Care Quality Commission

Southport and Ormskirk Hospital NHS Trust

Ormskirk District General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated the hospital as requires improvement overall which is no change from the last inspection in November 2015.The same four of the fivedomains were judged to be requiring improvement with the caring domain rated as good. Urgent care and outpatient services remained at a rating of good. Surgery and children's services moved down from a good rating to requires improvement andmaternity services had improved moving from an overall rating of inadequate to requires improvement. End of life services were inspected and reported in the Southport and Formby DGH report as the service was delivered by the same team trust wide.

Our key findings since our last inspection were as follows:

- Concerns raised regarding staffing in the paediatric emergency department (PED) had been addressed and staff were no longer pulled away from the department to undertake other duties. Work had been done to strengthen governance with regular meetings and risk registers were in place. We also found innovative work for orthopaedic care and goal directed therapy was undertaken in the PED.
- In the medical service the RMO position was unchanged however a foundation year two doctor had been recruited to support them. There were concerns regarding the nurse staffing especially at night and the lack of seven day working across the therapy services was having a detrimental effect on patients rehabilitation particularly in regards to swallow assessments where patients could wait three days over a weekend for assessment. There also appeared to be a lack of documented oversight of the matrons in regard to regular reviews of infection control measures, equipment and records.
- In the surgery services there remained a large number of staff vacancies in theatres and there was still no approved schedule for replacing older equipment. There were 10 vacancies in theatres and although it was reported that five new members of staff had been recruited, they had not commenced in post and no start date had been identified. The situation was unchanged from the last inspection. There remained no approved schedule for replacing older theatre equipment and there was no funding identified to address this. There was no clear vision for the future of surgical services at ODGH. There was extra capacity at the hospital, which contrasted sharply with the situation at Southport and Formby District General Hospital (SFDGH). We saw a business case for all urology procedures to be transferred to ODGH. We found that no decision had been made about the future, but could only be made as part of a decision in the wider healthcare economy.
- Following a rating of inadequate in maternity services the Royal College of Obstetrics and Gynaecology (RCOG) completed a review commissioned by the trust in August 2015. As a result of this review 26 recommendations were made which included immediate changes to procedures to improve patient safety, review of staffing arrangements and improvements in governance. At this inspection we found managers and staff had accepted the outcome of that report, identified the changes required and implemented an improvement plan to change practices and develop the service. Whilst some of this work was on-going a vast majority had been completed and both midwifery and medical staff spoke about the positive changes which had taken place. There was acknowledgement that some changes were in their infancy and results could not yet be measured and others were still to be implemented. However there were examples of service improvements which had resulted in positive changes to patient care and improvements in staff culture.
- In the Children’s and young people’s services safe, caring and well-led were rated as ‘good’ but it was deemed requires improvement in the effective and responsive domain because patient records were kept in unlocked trolleys across the service; paediatric policies, pathways and procedures were out of date or available and the dissemination of actions from complaints required strengthening as complaints were not addressed in a timely manner and there was no evidence of learning from them. The 2014 CQC inspection identified that the children and adolescence mental health service was limited, which often meant that children were not assessed during the

weekend. CAHMS support from West Lancashire team out of hours for patients who presented with psychosis or severe intent to self-harm remained restricted due to financial provisions. The ward did not have an isolated room available for CAMHS patients but side rooms were used if available however, staff carried out risk assessment before patients were placed in rooms.

- The rating remained the same for the outpatients and diagnostics departments who received a rating of 'good' for being safe, caring, responsive and well-led (effective is not rated under the current guidance). We found the hospital performed well against national targets. Waiting times for appointments were better than average. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment. There were a large number of appointment cancellations that had a variety of causes including IT issues; patients received multiple appointments in error. However, managers were gathering evidence and had set improvement targets.

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

In surgery

- The service must ensure that there are sufficient staff in theatre area.
- The service must ensure that that there is a schedule for the replacement of old theatre equipment.
- The service must ensure that the WHO checklist is completed in full on every occasion.
- The service must take action to develop an action plan to reduce the high readmission rate in elective surgery.
- The service must take action to ensure that mortality and morbidity events in surgical services are reported to the trust board.

In medicine

- The service must take action to ensure that all staff have the up to date training they require to be able to safety care and treat patients in line with trust policy.
- The service must ensure that all records relating to patients are kept securely.
- The service must ensure that there are always sufficient numbers of qualified, competent staff on the ward and ensure there is adequate medical cover to provide the RMO with sufficient time off.
- The service must take action to ensure that any patient who is deemed not to have capacity to consent to remain in hospital and does not wish to do so has a relevant and up to date deprivation of liberty safeguard in place. All actions taken in the patients best interests must be recorded.

In maternity and gynaecology

- The service must take action to ensure that controlled drugs on the labour ward are correctly stored and staff do not have to leave the operating theatre to obtain controlled drugs.
- The second obstetric theatre must be suitable for the purpose for which it is being used.
- The administration area for the community midwives must be fit for the purpose for which it is being used, including provision for ensuring the privacy of a service user when speaking on the telephone and between professionals.

In children's

- The service must ensure that all clinical pathways are up to date and reflect current standards and guidance.
- The service must ensure complaints are dealt with robustly and in a timely manner.

Summary of findings

In children's

- The service must ensure that all clinical pathways are up to date and reflect current standards and guidance.
- The service must ensure complaints are dealt with robustly and in a timely manner.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	Following previous concerns about staffing in the paediatric emergency department (PED), we saw practice had changed to ensure staff were not routinely undertaking duties which pulled them away from the department (such as on call bed management duties). There was a culture of reporting and learning from incidents. Areas we inspected were visibly clean and tidy and staff responsible for cleaning followed protocols which helped control infection. The infrastructure was fit for purpose and equipment, medicines and controlled drugs were stored appropriately.Records were stored securely with legible, relevant information recorded. Processes, guidelines and pathways supported staff reporting safeguarding concerns, ensured staff maintained compliance with training and helped staff manage potential risks to patients. Some local audits were done to measure outcomes. Staff worked together to provide care for patients. Where services were not available 24 hours per day, processes were in place to ensure care could still be provided. Pain was appropriately monitored, with pain relief provided if necessary. Patients and carers felt happy with the care provided, and felt that treatment was fully explained in a way they could understand. We observed compassionate care being provided by staff who were mindful of privacy and dignity when moving between areas. Bereavement support was available for those who had lost someone. Waiting areas catered for the needs of patients. Translation was available for patients whose first language was not English. A hearing loop and sign language facilities were also available. Specialist nurses provided specific care for certain ailments. Wait times were not excessive and department of health targets were being met. Low levels of complaints were received and findings were disseminated to staff to promote learning.

Summary of findings

Staff had visions of how services could be improved for patients. Work had been done to strengthen governance since our last inspection with regular meetings and risk registers in place.
We saw examples of managers engaging with staff. Staff told us they felt happy to work for the trust and proud of the teams they worked with.
Engagement with the public also took place to help educate and familiarise them with the service.
Innovative work for orthopaedic care and goal directed therapy was undertaken in the PED.

