracture clinic, ophthalmology, and therapy services. The hospital offers a comprehensive range of diagnostic and radiography services to patients including: general x-ray and ultrasound.

An outsourced dispensing service supplies all outpatient medicines on the hospital site.

Hospital episode statistics data (HES) March 2015 to February 2016 showed 610,732 outpatient appointments were offered across the trust. There were 200,118 appointments at the Chorley and South Ribble Hospital. The hospital was managed through the same leadership structures as the Royal Preston Hospital.

We visited the hospital as part of a comprehensive inspection of the trust between 27 and 29 September 2016 and we inspected all the outpatient and diagnostic services including fracture clinic, dermatology clinics, ophthalmology, physiological services, pathology, radiology and diagnostic imaging services.

During our inspection we spoke with 17 patients, one relative and 34 members of staff including, nurses, health care assistants, physiologists, clerical staff, doctors, physiotherapists and radiographers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and we examined 17 individual care records.

Outpatients and diagnostic imaging

Summary of findings

We inspected the hospital in July 2014 and gave outpatient and diagnostic imaging services an overall rating of requires improvement. Following this inspection we have maintained the overall rating because:

- The outpatients and diagnostics service was predominantly managed through the diagnostics and support services division. However key outpatient departments such as orthopaedics and ophthalmology were under a separate management structure. The recent changes in the divisional structure had led to some lack of clarity in terms of performance and governance.
- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- At our last inspection we found concerns within the ophthalmology department; clinics were sometimes cancelled at short notice and frequently ran late. At this inspection we found there were still issues regarding medical staffing and access to services in ophthalmology. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. The service had reported two serious incidents related to delays in accessing care and treatment.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Of the 16 separate specialties reported nine were below the England average.
- For incomplete pathways of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Although there was a clear process for reporting and investigating incidents, staff told us they had not received outcomes of incidents submitted. We found that improvements were required by the trust to ensure that staff received regular feedback on incidents.
- We found some areas did have significant vacancies such as radiology and ophthalmology. Staffing numbers and skill mix met the needs of the patients.
- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded. Patients were treated with dignity and respect by caring staff. However we observed patients having blood pressure monitoring in an open corridor. Patients spoke positively about staff and felt they had been involved in decisions about their care. Care provided was evidence based and followed national guidance. Across outpatients and imaging services we found there was good local leadership and staff were committed to meeting the needs of their patients. Overall staff worked well as a team and supported each other.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

At the previous inspection in July 2014 we rated safe as requires improvement mainly due to the issues with a move from paper to electronic records. We have maintained this rating following this inspection because:

- In the period 01/08/2015 to 31/07/2016, there had been one never event in the diagnostic services at the Royal Preston hospital. We found that staff at Chorley and South Ribble Hospital who worked across both hospital sites had responded appropriately to learn from the incident.
- At our last inspection we found all records were in the process of being scanned onto an electronic system, which would, over time, reduce the need for physical case notes in clinic. However at this inspection we found a mixed approach to the use of the electronic system. Staff were unsure which teams were using the system and others thought it was still in the pilot phase. We found that clinics had a mix of electronic records with one paper sheet with essential information as part of the booking in process. Other patients had a full set of paper records. We were unable to identify an agreed approach to the use of either paper or electronic records.
- We were not assured that the trust had ensured sufficient numbers of staff attended appropriate training to support the safeguarding of patients in the service.
- We were not assured that adequate numbers of staff had attended and completed identified mandatory training.
- We noted the sickness rate for additional clinical services was 15% for qualified outpatient nursing staff which was worse than the trust target of 4%.
- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded. We observed patients having blood pressure monitoring in an open corridor. Senior managers acknowledged the lack of space in the outpatients and diagnostic services. However staff told us and we observed that it was not always possible to separate vulnerable patients to reduce the risk of infection for some specialities.

However;

- An allied health professional and nurse staffing review was underway to review the appropriate skill mix and staffing levels to provide appropriate service delivery.
- There were a number of medical staff vacancies throughout the service although they were managing the situation with staff working additional shifts. We found that the majority of clinics were covered by consultants and their medical teams. However we found in dermatology the service was short one full time consultant from four. We also found shortages in Ophthalmology consultant staffing.

Incidents

- In the period 01/08/2015 to 31/07/2016, there had been one never event in the diagnostic services at the Royal Preston hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. A patient attended interventional radiology for a left sided procedure but the procedure was carried out on the right side. There was found to be no harm to the patient. The incident had been fully investigated and an action plan had been put in place to learn from the incident at both hospital sites.
- There were two serious incidents reported in outpatients over the same period related to access to appointments. All incidents were investigated using a root cause analysis (RCA) approach and all documented high level action plans and evidence of shared learning. An investigation using a RCA approach was also conducted for all diagnostic incidents within the imaging department.
- Incidents were reported using an electronic reporting system. Staff could describe how to use the system and the types of things that would constitute an incident. Staff meetings or morning briefings were held locally in the majority of teams within the outpatients and diagnostics which were minuted and lessons learned discussions took place.
- Data provided by the trust showed incidents were reported internally and externally, as required for diagnostic services. The service presented a review of clinical incidents, trends and any supporting action

plans at the imaging directorate clinical governance meetings. Mortality and morbidity meetings took place bi-monthly within the diagnostic imaging department governance and audit meetings.

- We noted that reported incidents were investigated by senior managers and themes and trends were discussed at the divisional governance meetings.
- The division of diagnostics and clinical support produced a Division Safety and Quality Report looking at themes and trends within the division. An incident data analysis showed from March 2012 to the June 2016, 11 patients had been harmed due to incidents relating to the Ophthalmology appointment system.
- In response to referral errors in Computerised Tomography clinicians had amended a checklist to include "hello can I check you are here today for x".
- Staff in pathology told us a newly introduced technology had eradicated transcription errors from the system. This was confirmed through an ongoing audit to evaluate the introduction of the system which reported through the divisional governance meetings.
- However, some staff said they didn't receive feedback. It is important that staff are aware of incidents and receive feedback to provide learning and prevent further reoccurrence.•In the 12 month reporting period prior to our inspection there were seven patient related radiation exposure dose incidents at Chorley and South Ribble Hospital. There had also been three staff incidents, two of which related to members of staff failing to wear protective aprons and the third to a damaged protective apron. These numbers represented an increase in the frequency of incidents as compared to the previous year and a continuation of an upward trend. Staff felt that the increase was in part due to an improved reporting culture.
- Many staff across outpatients and diagnostic imaging did not recognise the "Duty of Candour" regulation but they could describe the principle of it and gave examples of how they had been open with patients. 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.