Medical care (including older people's care) — **Requires improvement**

At the last inspection in November 2014, we rated medical services at Ormskirk district general hospital as requires improvement overall. The service required improvement in the safe, effective and responsive domains and was rated good in the caring and well-led domains.
At this inspection we rated medical services at Ormskirk district hospital as requires improvement because;
A Resident Medical Officer (RMO) was employed to provide medical cover 9am to 5pm through the day and on call through the night for a whole two week period without a rest break. There was also a junior doctor who worked Monday to Friday 8am to 6pm. The RMO also covered other wards at Ormskirk hospital. This risked that if the RMO was called out that they would not receive adequate breaks leaving them overworked and exhausted.
Overnight there were two qualified staff and no regular unqualified staff. Staff reported that this caused some difficulties as it often meant having to stop giving medication and attend to personal care tasks. It also meant that if trained nurses were attending to deteriorating patients then there were no staff to support patients with their personal care needs.
The service was not equitable across the week. There was no routine medical cover on H ward at weekends to see and treat any patients that required medical attention.A junior doctor on the ward worked Monday to Friday 8am to 6pm and any medical cover outside of this time was provided by the RMO on call. The therapy team worked Monday to Friday 8.30am to 4.30pm and there was no routine cover for patients to receive therapy over

the weekend this included swallow assessment and patients that were nil by mouth on a Friday would need to remain nil by mouth over a weekend This risked vulnerable patients who were already malnourished without access to diet and fluids over a weekend.
Records on the ward were not stored securely in a lockable trolley on the ward next to the nursing station and nursing assessments were stored in a plastic box under the desk. This did not provide the security required to ensure the confidentiality of patient records.
Compliance with core competency training was variable. There were no formal cleaning rotas in place but it was evident that the ward was being cleaned. We also found that matron checklists had not been completed formally since July 2015. The checklist ensures that ward quality is maintained and evidence that wards are compliant with all policy and procedures.
However,
Medical care services were delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect. Local leadership was good, and staff felt supported by their immediate managers. All patients we spoke with were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
The percentage of patients who returned back to their usual residence following rehabilitation was 77% and the average length of stay was17.3 days on the ward before being discharged. Discharge was supported by good communication and co-operation between the hospital staff and local community teams from both the NHS and local authority, which enabled safe, timely and effective discharge of patients.

Surgery **Requires improvement**

The previous inspection in November 2014 found all domains of surgical services at ODGH to be good apart from safe. Safe was found to require improvement because of the large number of

Summary of findings

vacancies in theatres, the lack of approved schedule for replacing older equipment used in theatres and that the only medical cover was provided by a resident medical officer (RMO).
This inspection identified that surgical services still required improvement in safe.We also found that it required improvement in well-led. For effective, caring and responsive we rated it as good.
There were still a large number of staff vacancies in theatres and there was still no approved schedule for replacing older equipment. There were 10 vacancies in theatres and although it was reported that five new members of staff had been recruited, they had not commenced in post and no start date had been identified. The situation was not very different from the last inspection.
There was still no approved schedule for replacing older theatre equipment. The issue appeared on the risk register of the planned care division, but there was no funding attached to it and it was clear that it would not be addressed until funding was identified.
In well-led, the situation had deteriorated from the last inspection because there was no clear vision for the future of surgical services at ODGH. There was extra capacity at the hospital, which contrasted sharply with the situation at Southport and Formby District General Hospital (SFDGH). We saw a business case for all urology procedures to be transferred to ODGH.We found that no decision had been made about the future, but could only be made as part of a decision in the wider healthcare economy.
Morale was poor amongst significant sections of clinical staff. Staff reported concern about the length of time that disciplinary investigations took and that clinical staff were suspended for lengthy periods of time. Staff reported that this approach created a culture of fear. There were high rates of sickness in some important areas of the service.
Staff based at ODGH felt isolated from the rest of the trust and reported that they did not see executive directors.
However;
Since the last inspection a foundation year two doctor had been recruited to support the RMO at ODGH.

Summary of findings

The standard of documentation was good, with evidence of all risk assessments being carried out and reviewed. Services were effective, implementing national and local guidelines. There were planned pre-operative assessments taking place.
Services were also responsive, in that they were planned to meet the needs of the local population and took into account the complex needs of individual patients.

Maternity and gynaecology

Requires improvement

At the last inspection we found maternity and gynaecology services to be inadequate overall. They were rated inadequate in safe and well led, requires improvement in effective and responsive and good in caring. Improvements had been made and at this inspection we rated them as requires improvement in safe, effective, responsive and well led and good in caring.
In August 2015 the Royal College of Obstetrics and Gynaecology (RCOG) completed a review of the obstetric care provided. This was commissioned by the trust to "review the obstetric services at Ormskirk District General Hospital based on the findings of the CQC report dated November 2014 with an emphasis on patient safety and clinical governance". As a result of this review 26 recommendations were made which included immediate changes to procedures to improve patient safety, review of staffing arrangements and improvements in governance.
At this inspection we found managers and staff had accepted the outcome of that report, identified the changes required and implemented an improvement plan to change practices and develop the service. Whilst some of this work was ongoing a vast majority had been completed and both midwifery and medical staff spoke about the positive changes which had taken place. There was acknowledgement that some changes were in their infancy and results could not yet be measured and others were still to be implemented. However there were examples of service improvements which had resulted in positive changes to patient care and improvements in staff culture.

Summary of findings

Whilst improvements had been made to the investigation and system for learning from incidents there were some delays in the production of reports and sharing of information.
Some practices did not meet national or local policy guidance this included infection control practices, medicine management and checking of emergency equipment.
There were risks of safeguarding information not being shared due to issues with the new patient electronic record system.
There were environmental concerns with the second obstetric theatre and the administration area for community midwives in Southport and Formby District General Hospital.
Some of the risks to patients of not receiving blood products in a timely way remained the same as the last inspection.
The issues with access to the patient electronic record system for community midwives meant they could not easily access information for community visits they had to complete.
Not all patient outcomes were benchmarked against available national data.
84% of nursing and midwifery staff were up to date with their mandatory training which did not meet the trusts' target of 90%. Appraisal rates for gynaecology nursing staff and midwives were below the trusts' target.
There was a lack of understanding of the deprivation of liberty safeguards on the gynaecology ward.
The hospital scored worse than other trusts in three questions in the labour and birth section of the 2015 CQC survey of Women's experiences of maternity services. An action plan was in place to address this.
Environmental constraints limited partners ability to be as involved as they would like during the hospital stay.
There was a lack of specialist midwives and a lack of facilities for bereaved parents.
However;