Cleanliness, infection control and hygiene

- Patients received care and treatment in visibly clean environments. Records indicated that outpatient areas, clinics and equipment were cleaned regularly. Cleaning schedules were in place and accurate records maintained. The service used "I am clean" stickers to identify equipment that had been cleaned.
- Staff followed good practice guidance in relation to the control and prevention of infection. We observed good hand washing and infection control practices throughout. This included the use of personal protective equipment where appropriate, e.g. disposable gloves. There was an ample supply of alcohol hand gel dispensers and hand washing facilities were readily available.
- There were trust-wide policies in place for infection control and hand hygiene which were seen to be in date at the time of the inspection. Staff were aware of them and showed us how they accessed trust policies from the intranet.
- The service carried out internal audits and checks relating to infection prevention and control. Data provided by the trust showed these were in house checks and compliance was 100% in most areas.
- Staff told us they would see any infectious patient last on the list and carry out a deep clean after the treatment session.
- However staff told us and we observed that it was not always possible to separate vulnerable patients to reduce the risk of infection for some specialities. All patients were in the same waiting area, including immunosuppressed cancer and transplant patients, renal patients, infective patients and patients attending hepatitis clinics.

Environment and equipment

- The environment in the general outpatient area was well maintained, although we found that some areas of outpatients were crowded. Senior managers acknowledged the lack of space in the outpatients and diagnostic services. We found some of the smaller sub waiting areas were overcrowded with poor wheelchair access. On the day of our inspection we observed 32 patients waiting for blood tests many of whom were

standing due to the lack of available seating. Staff told us that it was not always as crowded and we noted on our unannounced visit no one was standing in the waiting area.
- Throughout the outpatient area we noted that the corridors were busy and it was difficult to manoeuvre wheelchairs in some of the secondary waiting areas.
- Resuscitation trolleys were located in or close to each outpatient area and regularly checked and maintained. We found that none of the trolleys were locked in line with the rest of the hospital. We noted that saline bags were accessible within the trolleys. This was reported to the trust at the time of the inspection and appropriate actions were taken to secure these.
- The emergency resuscitation trolleys we reviewed were visibly clean and weekly checklists completed. Oxygen, suction and defibrillator checks were performed daily.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment. All equipment we looked at was in date with portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Occupational exposure to radiation was monitored for radiology staff. This ensured that the amount of radiation staff were exposed to as part of their work was checked.

Medicines

- The hospital used the services of a local pharmacy company to dispense all hospital prescriptions. Data showed outpatient medicines were delivered within the 20 minutes target for the 12 month period prior to our inspection.
- The service monitored all errors on written prescriptions, which were discussed at monthly intervention meetings with the trust.
- Medicines in outpatients and radiology were stored securely in locked cupboards or refrigerators, as appropriate, and in line with legislation.
- Medication fridge temperatures were checked daily and items were in date.
- Patient group directions (PGDs) were in place for a limited number of drugs including specific instructions for administering and staff using PGD's were competency assessed annually.
- Prescription pads were stored securely and their usage was tracked.
- Some staff within the outpatient services such as dermatology and chest clinic were registered nurse prescribers. Nurse prescribers are specially trained nurses allowed to prescribe any licensed and unlicensed drugs within their clinical competence.

Records

- At our last inspection we found all records were in the process of being scanned onto an electronic system, which would, over time, reduce the need for physical case notes in clinic. However at this inspection we found a mixed approach to the use of the electronic system. Staff were unsure which teams were using the system and others thought it was still in the pilot phase. We found that clinics had a mix of electronic records with one paper sheet with essential information as part of the booking in process. Other patients had a full set of paper records. We were unable to identify an agreed approach to the use of either paper of electronic records.
- During our inspection we found a large open box of case notes left unsecured on a trolley in one of the main outpatient areas. We raised this with senior staff and the box was removed immediately. At our unannounced inspection we found new procedures had been put in place to store records securely and maintain patient confidentiality.
- We looked at the systems and processes in place for managing patients' records and ensuring that medical staff had timely access to patient information and test results. There was a clear system in place to support this. If patient records were unavailable a temporary record was prepared, this meant that clinic appointments were not cancelled due to missing records. As part of this inspection we looked at 18 patient care records and saw records were well maintained and updated at timely intervals. Each professional had recorded their entries appropriately; documentation was accurate, complete, legible and up to date. There was a plan of care for each patient. Consent was documented and care plans present as appropriate.

Outpatients and diagnostic imaging

Safeguarding

- Trust-wide policies and procedures were in place, which were accessible to staff electronically for safeguarding vulnerable adults and children.
- Data provided by the trust showed 81% of medical staff had completed training for safeguarding adults (level two and three) in diagnostic services whilst other staff had achieved 44% and 51% compliance. In outpatients only 49% of medical staff had completed training in safeguarding adults, level 2 and 54% for level three. Other staff had completed 52% and 55% for safeguarding levels two and three which was below the trust target of 75%. We were not assured that the trust was providing appropriate training for staff to support the safeguarding of patients in the service.
- However we found staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults, and were aware of the process for reporting safeguarding concerns. Staff told us they felt confident to raise concerns and make safeguarding referrals, and felt well supported to do this.
- Staff told us they had access to a trust-wide safeguarding team for advice during normal working hours.

Mandatory training

- The trust had a core mandatory training programme on a rolling basis such as health and safety and fire. In addition other training was compulsory such as resuscitation. Training uptake was reported and monitored through the production of a standard report across all areas of the division.
- Information provided by the trust showed 84% compliance rates with mandatory training for the division of diagnostics and clinical support division overall which was above the trust target of 80%. The diagnostic services had a compliance total of 88% for mandatory training. It was noted that for nursing staff within the theatre and outpatient business unit the service was in line with the trust target of 80%. Staff told us that they were encouraged to complete their mandatory training; however this was difficult due to workload.
- The data showed 100% compliance for medical staff resuscitation training within the division. However the data showed for all other staff groups who required resuscitation training the average compliance rates were 49% for outpatients and 63% for diagnostics services which was below the trust target of 80%. In diagnostic services we found the average compliance rates for clinical movement of patients was 54% and 59% for outpatient clinical staff below a trust target of 60%. We were not assured that the service had in place adequate numbers of staff who had completed identified essential training.