Summary of findings

Changes to the risk assessments for patients at risk of a post-partum haemorrhage had been introduced with a process for meeting the RCOG recommendation of transferring those patients to other units.
Improvements had been made to mortality and morbidity reviews.
An electronic patient information system had been introduced although there were some issues with lack of compatibility with the other systems in use.
There was a full audit programme and changes were made as a result where necessary.
There were sufficient maternity, nursing and medical staff on duty.
Most guidelines were up to date and in line with relevant National guidance.
The referral to treatment times for gynaecology patients met the national recommendations.
Changes to the clinic environment meant gynaecology patients had a contained outpatient area.
Changes to the termination of pregnancy service meant those patients no longer came into contact with pregnant women.
A comprehensive information system for monitoring patient outcomes had been developed and monthly exception reports meant trends were identified, monitored and where necessary investigated.
There had been improvements in the training of midwives to assist in the operating theatres which increased their competence in this role.
We observed staff in the maternity and gynaecology services to be kind, caring and respectful. The privacy and dignity of patients was protected.
Changes to the maternity admissions system meant improvements for patients through triage and induction of labour.
Since the last inspection there had been significant and numerous changes to the management of the maternity services. This included improvements in the governance, risk management systems, development and implementation of a maternity improvement plan and increased staff and public engagement. The sustainability of these improvements would be vital to the continued success of the service.

Summary of findings

Services for children and young people

Requires improvement

The hospital was previously inspected by the Care Quality Commission in November 2014 and Children's and Young people's service received a good rating across the all domains. During this inspection, the Children's and young people's services received a rating of 'good' for being safe, caring and well-led however the overall rating was deemed requires improvement because the effective and responsive domain was rated as requires improvement.

- Although Staff knew what constituted as an incident and regularly reported them in categories of; no harm caused, low harm, moderate short term harm need further treatment / procedure or severe harm caused, we found 57 incidents relating to medication during February 2015 – January 2016. Discrepancies relating to medicine management had been addressed and involvement from the pharmacist was sought to improve practice.
- Patient records on the ward and neonatal unit were kept in unlocked trolleys across the service; this meant that they were accessible to visitors.
- There was no robust major incident planning, staff were not aware of their roles and responsibilities if a major incident was declared.
- Policies, pathways and procedures were out of date or available. This meant they did not reflect current guidelines and best practice. Reviewed pathways used by staff on a day to day basis were not referenced and therefore we could not determine which guidance they were taken from.
- Multidisciplinary team working was evident during ward rounds and handovers. However there was a lack of communication across other services such as theatres. Children attended pre op clinics alongside adults without informing clinical leads of the children's and young people's service.
- The public, parents of children and babies using the services were not involved in developing the service, however diabetes patients were offered meetings to share experiences and learn how to self-care for their condition.

Summary of findings

- Dissemination of actions from complaints required to being more robust, complaints were not addressed in a timely manner and there was no evidence of learning from complaints.
- Leaflets were not responsive to the needs of children's visiting the ward. Information was available in English but was not available in different languages. Patient information was not in a child friendly format, leaflets contained long descriptions of conditions such as bronchiolitis or febrile convulsion.
- The 2014 CQC inspection identified that the children and adolescence mental health service was limited, which often meant that children were not assessed during the weekend. CAHMS support from West Lancashire team out of hours for patients who presented with psychosis or severe intent to self-harm was restricted due to financial provisions. The ward did not have an isolated room available for CAMHS patients but side rooms were used if available. Staff carried out risk assessment before patients were placed in rooms. . However senior managers were aware, side rooms were not always available when the ward was busy and patients would be placed with other patients.
- Senior managers did not involve children and their families to develop and plan the children, and young people's,
- The service did not have an executive or non-executive lead, and therefore was not represented at board level.

However,

- The service actively audited hand hygiene practice and environmental checks were regularly recoded. Hand gels were readily available across the ward and neonatal unit.
- Safeguarding referrals were appropriately escalated, clinicians, nursing and social services staff met regularly to discuss concerns.
- Mandatory training arrangements were in place; staff who had not attended mandatory training were identified and given protected time to complete.

Summary of findings

- We reviewed a sample of staffing rotas between January – April 2016 whilst on inspection. Staffing reflected the British Association of Perinatal Medicine (BAPM) on the neonatal unit and the Royal College of Nursing (RCN) standards on the ward.
- Pain and nutritional and hydration needs of children was routinely assessed. The ward used the paediatric early warning score system to assess poorly children. A pain rating scale was used to help children communicate information about pain alongside assessments and observations. Fluid charts contained the weight and the child's age so that staff could calculate the appropriate levels of fluids
- The service participated in local and national audits; we found that staff actively reviewed patient outcomes to improve their service. Actions from audits were documented and timescales were set appropriately. The neonatal unit actively collected data for the Bliss audit and were awarded a prize of monetary value which was used to furnish the parent's room.
- Staff were competent in their roles and given opportunities to upskill themselves. We saw a number of competency frameworks to support staff when staff were rotated across the service or sent to help busy areas such as a paediatric nurse sent to alleviate staffing pressures on the neonatal unit. Annual appraisals were regularly completed and personal development opportunities were identified and supported.
- The transition pathway was clear and supported by a three step guide to transitioning children. Children and their families were supported by clinicians and nursing staff, who coordinated care.
- Staff sought appropriate consent from patients and those close to them before delivering care and treatment. Gillick competency guidelines were used to decide whether a child or young person had the mental capacity to understand information about their care and treatment.
- Staff delivered compassionate care to children, the privacy; dignity was respected and maintained when care was provided. Families

Summary of findings

were informed about their child's care and actively participated in developing their child's care plan. Staff recognised when children and their families required additional support such as the need for an interpreter. Staff demonstrated an empathetic and considerate attitude towards children and their families.

- The local leadership on the ward and unit was visible and leaders were approachable.
- Staff received information about changes to practice and policies through staff meetings and emails. The trust wide newsletter was sent to staff, this announced achievements to other services.
- Senior managers recognised the need to consider innovative ways to develop their service. Senior managers had written a business case to employ two more Advanced Paediatric Nurse Practitioners to increase the workforce because the senior managers believed there would be a shortage of junior doctors in the future.

Outpatients and diagnostic imaging

Good

The hospital was previously inspected by the Care Quality Commission in November 2014 and outpatients and diagnostic imaging received a good rating across the domains. At this inspection, the rating remained the same and the outpatients and diagnostics departments received a rating of 'good' for being safe, caring, responsive and well-led (effective is not rated under the current guidance). At this inspection, we found the hospital performed well against national targets. Waiting times for appointments were better than average with 50% of patients receiving an appointment within five weeks of referral. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment. There were a large number of appointment cancellations that had a variety of causes including IT issues, patients received multiple appointments in error. However, managers were gathering evidence and had set improvement targets.