Assessing and responding to patient risk

- The Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results to measure and monitor local improvement. The safety thermometer includes a function for merging patient safety data across all the teams and wards within the trust. The outpatients and diagnostics service was not using the safety thermometer.
- Staff were able to describe the procedure if a patient became unwell in their department.
- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- Imaging requests for inpatients were completed electronically. Requests from general practitioners were a combination of electronic and paper referrals and any paper requests required a GP stamp to confirm the referrer for the procedure to be completed.
- Forms were completed for women of child bearing age before exposure to radiation in case of pregnancy. Completed forms were signed by the patient and then entered into the medical records.
- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time. Staff in radiology were observed obtaining name, address and date of birth of patients on arrival which related to a requirement of the Ionising (Medical Exposure) Regulations (IR (ME) R 2000).
- Radiation Protection Supervisors were appointed in each clinical area within the diagnostic and imaging departments and staff could identify these personnel.

Nursing staffing

- Outpatient clinics were staffed by a combination of specialist and outpatient nurses and staff worked across both the Chorley and Preston Hospital sites.
- A review of outpatients staffing had been commenced but the outcome was not yet finalised and was dependent upon the ongoing outpatients service review. Non ward based departments were also having

staffing reviews as part of the wider nursing and midwifery staffing review process. Senior managers told us the service was out to consultation about changes to working practices.

- Staff told us that the number of extra waiting list initiative clinics had added extra pressure to nursing staff in outpatients with many working extra hours on a good will basis. •The service did not use agency staff but relied on extra band three staff and the use of substantive staff working extra hours.
- Data showed the trusts annualised sickness absence rate for 2015/16 was 5.19%, which was better than the England average of 4.5%.
- Average sickness rate for the trust at 5.5% was worse than the England average of 4.5%. We asked the trust for the specific sickness data for outpatients and diagnostic imaging. The 2015/16 annualised sickness absence rates for qualified nurses and nursing support staff in Chorley's outpatients department were 4.7% and 14.56% respectively. However we were unable to review detailed sickness rates for all areas of the service.

Allied Health Professionals

- Radiographers provided a 24 hour seven day service. The trust had seven vacancies at the time of our inspection, however recruitment was in progress.
- An allied health professional staffing review was underway to review the appropriate skill mix and staffing levels to provide appropriate service delivery. The 2015/16 annualised sickness absence rate for qualified allied health professionals within the core therapies service was 2.5%.

Medical staffing

- The radiology department was staffed by consultant radiologists. The Imaging Directorate provided 24/7 cover for both hospital sites. The core hours of work for radiology staff were 9am to 5pm Monday to Friday. From 5pm to midnight on-call support was provided for emergencies by a Radiology Registrar who was first on-call and a Consultant Radiologist who was second on-call.
- Overall there was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by consultants and their medical teams. However we found in dermatology the service was short one full time consultant from four. We also found shortages in Ophthalmology consultant staffing. There were currently two full time Ophthalmology Consultants and one full time Specialty doctor vacancies. As a result the service was reliant upon locum agency staff. Senior managers told us the service continued to proactively recruit to vacant posts however this had proven difficult due to a national shortage of Ophthalmology specialists.Major incident awareness and training
- There was a clear policy of action to be taken if the hospital was involved in a major incident. Staff members were aware of the policy and how to locate it on the trusts intranet.
- There were business continuity plans in place to ensure the delivery of the service was maintained.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate Outpatients and diagnostics services for effective. Our findings were:

- Patients who attended outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.
- The radiology and diagnostic service was provided seven days a week.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available if required.
- Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment and staff had access to previous x-ray images. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.
- Staff were competent to perform their roles and were supported by the trust to develop.
- Follow up to new appointment rates at both sites were slightly worse than the England average between March 2015 and February 2016. Rates were around 3% on average, putting the trust in the top quartile in England for follow up rates. The trust was unable to provide site specific location data.
- Care and treatment within the outpatient and diagnostic imaging department was delivered in line

with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).

However:

- At our last inspection staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- The head and neck service had been the subject of an external review which had raised concerns about teamwork and clinical effectiveness in the outpatient multidisciplinary team (MDT). The report produced recommendations from which an action plan had been formulated. We raised this with the trust senior executives and further meetings were planned for the autumn to seek assurance that improvements had been sustained in line with the action plan. We were not provided with evidence of any final outcomes or completed actions or changes in team working at the time of our inspection.
- Staff within the physiology department were unable to follow best practice guidance such as the national (British Thoracic Society) Standardised Guidelines due to environment restrictions. The environment was not large enough to carry out a specific exercise test.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as those from the National Institute for Health and Care Excellence (NICE).
- Audit and staff meetings were held in diagnostics and imaging, dermatology and SMRC to share information and promote shared learning.
- Audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were completed and Radiation Safety Committee meetings were held twice a year to monitor radiation safety throughout the trust.
- Diagnostic reference levels (DRL's) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part.
- We reviewed minutes from Radiation Protection Supervisor meetings which reviewed radiation incidents and issues and observed an action plan to maintain quality assurance. Audit and staff meetings were held in radiology to share information and promote shared learning.
- The pathology service had achieved national accreditation.
- The service had implemented a pathway for the management of skin cancer patients referred from dermatology to oncology who had been deemed unsuitable for radiotherapy to ensure care was provided in a timely manner by the most appropriate service.
- The diagnostic imaging service took part in the "Imaging Services Accreditation Scheme" (ISAS) to ensure they met quality standards.
- The physiological measurement services participated in the "Improving Quality in Physiological Services" (IQIPS) accreditation scheme. However we noted staff within the physiology department were unable to always follow best practice guidance. For example the department was not large enough to carry out a specific exercise test as part of the British Thoracic Society national standardised guidelines.
- Clinical audits were in place in speech and language therapy and musculoskeletal physiotherapy services looking at outcomes of therapy intervention and the quality of service delivery.

Pain relief

- There was a newly appointed clinical lead for the pain clinic. Patients could be referred to the pain management clinic by their consultant.
- Patients had access to pain relief as required. This could be prescribed within the outpatients department and subsequently dispensed by the pharmacy department, which was located within the outpatient's reception area.
- Staff told us they followed the national guidance on "oral analgesia in the management of acute pain in adults".

Outpatients and diagnostic imaging

Nutrition and hydration

- Refreshments were available in the main entrance to the hospital as well as a restaurant on site. Staff in the ophthalmology clinic and discharge lounge provided drinks for patients.
- The service was aware of the needs of diabetic patients and we observed the use of a drinks trolley for patients in the eye clinic.

Patient outcomes

- Follow up to new appointment rates at both sites were slightly higher (worse) than the England average between March 2015 and February 2016 Rates were around 3% on average, putting the trust in the top quartile in England for follow up rates although rates were similar to the England average. This meant that patients may be returning for appointments more frequently which may impact on the effectiveness of treatment. This information was trust-wide across outpatient and outpatient and diagnostic services and not specific to the Chorley and South Ribble Hospital. We noted follow up rates were higher (worse) than the trust average for ophthalmology and ENT.
- Data provided by the trust showed that Dermatology outcomes were better than the national average.

Competent staff

- At our last inspection we found staff had not received clinical supervision, as required by the hospital's own policy and procedures. At this inspection we found this was still the case. Some staff told us that they had regular morning briefings and managers were accessible but they had not received and the trust did not provide details of staff uptake of clinical supervision.
- Competency assessments were in place throughout outpatients and imaging services for example in the main outpatient clinic dermatology and dermatology. Staff were able to assess their ability and review the effectiveness of the guidance provided.
- Specialist nurses were in post and provided a wide range of nurse-led clinics including dermatology, ENT and foot clinics. The specialist nurses and therapists had also completed extended prescribing courses to expand their skills and improve the quality of service delivery.
- New staff were required to complete a full day corporate induction and a local induction before undertaking their role.
- Staff told us they had received annual appraisals known as personal development reviews. Records showed that personal development reviews had taken place and that staff were supported with their development and educational needs.
- We saw staff had access to training specific to their clinical area of practice. Staff told us they had access to appropriate and job-specific training opportunities. In radiology all staff training and student supervision was in place, up to date and appropriate.

Multidisciplinary working

- The head and neck service had been the subject of an external review which had raised concerns about teamwork and clinical effectiveness in the outpatient multidisciplinary team (MDT). The report produced recommendations from which an action plan had been formulated. We raised this with the trust senior executives and further meetings were planned for the autumn to seek assurance that improvements had been sustained in line with the action plan. We were not provided with any evidence of any completed actions or changes in team working at the time of our inspection.
- The diagnostic imaging and outpatients departments were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- Specialist nurses were in post and provided a wide range of nurse-led clinics including ENT and Dermatology.
- Monthly team meetings were held within the therapy department involving all disciplines to exchange information.Seven-day services
- At weekends from 9am to midnight on-call support was provided for emergencies by a Radiology Registrar who was first on-call and a Consultant Radiologist who was second on-call. From midnight CT and MRI scans for cord compressions are covered by an external supplier. Pathology services offered a seven day service.
- Alongside the general radiology on-call rota there was a neuro-radiology on-call service 24/7 and an interventional radiology on-call service which operated 24/7 cover. This had commenced in September 2016.
- Outpatient services had introduced a range of waiting list initiative clinics on Saturdays.

Outpatients and diagnostic imaging

Access to information

- The radiology department used a nationally recognised system to report and store patient images.
- The pathology service had introduced new technology which had improved access to investigation results.
- Staff told us that appointments were not cancelled due to unavailability of records, as a temporary record was raised that included new patient referral letters. Previous investigation results and letters were available electronically for patients attending a follow up appointment.
- Regular monthly audits were undertaken to monitor availability of records and reported to the trust board. Data provided by the trust showed for the period January 2015 – December 2015 showed 99% availability of notes in clinics.
- Staff told us some information, such as test results and x-rays, were accessed electronically and computers were available in all clinics.
- Staff were able to access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. If written consent was required for more complex procedures this was obtained in outpatients' clinic by medical staff or nurses who had received additional training.
- Before having a procedure undertaken patients' consent was obtained verbally and noted in their records. For biopsies or more invasive tests, consent for procedures was formally documented using consent forms. The risks and benefits of treatment were discussed with the patient before starting the procedure.
- Staff were provided with training and guidance on the Mental Capacity Act 2005. Staff were aware of the requirements to ensure that people were treated appropriately.

Are outpatient and diagnostic imaging services caring?

Good

At the previous inspection in July 2014 we rated caring as good and we have maintained this rating following this inspection because:

- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- The trust had a number of clinical nurse specialists and lead nurses available to support patients in managing their condition.
- There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.

However;

- Some patients told us that they had been left waiting a long time for their appointment and had not been kept informed about what was happening.
- We found the environment was rather crowded and the lack of privacy sometimes made it difficult for patients to have a private conversation about their medical condition or treatment.

Compassionate care

- We found individual examples of compassionate care within outpatients and diagnostic services. We observed staff dealing with patients in a very supportive manner, especially in the dermatology unit.
- Patients and relatives told us that staff introduced themselves and they were treated with kindness and compassion. Some patients told us that the outpatient department could be very busy and rather overcrowded which made it difficult to have a private conversation about their medical condition.
- We witnessed reception and nursing staff being polite and helpful both in person and during telephone contacts.

Outpatients and diagnostic imaging

- The main x-ray department had signs asking patients to respect patient confidentiality and wait to be called forward.
- The radiology department had provided an additional gown as a dressing gown worn to cover people's dignity whilst having an x-ray or ultrasound.
- The trust had a chaperone policy and signs were visible throughout the service informing patients how to request a chaperone.
- The NHS Friends and Family Test which assesses whether patients would recommend a service to their friends and family showed that in August 2016, 95% of patients attending Chorley and South Ribble Hospital outpatient services were likely or extremely likely to recommend the service with an average response rate of 12%.