Summary of findings

A large number of audits were performed to ensure patients received treatment in line with best practice guidance and there was evidence of collaborative working with neighbourhood trusts.
Staff were positively encouraged to further their education and gave us examples of courses and qualifications gained within their speciality. Some areas of mandatory training showed poor results and managers acknowledged that work was needed.
When something went wrong, the outpatients and diagnostic departments responded well to patients and investigated the causes to make sure errors did not reoccur.
Patients had positive opinions about the hospital and a recent survey of 86 people gave the hospital an overall rating of 4.4 out of 5.
The outpatient improvement project was still progressing from 2014; changes had been made to the environment, clinical coding and staffing ratios. Phase four had been suspended due to staffing issues, which was to address the high cancellation numbers.

Ormskirk District General Hospital

Detailed findings

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

Detailed findings

Contents

Background to Ormskirk District General Hospital

Southport and Ormskirk NHS Trust has two hospitals and a walk in centre and provides community services to a local population of 258,000 people across Southport, Formby, Sefton and West Lancashire. The health of people in Sefton is mainly worse compared with the England average.

The trust is an integrated care organisation (ICO), delivering care in hospital and the community and employs approximately 3,242staff, 270 Medical, 1,052 Nursing and 1920 other disciplines.

Urgent care for adults is provided at Southport and Formby DGH whilst children's urgent care services are provided from Ormskirk DGH. Acute care is provided at both hospitals and there were23,084 admissions between September 2014 and August 2015 across the trust. There are 497 beds, 455 General and acute beds across the trust. Critical care services are provided through 15 critical care beds at Southport and Formby DGH. Maternity services are provided from 27 beds at Ormskirk District General Hospital.

The trust has a revenue of £188m and Full Costs of £189m giving them a Surplus (deficit) of (£896,000).

We inspected the trust as a focussed follow up to the inspection in November 2014 where the trust was found to require improvement. We visited between 12 and 15 April 2016. We visited Southport and Formby District General Hospital; Ormskirk District General Hospital; The Skelmersdale walk in Centre and community services for adults and community sexual health services for children.

The trust had recently stopped providing community health services for adults in West Kirby and were engaged in a tendering process for the remaining community health services for adults.

Our inspection team

Our inspection team was led by:

Chair: Professor Iqbal Singh;

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two Inspection Managers, 12 CQC inspectors, a CQC Pharmacy Inspector and a variety of specialists including Executive Director of Nursing & Quality; Senior Quality and Risk Manager; Head of Safeguarding; Race and equality expert; A&E Consultant; A&E Staff Nurse; Medical Consultant; Ward Manager in Medicine; Surgical Consultant; Theatre Manager; Critical Care Consultant; Advanced Nurse Practitioner; Paediatric Consultant; Paediatric Nurse; Outpatients Nurse; Retired

Detailed findings

Consultant in Palliative Care; EOLC Nurse - Director of Nursing; Consultant in Trauma & Orthopaedics; Consultant Nurse Orthopaedics; Occupational Therapist; Health Visitor.

CQC Deputy Chief Inspector, Hospitals North also joined the inspection for a day. We were also supported by three Experts 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?

The inspection team inspected the following six core services at Ormskirk District General Hospital:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Maternity and family planning
- Services for children and young people
- 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 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 Southport and Ormskirk Hospitals NHS Trust.

Facts and data about Ormskirk District General Hospital

The population is of high levels of older people and young families. Deprivation is slightly lower than average, however about 20% (9,340) children live in poverty. Life expectancy for both men and women is lower than the England average. The health of people in West Lancashire is mixed compared to the England average. Deprivation is about the same as the average and about 16% (3,250) children live in poverty. Life expectancy for both men and women is lower than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services are provided at Ormskirk Hospital by the paediatric emergency department (PED) and the West Lancashire Health Centre (WLHC). The PED is managed under the women and children's directorate and the West Lancashire Health Centre (WLHC) which is a walk in centre treating minor illness, ailment or injury, is managed under the urgent care directorate. The walk in centre was placed under the management of the trust in December 2015 having previously been managed by another provider.

The PED operates 24 hours a day, seven days a week providing care for children under the age of 16. The WLHC opens at 8am every day but has two closing times; 8pm for minor illness and 10pm for minor injury.

Between April 2015 and January 2016 the PED saw 22,058 patients, 6% of which arrived by ambulance. The majority of patients were children with only 29 adults seen during this time. On average, 72 children attend the PED each day.

Despite this being a children's emergency department, patients over the age of 16 will still be assessed. If their condition is not life threatening they are referred to the main emergency department at Southport & Formby District General Hospital.

Whilst the PED can provide care for children suffering trauma, it is not a major trauma centre. More severely injured children are therefore taken by ambulance or helicopter to the nearest trauma centre at a local children's hospital if their condition allows them to travel. If not, they are stabilised and then treated or transferred in line with their needs. The PED site has a helipad.

Following arrival, ambulatory patients wait in a seated waiting area or a playroom until they are called to the triage room and assigned to a suitable area of the PED. Patients arriving by ambulance are assigned to a suitable area upon arrival.

Patients with minor illnesses or injuries are treated in one of three 'minors' bays. Patients with more serious illness or injury are seen and treated in the 'majors and resuscitation' area which has two bays and one cubicle. Patients under observation are accommodated in one of six assessment bays. A treatment room is also available for infectious patients or those requiring a more private environment and there is a plaster room where treatment for limb injuries is provided.

Between April 2015 and January 2016 the WLHC saw 16,254 patients, with less than 1% arriving by ambulance. 15,795 of these patients were adults and 459 were children. On average, 51 adults and two children attend the walk in centre each day.

Patients wait to be seen in the main waiting area before being seen in one of seven treatment rooms. There is also a resuscitation room for patients attending with serious illness or injury and a four bedded observation area for patients requiring treatment such as dressings or blood tests.

During the inspection we spoke with seven patients and carers and 17 staff from different disciplines including

clinical directors, doctors, matrons, nurses, reception and domestic staff. We also reviewed five patient records and observed daily activity and clinical practice within both the PED and the WLHC. Prior to and following our inspection we analysed information provided by the trust about the services.

Summary of findings

Following our inspection report published in May 2015, urgent and emergency services at Ormskirk District General Hospital were rated as good overall. However it should be noted that the WLHC was not included in that inspection. Following this inspection of both the PED and the WLHC, we have again rated services as good.

This is because:

- Following previous concerns about staffing in the PED, where senior nurses were being called away from the department to undertake bed management duties, we found that this practice had now changed and staffing was appropriate.
- There was a culture of reporting and learning from incidents.
- Areas we inspected were visibly clean and tidy and staff responsible for cleaning followed protocols which helped control infection. Hand hygiene was monitored and departments scored 100% for compliance between September 2015 and February 2016. The infrastructure was fit for purpose in both the PED and the WLHC with suitable seating and age appropriate decoration. Equipment, medicines and controlled drugs were stored in an organised way and within expiry dates in relation to usage and portable appliance tests.
- Records were stored securely with legible, useful information recorded.
- There was a process in place to support staff reporting safeguarding concerns. Processes were in place to ensure staff maintained competencies at work. Overall figures for mandatory and statutory training met the trust compliance target.
- Processes were also in place to help staff manage potential risks to patients. Guidelines and pathways supported staff delivering care. Some local audits were done to measure outcomes. Staff worked together locally and regionally to provide care for patients. Where services were not available 24 hours per day, processes were in place to ensure care could still be provided even if this involved transfers to other sites.