Understanding and involvement of patients and those close to them

- We spoke with patients and those close to them about the care and treatment they received in outpatient services. Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- Patients and relatives said they felt involved in their care and were able to make informed decisions. Patients we spoke with said they had received good information about their condition and treatment.
- Patients told us they understood when they would receive their test results and next appointment and how they could contact the service if needed.
- Patients were informed following diagnostic investigations when they should contact their GP for the results.

Emotional support

- Patients told us they were always involved in discussions about their treatment.
- The trust had a number of clinical nurse specialists and lead nurses available to support and reassure patients regarding the management of their condition.
- There was access to volunteers and local support groups such as a cancer charity which offered both practical advice and emotional support to both patients and carers.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

At the previous inspection in July 2014 we rated responsive as requires improvement mainly due to the cancellation of outpatient clinics at short notice. We have maintained this rating following this inspection because:

- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was better than the standard for the last three quarters of 2015/16 but was worse than the standard in the first quarter of 2016.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Non-admitted pathways mean those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Chorley and South Ribble Hospital. Of the 16 separate specialties reported nine were below the England average.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. For incomplete pathways, referral to treatment rates were similar to the standard between July and November 2015 before falling below the standard and continuing to fall gradually each month until June 2016. Of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%. This information was trust-wide and not specific to Chorley and South Ribble Hospital.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters. We discussed the service performance with senior managers. They acknowledged an increased demand within outpatient services. In Ophthalmology there had been follow-up capacity pressures which had led to service governance concerns. Ophthalmology had had a full service review and redesign and an action plan was in place. The service had reported two serious

incidents related to delays in accessing care and treatment. The capacity problems within Ophthalmology had resulted in a number of patients waiting longer than advised for review in clinic.
- Data provided by the trust showed only 65% of patients were seen within 30 minutes of their appointment time compared with the trust average of 91%. However we noted the figure was as low as 19% in ophthalmology. This meant patients in ophthalmology were waiting a significantly longer time in clinic than all the other trust outpatient services.

However;

- At our last inspection we told the trust to prevent the cancellation of outpatient clinics at short notice and ensure that clinics ran to time. Data provided by the trust showed an improvement since our last inspection. Between April 2016 and July 2016 the percentage of clinics cancelled within six weeks averaged 2.5% with one exception of 11% in April. Clinics cancelled over six weeks ranged between 9% and 4%. The main reasons for cancellation were annual leave, study leave and sickness. This information was trust-wide and not specific to Chorley and South Ribble Hospital.
- The 'did not attend' (DNA) rate were similar to the England average at all sites within the trust.
- Diagnostic imaging waiting times (percentage over six weeks) were better than the England average between July 2015 and May 2016.
- The percentage of people seen by a specialist within two weeks of urgent GP referral was above (better than) the national standard in the last four quarters prior to our inspection.
- The 31 day wait performance was better than the national standard for the last three quarters of 2015/16 but was worse than the standard in the first quarter of 2016.
- The two week wait performance was better than the national standard in the last four quarters prior to our inspection. The service provided a number of rapid access clinics such as chest pain and emergency eye clinic to enable patients to access an appointment quickly.
- Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times.
- Access to interpreter services could be arranged by telephone for those patients whose first language was not English.
- We noted appropriate provision was made for bariatric patients.
- Within the outpatient areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. However they were not available for patients whose first language was not English. Staff confirmed the leaflets could be ordered in other languages or alternative formats if required.
- Laboratory reporting times were in line with the nationally recommended turnaround time target of 90% of cases reported in 10 working days.

Service planning and delivery to meet the needs of local people

- At our last inspection patients who drove themselves to their appointment told us they found car parking difficult because the demand for spaces was high, and they often had a long walk to get to the department. Some people told us they had problems finding a department because of poor signage which made them feel anxious.
- At this inspection we found that demands on car parking were still evident. There was no clear signage to help patients identify the individual clinics.
- We observed signposting throughout the hospital to the diagnostic imaging departments. The main x-ray department and reception desk had signs asking patients to respect patient confidentiality and wait to be called forward. Patients told us they received instructions with their appointment letters and were given written information, as needed.•Waiting areas did not always have sufficient seating available and we found some toilet signs were not compliant with dementia friendly guidelines.
- Additional clinics were being held in the evenings or at weekends to reduce waiting times for patients.

Access and flow

- Diagnostic imaging waiting times (percentage over six weeks) were better than the England average between July 2015 and May 2016.
- The two week wait performance was better than the national standard in the last four quarters prior to our

inspection. The service provided a number of rapid access clinics such as chest pain and emergency eye clinic to enable patients to access an appointment quickly.

- The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was better than the standard for the last three quarters of 2015/16 but was worse than the standard in the first quarter of 2016.
- The trust performed worse than the England average for referral to treatment times for non-admitted referral to treatment pathways in October 2015 and remained below the average each month to June 2016. Non-admitted pathways mean those patients whose treatment started during the month and did not involve admission to hospital. This information was trust-wide and not specific to Chorley and South Ribble Hospital. Of the 16 separate specialties reported nine were below the England average.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. For incomplete pathways, referral to treatment rates were similar to the standard between July and November 2015 before falling below the standard and continuing to fall gradually each month until June 2016. Of the 16 separate specialties reported, nine were below the England average, the lowest scoring being plastic surgery at 75%. This information was trust-wide and not specific to Royal Preston Hospital.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment was worse than the standard for three of the four most recent quarters.
- Each performance business manager was able to request extra clinics as part of waiting list initiatives. A weekly performance managers meeting was held to review all waiting times. As of 27 September 2016, 2375 patients were waiting for a new first appointment. We discussed the service performance with senior managers. They acknowledged an increased demand within outpatient services. In Ophthalmology there had been follow- up capacity pressures which had led to service governance concerns. Ophthalmology had had a full service review and redesign action plan was in place. The service had reported two serious incidents related to delays in accessing care and treatment. The capacity problems within Ophthalmology had resulted in a number of patients waiting longer than advised for reviews in clinic. We were told that there was no booking strategy and the current access policy was due for review in December 2016. The lack of clear management approach to managing appointments may impact on the service ability to manage its risk demand management and referral pathways.
- Data from the trust showed that inpatient radiology examinations were reported on the same day. There was a two week turnaround for routine cases. Reports for CT trauma were completed within an hour.
- Information from the trust showed that laboratory reporting times were in line with the nationally recommended turnaround time.•The trust had a number of patients who failed to attend for their appointments. The 'did not attend' (DNA) rates were similar to the England average at all sites within the trust.
- At our last inspection we told the trust to prevent the cancellation of outpatient clinics at short notice and ensure that clinics run to time. Data provided by the trust showed an improvement since our last inspection. Between April 2016 and July 2016 the percentage of clinics cancelled within six weeks averaged 2.5% with one exception of 11% in April. Clinics cancelled over six weeks ranged between 9% and 4%. The main reasons for cancellation were annual leave, study leave and sickness. This information was trust-wide and not specific to Chorley and South Ribble Hospital.
- The average figure for the trust as a whole was 91% of patients were seen within 30 minutes of their appointment time. Data provided by the trust showed 90% were seen in ENT and only 65% of patients were seen within 30 minutes of their appointment time. The trust average for waiting times over 60 minutes was 1.5%. However we noted the figure was as low as 19% in ophthalmology. This meant patients in ophthalmology were waiting a significantly longer time in clinic than all the other trust outpatient services.
- We found that a nurse led foot clinic enabled patients to be discharged in line with set protocols. However we noted that there was no cover for annual leave which meant that the clinic didn't take place when the member of staff was absent and patients did not have access to the clinic.