Urgent and emergency services

- Staff could access the information they required to provide care such as advice, information or x-ray images.
- Pain was appropriately monitored with pain relief provided if necessary. Patients and carers told us they were happy with the care provided, and that treatment was fully explained in a way they could understand. Staff were mindful about privacy and dignity when moving between areas. We observed compassionate care being provided by staff and saw that bereavement support was available for those who had lost someone.
- Staff were familiar with the local population and the reasons patients attended.
- Waiting areas catered for the needs of patients, with enough seating, toilets, and hand washing facilities. Translation was available for patients whose first language was not English. A hearing loop and sign language facilities were also available. Specialist nurses provided specific care for certain ailments such as deep vein thrombosis and epilepsy.
- Wait times were not excessive and department of health targets were being met.
- Low levels of complaints were received and findings were disseminated to staff so that learning could take place.
- Staff had visions for improved services. Work had been done to strengthen governance since our last inspection with regular meetings and risk registers in place which captured the concerns described by senior managers.
- We saw examples of leaders engaging with staff. Staff told us they felt happy to work for the trust and proud of the teams they worked with. Engagement with the public also took place to help educate and familiarise them with the service.
- Innovative work for orthopaedic care and solution-focused therapy was undertaken in the PED.

However:

- Despite nursing staff being compliant with safeguarding training, not all medical staff were trained to the required standard.
- Whilst overall training figures met the trust target, we found some modules where there was low compliance.
- There were difficulties with staffing in the WLHC but managers reported being unable to make changes until the outcome of a tender bidding process in September 2016.
- Not all staff felt heard by executive leaders and some said they did not visit the departments very often.

Urgent and emergency services

Are urgent and emergency services safe?

Good

Following a rating of requires improvement in our report in May 2015, we have now rated urgent and emergency services as good in keeping people safe and protected from abuse and avoidable harm.

This is because:

- The practice whereby senior nurses were called away from the department to assist with bed management duties had now been addressed.
- There was a culture of reporting and learning from incidents.
- Areas we inspected were visibly clean and tidy and staff responsible for cleaning following protocols to aid infection control. Hand hygiene was monitored and the departments regularly scored 100% for compliance.
- The infrastructure was fit for purpose in both the PED and the WLHC with suitable seating and age appropriate decoration. Equipment was stored in an organised way and electrical appliance tests were within expiry date.
- Medicines and controlled drugs were stored appropriately and within expiry dates.
- Records were stored securely and showed legible information was recorded such as time of attendance, presenting complaint, and treatment plan. Staff in the PED kept up to date records of known children with complex needs, and systems allowed staff to provide extra information about allergies, social circumstances and even missing children.
- There was a process in place to support staff reporting safeguarding concerns. All nursing staff were trained to the required standard. Overall figures for mandatory and statutory training met the trust target for compliance.
- Processes were in place to help staff manage potential risks to patients.
- Staffing levels were appropriate in the PED.
- Staff had an appropriate knowledge of major and chemical incidents.

However:

- Although there was a culture of reporting and learning from incidents, senior clinical staff did not have a focused approach to reviewing patient deaths (mortality).
- Cleaning records were not stored which meant we could not corroborate what staff told us about cleaning regimes.
- Despite nursing staff being compliant with safeguarding training, not all medical staff were trained to the required standard.
- Whilst overall training figures met the trust target, we found some modules where there was low compliance.
- Staffing levels in the WLHC had not been calculated for some time and managers struggled to provide cover at all times. However, the service had only been acquired by the trust in December 2015 and was undergoing a tender process which meant managers could not make changes to staffing levels until the process was complete in September 2016.

Incidents

- There was a culture of reporting and learning from incidents amongst staff.
- Incidents were reported electronically. Staff received automatic email receipts following submission.
- Between February 2015 and January 2016, the PED reported 106 data incidents; of which 98 resulted in low or no harm (seven were near miss incidents). Between December 2015 and January 2016 the WLHC reported 18 incidents, 17 of which resulted in no harm or low harm.
- One serious incident and no never events were reported by the trust since February 2015. Never Events are serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers were available and should have been implemented. The serious incident related to the death of a child following attendance and discharge from the PED and was under investigation at the time of our inspection.
- Debriefs took place following distressing incidents which provided opportunities for staff to discuss what happened. A range of other staff such as paramedics, radiographers and reception staff were able to attend and counselling was available if required.
- Senior medical and nursing staff were aware of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify

patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw examples of Duty of Candour being implemented when required.
- Divisional harm meetings were held weekly where incidents reported the previous week were discussed. Additionally, senior clinical managers received information about incidents reported the previous 24 hours each day.
- Mortality meetings were not held routinely. Senior medical staff explained these had stopped but instead when a patient death occurred this could be discussed in other meetings. However, despite reviewing minutes of a number of departmental meetings, we found no evidence that mortality was discussed formally. Reviewing mortality helps promote learning and provides assurance that patients are not dying as a result of unsafe care. Without this, we were concerned there was a lack of assurance of safe care and that staff may not identify areas for improvement if required.

Cleanliness, infection control and hygiene

- All the areas we inspected were visibly clean and tidy.
- The PED employed a housekeeper each week day morning and additional domestic staff cleaned every afternoon.
- Processes were in place to ensure areas were cleaned regularly, with colour coded equipment to aid infection control. Toys were disinfected on a daily basis by health care assistants. A book was used to record issues such as outstanding cleaning. However, there were no cleaning records to evidence daily cleaning tasks over time. This meant we were unable to corroborate what we were told. Despite this, all the nursing staff we spoke to explained that daily cleaning was undertaken with enthusiasm and dedication and we saw no areas of concern during the inspection.
- Monthly infection prevention and control audit reports were completed by the trust. We reviewed a number of these, which covered the incidence of hospital acquired infections; Clostridium Difficile (C-Diff) and methicillin-resistant Staphylococcus aureus (MRSA) and hand hygiene compliance. Reminders about how to reduce infection were also included. The reports showed there were no cases of C-Diff or MRSA in the PED between September 2015 and February 2016. Hand hygiene scores were 100% throughout this period.
- Curtains were disposable and those checked were within the time limit for changing which was done every four months.
- Water taps were run three times weekly to limit the risk of legionnaire's disease infecting water supplies.
- Hand sanitizers were available and hand washing guidance was visible throughout the department.