Meeting people's individual needs

- Patients had a choice of appointments and additional clinics were held in the evenings or at weekends to reduce waiting times.

Outpatients and diagnostic imaging

- We observed in the main outpatient area the proximity of other patients waiting to the person booking in meant that patient confidentiality could not always be assured.
- Staff tried to meet the individual needs of patients. Other patients had arrived on the wrong day for an x-ray but had been seen by the department.
- Translation services and interpreters were available to support patients whose first language was not English. If staff were alerted to a patient's requirements, face to face translators could be booked in advance.
- Staff acknowledged the service had been limited for people with hearing impairment but the trust was piloting using skype for sign language. In the outpatient and imaging services sign language interpreters could be 'requested' in advance for patients.
- We saw that nursing and therapy staff liaised with other agencies and families and carers to maintain daily routines and support patients in vulnerable circumstances. However we noted that there was no system in place to alert the staff in advance to help meet any specific needs such as people living with dementia or learning difficulties.
- Staff could not confirm what information was available for people living with dementia and learning disabilities. There was a limited access to information for patients who had a visual impairment.
- There was a range of information leaflets in clinical areas on topics such as tests and screening, health promotion and other sources of support. Staff confirmed the leaflets could be ordered in other languages or alternative formats if required.
- Staff treated patients in a discreet and dignified manner within the limits of the environment. Privacy and dignity were maintained in radiology. In imaging we noted a sign requesting patients not to use social media or take photographs to respect individual patients' privacy and dignity.
- We found the limited space and the design of the outpatient and diagnostic areas meant that it was hard to maintain privacy and dignity for example staff had to take blood pressure readings in a corridor within the main outpatient area due to the lack of access to a private area.
- Staff confirmed patients had access to both psychiatric and counselling services as and when required.

Learning from complaints and concerns

- Initial complaints were dealt with by clinic managers in outpatients and diagnostic imaging in an attempt to resolve issues locally. However if this was unsuccessful patients would be referred to the patient and liaison service (PALS).
- We saw PALS posters were clearly displayed and complaint information leaflets were available in each of the areas we visited. However this information was not available in languages other than English.
- We found in radiology the service had provided a notice board for patients to see what had been done in response to concerns and suggestions for improvements raised for example the service had introduced higher chairs for people with limited mobility to use.
- A current trust complaints policy was in place. For the period August 2015 to July 2016 the trust received 553 formal complaints. The numbers of complaints related to outpatients and diagnostic imaging was 203. Of the complaints we reviewed 40 related to staff attitude, 46 related to delayed or cancelled appointments and 54 related to concerns about clinical treatment.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

At the previous inspection in July 2014 we rated well led as good. Following this inspection we have rated Outpatients and Diagnostic Imaging services as requires improvement because:

- Staff morale varied across different teams. In some areas we found that morale was low and staff felt under pressure because of the workload and lack of capacity to meet the targets.
- We found that staff were unclear about the recent divisional changes and were not aware of a local vision for outpatients and imaging services. The hospital was managed through the same leadership structures as the Royal Preston site.
- Due to the recent changes to governance systems within the individual divisions and departments, assurance as to the robustness of these structures, including committee membership was limited. The lack of clearly

identified and managed risks for each individual area within outpatients and diagnostic imaging meant that we were not assured that the service had a full oversight of the governance, quality and risk management of the services.
- Many staff told us they were unaware of any recent patient feedback. The lack of patient engagement and feedback could impact on the ability of the service to learn and improve the quality of service provision.

However;

- We found individual leaders were visible and approachable.
- The diagnostic services were actively managing their own risk registers.
- There was an open and honest culture within the service. In dermatology and diagnostics morale was very positive.
- At this inspection we found that the trust had introduced systems to gather the views of patients within outpatients and diagnostic imaging via the NHS Friends and Family test using text systems. We found comment cards in the X-ray and ultrasound waiting area.

Leadership of service

- At our last inspection the outpatient staff had undergone a service transformation in the 18 months prior to our inspection which had resulted in low morale. At this inspection we found that further reorganisation was ongoing with new middle and senior managers in post. A quarter of staff were unclear about the new divisional leadership structure and could not identify either which division they reported under or the names of their divisional leaders.
- Staff felt locally supported however they said that the senior executive team were not always visible but had attended the department recently.
- The staff were very positive about the clinical leads in dermatology and felt well supported.
- The radiology and imaging leadership programme for newly appointed managers had been very well received.

Vision and strategy for this service

- The trust had a vision and strategy to provide “excellent care with compassion”. This was displayed throughout the outpatient and diagnostic departments. Staff said they were aware of the wider trust vision.
- However we found that staff were unclear about the recent divisional changes and were not aware of a local vision for outpatient and imaging services.
- Within the dermatology service staff were very clear about their own vision to be the best service in the region.

Governance, risk management and quality measurement

- Clinical governance meetings were held monthly in radiology to review incidents, including mortality and morbidity.
- Radiation safety meetings were held to ensure clinical radiation procedures in the trust were undertaken in compliance with ionising and non–ionising radiation legislation. The trust also held Radiation Protection Supervisors meetings which detailed discussion regarding radiation procedures, incidents and protocols.
- Due to the recent changes in governance systems within individual divisions and departments, we found limited assurance in the effectiveness of these structures, including limited committee membership and representation. For example, we reviewed the minutes of the “Anaesthetics and Outpatient (OPD) directorate governance” meeting for the three months prior to our inspection. A patient's safety report was presented at these meetings. We found a lack of representation at this meeting from the majority of the outpatient departments including ENT, cardio respiratory and dermatology. It was unclear how individual departments and teams were able to participate in discussions related to safety and quality without clear structures and communication systems.
- The lack of clarity in reporting structures for individual teams also impacted on the level of assurance within the division in regards to the identification, management and mitigation of risk. For example: ophthalmology services reported under two divisional structures and outpatient physiotherapy services reported under a separate division which may mean a risk identified may not be clearly communicated through the correct division for appropriate action.
- We reviewed the trust wide risk register which did include individual department risks. However we found that only diagnostic imaging had been actively managing departmental risks. The lack of clearly identified and managed risks for each individual area

within outpatients and diagnostic imaging meant that we were not assured that the service had a full oversight of the governance, quality and risk management of the services.

- A weekly performance meeting was held to manage performance waiting times. Patients waiting over 18 weeks were identified and oversight was provided by clinicians to ensure priority was given to the most clinically urgent patients. The trust provided a diagnostic and clinical support division safety and quality report for July 2016 which outlined key patients safety and performance indicators including theatre performance data. The cross divisional reporting structures resulted in no overarching quality and performance dashboards being available for all the outpatient and diagnostic services. We raised this with divisional senior managers who confirmed that new governance structures were in place and plans included further devolvement of risk and quality management to individual teams and managers.
- The patient experience group arranged observational visits to outpatient and diagnostic areas, following an agreed checklist including questions for both patients and staff about the quality of the service. The team produced a report and any actions required were then followed up.
- The trust had weekly inspections arranged by nursing teams to review service provision such as cleanliness and patients' safety. We saw examples of the reviews and action plans which had been put in place for example highlighting hand hygiene and improved communication with patients.

Culture within the service

- In radiology and imaging and pathology all staff spoken to said they felt very supported by their line manager and morale was good.
- Staff felt part of the wider hospital trust despite some departments being based away from the main hospital site.
- There was an open and honest culture across the outpatient and diagnostic imaging services and staff were candid about the challenges they faced. Staff understood the need for openness and transparency and were knowledgeable about their responsibly under the duty of candour regulations.
- Staff morale varied across different teams. In dermatology morale was very positive. However in ophthalmology and ENT we found that morale was low and staff felt under pressure because of the pressure of work and lack of capacity to meet the targets. Morale was low within the core therapy services with staff concerned about frozen posts and the ongoing therapy and nursing workforce review.
- In general outpatients we found that staff were committed to trying to work with the trust managers to deliver the services. However we found the "goodwill" of staff was being tested in part due to the increased number of extra clinics in place to meet the demand on the service and further planned changes to staff pay and conditions.

Public engagement

- At our last inspection we told the trust they should ensure it receives feedback from patients within the outpatients departments to monitor and measure quality and identify areas for improvement. At this inspection we found that the trust had introduced systems to gather the views of patients within outpatients and diagnostic imaging via the NHS Friends and Family test using text systems. We found comments cards in the X-ray and ultrasound waiting area. However we only saw patient feedback information on display in dermatology and x-ray. Many staff told us they were unaware of any recent feedback and some staff told us that they thought that the trust no longer collected patient feedback. The lack of patient engagement and feedback could impact on the ability of the service to learn and improve the quality of service provision.
- The majority of people we spoke with were positive about their care but voiced concerns about some delays in receiving their appointment and parking facilities on site.
- The trust had established a patient experience improvement group with non-clinical members to promote greater patient engagement.

Staff engagement

- Results of the 2015 NHS Staff survey showed the trust scored worse than the national average for effective team working and organisation and management interest in and action on staff health and well-being. The trust scored in line with the national average for the majority of indicators and performed better than average for three indicators related to the levels of bullying from both staff and patients and staff working

extra hours. The trust performed in line with the national average for 23 indicators. However it was noted 14 out of the 23 indicators were worse than the previous survey results.

- Physical and psychological support services were available to staff and staff were aware of how to access these services.
- Staff were recognised for their work by positive feedback and recognition awards known as “Fabulous Feedback Fridays” These were seen as a positive by staff.

Innovation, improvement and sustainability

- The introduction in dermatology of a computerised diary, which colour coded patients by procedure enabled the service to plan a block of 12 week care in advance to suit the requirements of each patient. It also flagged and calculated potential breaches giving better patient flow, enabling comprehensive audit of care provision and treatment outcomes.

Outstanding practice and areas for improvement

Outstanding practice

- In outpatients the introduction in dermatology of a computerised diary colour codes patients by procedure enabling the service to plan a block of 12 week care in one go to suit the requirements of each patient. It also flags and calculates potential breeches giving better patient flow, facilitating comprehensive audit of care provision and outcome of treatment.
- In the urgent care centre the housekeeper helped make sure elderly patients being discharged home had basic groceries provided such as bread or milk.

Areas for improvement

Action the hospital MUST take to improve

Urgent Care services

- Take action to help control risks associated with the room identified for mental health patients must be actioned and appropriately documented.
- Ensure records of controlled drug use in registers are kept in line with trust policy.
- Ensure mandatory training compliance reaches and consistently achieves the trust target.
- Ensure clinical staff are aware of and adhering to the requirement for senior review of specific patient groups prior to discharge from the ED.
- Ensure action plans following CEM audits target areas of poor performance and improve practice and that clinical staff are aware of and engaged with the process of clinical audit.
- Ensure version control for policies, procedures and guidance is robust and that these are kept up to date and reviewed regularly.
- Ensure the department has a dedicated risk register with start dates, timelines, mitigating action and responsible person and review dates included.
- Ensure major incident plans are updated to reflect the current use of the department.
- Improve communication and improve the negative culture centred on a lack of communication and feelings of mistrust amongst staff.