Environment and equipment

- The infrastructure of both the PED and the WLHC were fit for purpose. The PED was decorated with brightly coloured wall designs for children. The WLHC was light and spacious, with large scenic pictures in the waiting area.
- Access to the PED was restricted between the hours of 10pm and 7am. Swipe card access was used at all other times to limit unauthorised access and push button exits helped prevent small children from roaming. Swipe access and push button exits were also used in the WLHC.
- Resuscitation equipment in the PED and WLHC was stored in an organised way. In the PED we were told the trolley and anaesthetic equipment was checked daily. Records of checks done between 16 and 28 May 2016 confirmed this except for three dates when the anaesthetic machine check was not documented. Daily checks of resuscitation equipment in the WLHC were reviewed and records showed these were complete and up to date.
- All other equipment we checked such as nebulisers, syringes and swabs were stored in an organised way. We saw stickers confirming that portable appliance tests were up to date on electrical appliances.
- Trolleys containing specific items for catheter care and 'bladder packs' for patients to take home, were already set up, enabling staff to implement treatment pathways more efficiently.
- Stretchers or chairs were placed in each bay. One stretcher was available in the WLHC for bariatric patients.

Medicines

- We checked a sample of medicines and controlled drugs stored in the PED and WLHC. Whilst controlled drugs were not kept in the WLHC, some stronger pain relief was treated in the same way. These were all within

their expiry date. Checks were done daily to ensure stock was correct. Any missing items were reported as incidents and referred to the matron and pharmacy team.
- The majority of nursing staff in the WLHC and some staff in the PED were trained to prescribe medicines. Those without prescribing qualifications used Patient Group Directives (PGDs). PGDs allow some registered health professionals to provide certain medicines to a pre-defined group of patients, without them having to see a doctor.
- Records showed that fridges storing drugs at low temperature were checked daily with minimum and maximum temperatures recorded on a checklist
- Patients had access to an onsite pharmacy. Alternatively medications could be collected at a local pharmacy, the main hospital site in Southport or delivered home.
- Senior clinical leads in the PED described a new initiative starting in May 2016, called a 'Druggle'. Druggles were meetings focusing on drugs, including discussing incidents and feeding back outcomes to improve performance.
- In the meantime, reminders about correct practice were issued in 'read and sign documents. These were produced for staff to read and then sign to confirm receipt of the information.

Records

- Patient records in the PED were in paper format and stored securely behind the reception area. The WLHC used electronic records except for patients using the deep vein thrombosis service where paper records were used.
- We reviewed five patient records during the inspection. These were legible with assessment times, a clear description of the problem and a treatment plan.
- Staff in the PED kept a file containing information about regular attenders with complex needs. The file was kept securely in an office and acted as a reference for staff providing care.
- Alerts about certain children could also be placed onto the PED IT systems such as allergies, safeguarding concerns, complex needs. Information about missing children could be included if required.
- Reminders to help maintain good record keeping practice were included in 'read and sign documents. We saw one document reminding staff to ensure patient names were correct when checking records.

Safeguarding

- Staff used safeguarding flow charts to support the referral process. These were visible on staff noticeboards and provided clear instructions for staff to follow.
- Safeguarding training for children and adults was mandatory with a compliance target of 90%. Staff completed one of three levels of training based on the level of contact with patients. NHS England guidance states that all non-clinical staff should complete level one safeguarding training and that clinical staff should complete level two training as a minimum.
- Figures showed that 100% of nursing staff in the PED and the WLHC were trained in level one and level three safeguarding. Figures were not provided for medical staff working in the WLHC. In the PED, all medical staff were compliant with level one training but only 20% were compliant with level three training. No figures were provided for level two training which made us unsure whether staff were compliant. We queried this with the trust but the information they provided did not clarify the situation.
- Staff told us that during office hours they sought safeguarding advice from line managers or link nurses, and that out of hours advice was available via the bed manager or on call manager. However, we were unsure about whether these managers were appropriately qualified to provide advice. For example, only 83% of bed managers had level one and 45% had level two safeguarding training.
- We saw that safeguarding information was recorded appropriately in the records we reviewed.

Mandatory training

- Training was described as mandatory or statutory depending upon the topic. Mandatory topics included hand hygiene, infection control and information governance. Statutory topics included resuscitation, consent, Mental Capacity Act and Duty of Candour.
- Personal training compliance could be viewed by each staff member via the intranet.
- Practice development facilitators, link nurses, and matrons worked to ensure staff training was up to date. We saw minutes of staff meetings where reminders were issued to complete training.
- The trust had a compliance target of 90% (95% for information governance) for training. The overall

compliance figure for nursing staff in the WLHC was 93%. We saw that 100% of staff were compliant in all mandatory training except infection control which was 0%. For statutory training, staff were compliant with some but not all modules. For example, all staff had completed intermediate and basic life support, Mental Capacity Act and consent training, but no staff (0%) had completed training for duty of candour or safe working practice. We were not provided with any records relating to medical staff.

- The overall compliance with training in the PED was 90% for medical staff and 92% for nursing staff. Nurses were compliant in mandatory areas such as moving and handling, hand hygiene and basic life support. Medical staff were 100% compliant in most areas of mandatory training including infection control, slips, trips & falls, information governance and security. However, nurse mandatory training fell below the compliance target for fire safety (78%), infection control (72%) and information governance (72%). Medical staff fell below the target for equality and diversity (75%) and basic resuscitation (75%). In relation to statutory training, all nursing and medical staff were 100% compliant in all areas. We noted that four staff were unable to undertake training due to being absent through sickness or maternity leave.
- PED staff attended study days annually where topics such as safeguarding, blood transfusion, mathematics, female genital mutilation and PREVENT (specific training about radicalisation) were covered.

Assessing and responding to patient risk

- Processes were in place to manage potential risks for patients. These processes worked by helping staff assess a patient's condition and prioritise the order in which they were cared for.
- Baseline clinical observations were taken and 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. 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 patients being triaged in both the PED and the WLHC and saw staff obtain a medical history and clinical observations as well as details about allergies and current medication.
- IT systems automatically flagged certain medical conditions which required senior medical review. This helped ensure that feverish babies under one year old or children re-attending within 72 hours were reviewed by someone with senior clinical experience.
- All senior nurses in the PED had advanced paediatric life support training (APLS). Three nurses and four doctors were APLS instructors, which ensured that at least one member of staff with APLS training was always on duty in the PED.
- WLHC staff explained the process for managing patients suffering with sepsis (a potentially life threatening condition triggered by infection or injury) which included transferring the patient to the resuscitation bay and requesting an emergency ambulance to transfer them to the main ED at Southport.
- Call buzzers were available in all bays in the PED observation area for visitors or patients to use should they require urgent assistance.
- When PED doctors went home at midnight, middle grade doctors were available on the adjacent children's ward and the neonatal ward if required. Senior on call clinical advice was also available if required.
- Children or adolescents with mental health needs were cared for in a treatment room which had two exits. However, the room was not secure and the matron confirmed items such as tubing would need to be removed to reduce ligature risks. To mitigate these risks, one to one care could be provided with a view to referring to the paediatric ward as soon as possible. We noted this issue was listed on the department risk register.
- Ambulance handover times should not exceed thirty minutes and delays were regularly monitored. Between February 2015 and April 2016 there were only six occasions when ambulance handovers took between 30 and 60 minutes in the PED and none in the WLHC. No handovers took longer than 60 minutes in either department.