Medical Care (including older peoples care)

- The trust must ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- The trust must ensure that records are kept secure at all times, so that they are only accessed by authorised people.
- The trust must ensure procedures in place around medicine management are robust and that policies are followed.
- The trust must ensure the risk registers are consistent and demonstrate mitigating actions and review dates.

Surgery

- Take appropriate actions to improve compliance against 18 week referral to treatment standards.
- Take appropriate actions to reduce the number of cancelled operations and the number of patients whose operations were cancelled and were not treated within the 28 days.
- Take appropriate actions to improve staff training compliance in adult and children's safeguarding training.

Critical Care

- Improve the uptake of mandatory training particularly in safeguarding children and adults.

Maternity & Gynaecology

- The hospital must ensure midwifery and support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- The hospital must ensure all necessary staff completes mandatory training, including Level 3 safeguarding training and annual appraisals.

Outstanding practice and areas for improvement

- The hospital must complete risk assessments for midwives carrying medical gases in their cars and develop a Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.
- The hospital must ensure that all staff receives medical devices training to ensure all equipment is used in a safe way

Outpatients and diagnostic imaging services

- Ensure that clear processes and structures are in place for the management and reviewing of governance, quality and risks.
- Review the processes for managing access and flow for outpatient services to ensure patients are not at risk.
- Ensure staff complete mandatory training as per the trust policy.

Action the hospital SHOULD take to improve

Urgent Care services

- Have access to written information in languages other than English.
- Encourage staff to use an approved method of translation rather than relying on web based public translation tools.
- Hold regular staff meetings with minutes taken to record discussions.
- Improve access to regular teaching for medical staff
- Introduce a mandatory daily handover between staff starting and finishing work, and document the details being discussed.
- Rotas should be stored in an organised and accessible to the right staff at all times.
- Improve root cause analysis to include the root cause of the incident.
- Improve the attendance of staff invited to safeguarding meetings
- Provide staff with results from hand hygiene and cleanliness audits for their department to help make sure they are able to monitor staff performance rather than results inclusive of multiple wards or directorates.

Medical Care (including older peoples care)

- The trust should ensure that patients are discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should ensure that patients have access to pressure relieving equipment at all times.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.

Surgery

- Take appropriate actions to improve staff appraisal completion rates.
- Take appropriate actions so that emergency equipment is securely stored.

Critical Care

- Consider improving appraisal rates as these were lower than at the previous inspection.
- Consider improving the management of the followed up of audit action plans.
- Consider increasing the number of staff who had undertaken a post qualification course in critical care nursing in order to meet the Intensive Care Standards guidelines.
- Consider improving the access to specialist critical care trained pharmacist services on weekends.
- Consider increasing the monitoring of patient satisfaction as the service did not participate in the NHS friends and family test.
- Consider improving the level of Physiotherapy staffing to meet the minimum expected standards.

Maternity & Gynaecology

- The hospital should improve the recording of the review dates and version control of all policies and procedures.
- The hospital should improve attendance at governance meetings.
- The hospital should improve staff annual appraisal rates.
- The hospital should increase staff training uptake for Female Genital Mutilation (FGM) training.
- The hospital should work to better understand the variation in unplanned home birth rates to ensure safety of patients and babies.
- The hospital should strengthen the risk registers to support the management of risk.

Outpatients and diagnostic imaging services

Outstanding practice and areas for improvement

- Consider monitoring and reviewing the procedures for caring for vulnerable patients attending for cancer therapy.
- Consider improving the environment in the Outpatients department to ensure privacy and dignity is maintained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(b): Providers must do all that is reasonably practicable to mitigate risks. They should follow good practice guidance and must adopt control measures to make sure the risk is as low as possible. The risk assessment for the room assigned for mental health patients in the urgent care centre, had been risk assessed but the assessment showed that no action had been taken to try to mitigate or control the risk. 12(2)(b): Staff must follow plans and pathways. Urgent Care Centre medical staff were not all aware of the need for senior clinical review of certain patients prior to discharge. 12(2)(e) Ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way: Not all staff in Maternity services received medical devices training to ensure all equipment was used in a safe way. 12(2)(g): Staff must follow policies and procedures about managing medicines. We found entries relating to the use of controlled drugs and checks were not entered into the controlled drug register in the Urgent Care Centre. Systems in place for medicine management across medical services were not always robust or followed, which put patients at risk.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Maternity and midwifery services

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17(2)(a): Information must be up to date, accurate and properly analysed and reviewed.

Guidelines, policies and procedures being used in the Urgent Care Centre had review dates which had expired.

The major incident plan referred to the Urgent Care Centre as an Emergency Department and there was reference to alternative provision when the centre was closed overnight.

17(2)(b): assess, monitor and mitigate risks: Providers must have systems and processes that enable them to identify and assess risk to the health, safety and/or welfare of people who use the service.

Across medical, urgent and emergency services inconsistencies in risk registers did not give assurance that they were managed effectively or within a timely manner.

There were no completed risk assessments for midwives carrying medical gases in their cars and there was no Standing Operating Procedure (SOP) or protocol for carrying medical gases by car.

Processes and structures for governance in outpatients lacked clarity.

Processes for managing access and flow in outpatients were not robust.

There was non compliance with the 18 week referral to treatment standards.

The number of cancelled operations was of concern as was the number of those patients not treated within 28 days.

17(2)(c): Records must be kept secure at all times.

Records were not always kept secure across medical wards therefore they were accessible to the public.

17(2)(e): Providers must seek and act on feedback for the purpose of continually evaluating and improving such service.

This section is primarily information for the provider

Requirement notices

Action following poor results from College of Emergency Medicine audits was insufficient. Staff in the urgent care centre were not aware of clinical audits being undertaken which meant they were less likely to be in a position to help improve services.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed: Midwifery and support staffing levels and skill mix were not always sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient. 18(2)(a): receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Mandatory training compliance for staff across urgent care, medical, surgical, maternity and gynaecology, critical care and outpatient services, in a number of areas was low and did not reach trust compliance targets. Not all staff had received their annual appraisal.