Nursing staffing

- The PED and the WLHC assigned different grades of nursing and medical staff to areas of the departments in an organised way, for example in the PED four (three whole time equivalent) emergency nurse practitioners assisted medical staff in the minors area.
- Nursing establishment in the PED was calculated using the paediatric baseline emergency staffing tool (BEST) devised by the Royal College of Nursing. In January 2016, the tool identified an additional 2.7 whole time equivalent trained staff were required. A business case was in progress at the time of our inspection. In the meantime, three whole time equivalent emergency nurse practitioners, one senior sister, 4.6 whole time equivalent sisters and 11 staff nurses rotated between the PED and the children's ward to provide cover. Any gaps in the rota were covered through overtime shifts.
- PED managers told us that agency nurses were rarely required to fill vacant shifts and figures supported this with only 0.1% of PED nursing shifts covered by agency between April 2014 and March 2015.
- In the PED, fill rates were used to calculate the percentage of staff on duty against planned staffing. This showed that on average, between November 2015 and January 2016, staffing was 99% for nurses and 101% for healthcare assistants during the day, and 100% for nursing staff and 94% for healthcare assistants at night.
- WLHC managers told us that staffing had not been reviewed in the last five years but that the last review only calculated establishment based on the service closing at 8pm. However at the time of the inspection, the service operated until 10pm and managers said no further changes to staffing levels were being authorised during the tender process, ongoing until September 2016.
- In total two senior nurses, four staff nurses, eight emergency nurse practitioners and five advanced nurse practitioners were employed on a full or part time basis in the WLHC. Advanced nurse practitioners (ANPs) covered the minor ailments element of the WLHC service along with GPs and emergency nurse practitioners covered the minor injuries element (GPs also covered the minor illness element of the service but only until 8pm).
- To cover the shortfall between 8pm and 10pm, agency nurses were required. However agency could not be sourced for only two hours daily. Instead, they were sourced for shifts between 2pm and 10pm but this was not always possible. We saw that, on 12 dates between January and March 2016, these shifts were not covered. Instead, staff already on duty offered to work late to ensure at least one member of staff was available, enabling the centre to remain open until closing time at 10pm.
- Sickness absence rates were monitored. Between April 2015 and March 2016 the average sickness rate for nurses in the WLHC was 8.9% and in the PED was 4.8%. This was above the average sickness rate for NHS staff nationally (4.2% between May 2015 and March 2016).
- In the previous inspection report we described pressures on nurse staffing in the PED because senior nurses had to undertake bed management duties at the same time as working in the PED. The matron advised that this practice had now stopped.
- Handovers took place each morning in 'safety huddles' in the PED. Here each patient in the department was discussed, as well as breeches and incidents. Smaller handovers in the WLHC took place in the afternoon to enable staff starting work to obtain any useful information.

Medical staffing

- In the PED consultants worked between 8am and 5pm seven days a week. Middle grade doctors staffed the PED until midnight and between midnight and 8am the unit was covered by medical staff on the adjacent children's wards. A trauma on call facility was available via the main ED 24 hours a day, seven days a week.
- One paediatric consultant was based solely in the PED. Four additional consultants and one locum rotated between the PED and the adult ED at Southport and Formby District General Hospital. The percentage of locum use in the PED between April 2014 and March 2015 was 11%, although rates fell to 0.5% in December 2014 and were zero between January and March 2015.
- We reviewed staffing in April 2016 which showed that all medical shifts were covered. The paediatric consultant told us she was assured that adequate medical staffing was always provided in the PED.
- Sickness rates amongst PED medical staff between April 2015 and March 2016 were 0.97%, which was well below the NHS average of which was below the NHS average sickness rate of 4.2% (between May 2015 and March 2016).

Urgent and emergency services

- In the WLHC, three full time and one part time GP cared for patients with minor illness between 8am and 8pm. However one GP also had senior management responsibilities which reduced the number of hours available for clinical work.
- Managers told us that two GPs were required to work each day which was not possible with so few employed. They had also tracked an increase in activity over time to justify this. Despite this, extra employment had not been authorised due to the tender process which would not be announced until September 2016.
- In the meantime, vacant shifts were filled by locums but the trust did not provide this information or information relating to sickness rates. However, we noted that trust management of this centre had only begun in December 2015.
- Medical handovers took place in the PED each morning and afternoon and in the WLHC each afternoon, to ensure staff starting work were fully informed about the progress of and requirements of patients in the PED.

Major incident awareness and training

- The trust had an up to date policy and plan for major incidents, including pandemics. However, the departments were not designated receiving sites for major incident patients.
- Chemical decontamination training took place for on-call managers and mandatory training providing a basic knowledge of major incidents was provided for all other staff.
- The PED kept a contingency box for use during large scale incidents or electrical failure. This was checked weekly and included torches, batteries, call bells, whistles and emergency phone numbers.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Previously we rated urgent and emergency services as good for providing effective care. Following this inspection, we have maintained the rating of good in the effective domain.

This is because:

- Staff followed guidelines and pathways when caring for patients and some local audits were in place.
- Pain was appropriately monitored with pain relief provided if necessary.
- Processes were in place to ensure staff maintained competencies at work. These included working through competency checklists, and developing further skills through study.
- Staff worked together locally and regionally to provide care for patients.
- Where services were not available 24 hours per day, processes were in place to ensure continuing care was provided.
- Staff were able to access the information they required to provide good care such as x-ray images, advice or information.

However:

- The number of local audits completed was limited and there was a lack of action to improve care following The Royal College of Emergency Medicine (CEM) audit findings.
- Out of hours arrangements for patients requiring mental health care differed depending upon area of residence. However this was not something the hospital could change given that they did not have commissioning responsibilities.

Evidence-based care and treatment

- Staff followed guidelines issued by the National Institute of Health and Care Excellence (NICE) (such as head or neck injury guidelines), and the Resuscitation Council (such as resuscitation guidelines) to help care for patients. Guidelines were accessible on the trust intranet with paper copies in folders or on staff noticeboards.
- Staff also had access to local care pathways such as orthopaedic or cellulitis pathways. These were based on national guidance and some were in partnership with the local children's hospital. Updates to pathways were disseminated in staff meetings and promoted through staff notices.
- Some local audits were completed to ensure pathways were followed correctly. For example, WLHC staff audited the care of patients diagnosed as having deep vein thrombosis in 2014 and identified that some embolisms were being missed during first scans. The

team liaised with radiology colleagues and further training was provided. Following a second audit the results identified no further issues identifying embolisms during first scans.
- The PED was involved in some clinical trials for paediatric treatment for illness such as migraine or the use of intra-nasal morphine. The trial for migraine had helped confirm that a particular type of medicine called a Triptan was safe for children to use.

Pain relief

- Pain was assessed using a score based system where zero indicated no pain and ten indicated significant pain. This allowed staff to quantitatively measure pain and provide appropriate pain relief if required.
- Pictorial pain score charts were available for younger children. These used happy and sad faces to depict the level of pain.
- We observed the care provided for three families whilst in the PED and observed that pain was assessed and medicine to manage pain was given along with verbal advice about use.
- In five records we reviewed, pain scores and medication provided were appropriately recorded.

Nutrition and hydration

- A coffee bar situated in the main entrance was open between 9am and 4pm Monday to Friday. A restaurant serving hot and cold food with halal and vegetarian options was open between 8:30am and 6:30pm each weekday and until 6:15pm at weekends. Outside of these hours a microwave was available in the restaurant for visitors to use if required.
- Vending machines were available nearby to the WLHC and the PED so that patients could obtain food or refreshments if required.
- In The WLHC, tea coffee and bread were also available so that staff could provide food or refreshment if required. However, patients were usually seen and treated within the hour which meant this was rarely required.
- In the PED, drinks were provided for patients waiting and snack boxes were available at all times if required.

Patient outcomes

- The PED participated in three yearly national audit programmes by the College of Emergency Medicine (CEM) for asthma in children (2013/14) and initial management of a fitting child (2014/15).
- The audit for asthma in children found that the hospital performed better than the England average in a number of areas. For example, despite not reaching the target of 100%, initial observations such as respiratory rate and oxygen saturation were performed with 15 minutes in 80% of children, pulse was recorded in 78% of cases and intravenous hydrocortisone or oral prednisone were provided for 78% of children. However, blood pressure was only recorded in 26% of cases and peak flow was recorded in only 2% of cases (lower than the England average of 10%), both of which also had a target of 100%.
- The audit for initial management of the fitting child found that out of 30 children, eye witness history was recorded in all records (better than the national average of 96%) and presumed aetiology was also recorded in all records (comparable with the national average of 100%). However, out of seven records, none evidenced that written information had been provided against a target of 100%. This was worse than the England average of 25%.
- A senior consultant acknowledged some findings were concerning and acknowledged that actions to improve services following these audits had not occurred due to high clinical activity. For example, only two audit meetings were held each year. Instead senior managers measured clinical performance through the number of complaints or incidents.
- Another consultant told us that, despite not measuring improvements formally, some improvements such as recording blood pressure were seen as part of day to day work. However, we remained concerned that this informal measure would not provide enough assurance of overall good practice in the department.
- We saw that some local audits were scheduled for the year ahead, starting in April 2016. These included an audit to measure adherence to guidelines regarding ketamine (a type of tranquillizer) sedation in children, a renal colic pathway and head injury.
- The trust also monitored how many patients unexpectedly re-attended the PED within seven days of discharge. It is good practice for less than 5% of patients to re-attend. Between February 2015 and April 2016, re-attendance rates varied between 1.2% and 2.4% with

an average of 1.9% patients re-attending the PED. The trust also gathered this data in relation to the WLHC and figures showed that no patients re-attended between February 2015 and April 2016.

Competent staff

- Processes were in place to ensure staff were competent in their roles.
- A practice educator worked in the PED two days a week, supporting staff and monitoring compliance with training.
- New nursing and medical staff underwent a trust induction. Local induction also took place and we saw checklists used to ensure appropriate details were provided for bank, agency or new staff. New WLHC nursing staff received information packs with details about allocated breaks, deep cleaning arrangements, where to find safeguarding information, how to access policies and how to report incidents.
- PED staff underwent a preceptorship period of up to six months to gain experience under supervision prior to becoming a substantive member of staff.
- Staff received annual appraisals via their line manager. Records showed that all nursing staff in the WLCH and PED were up to date with appraisals.
- Nurses rotated between the PED, the adjacent children's ward and assessment unit to maintain skills in each area.
- There were opportunities to develop professionally. For example, senior nurses helped staff nurses gain competence in areas such as assessing seriously ill children, conducting electrocardiogram (ECG) tests, knowledge of the Manchester Triage System (MTS) and processing radiology requests. Some staff gained further development through university attendance, completing relevant modules such as medicine and noncomplex nursing which was funded by the trust.
- Nurse revalidation was in progress in the PED and so far two staff had been through the process. The matron confirmed that information provided by the trust each month showed which staff were due revalidation or recertification of their registration.
- Consultants acted as clinical supervisors for medical staff on placement in the ED. This involved meeting with trainee doctors regularly to monitor educational progress. One consultant used College of Emergency Medicine resources which provided helpful and supportive advice for doctors at any level of training.

Multidisciplinary working

- Staff worked well together to provide care for patients. For example, link nurses and specialist nurses worked in the ED to provide extra knowledge, when required.
- PED staff worked in partnership with staff from the children's ward and with a locally commissioned psychiatric team ensuring specialist care provision for children with mental health problems. They also worked closely with the local children's hospital sourcing advice, or referring children when required. A joint training programme for advanced paediatric life support was run between these two hospitals.
- The paediatric consultant attended regional paediatric network meetings to develop a clinically managed regional network for women and children's services.
- We saw evidence of links between the PED and the adult ED based at Southport District General Hospital. For example, paediatric staff mobilised to assist the main ED and provide ongoing support following the arrival of a seriously ill child.
- The PED also worked with the North West and North Wales Transport Service, a 24 hour, seven days a week service for transferring critically ill children from District General Hospitals to one of the two Paediatric Intensive Care Units (PICUs) within the North West and North Wales area.

Seven-day services

- The ED was open 24 hours a day, seven days a week, 365 days a year. The WLHC was open between 8am and 10pm, seven days a week, 365 days per year.
- X-ray services were available on site until midnight. After this time patients requiring x-ray were either admitted until services opened the next morning, transferred to the main site at Southport, or to other hospitals for specialist care.
- Pathology services were only available on site until 10pm. After this time samples were sent to the main site at Southport for processing.

Access to information

- IT systems provided staff with information about patients and capacity within the department.
- Locums working in the WLHC had access to local contact numbers for the ambulance service, bed managers, and the main site at Southport (including telephone numbers for the ED).

- WLHC staff had access to a variety of protocols such as undertaking blood transfusions or treating acute chest pain.
- A Picture Archiving and Communication system (PACS) allowed designated staff to view scans of patients taken anywhere in the region.
- Staff accessed a national database by the National Poison Information Service to locate details about potentially harmful substances. A 24 hour telephone advice service was also available.
- Link nurses and specialist nurses provided information to staff in areas such as medicines management, diabetes and safeguarding.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, PED staff obtained consent from children, working to ensure they understood their care and treatment. For those unable to provide consent (for example, children deemed not to be Gillick competent or unconscious patients) decisions were made in line with best interests and through discussion with parents or carers.
- Staff in the WLHC worked on the principle of implied or verbal consent but medical staff told us they did not record this in patient records.
- Staff learnt about consent during annual study days. In the PED, five out of 27 staff were awaiting training due to the last cohort being full.
- The trust had a process for assessing mental capacity. Forms were available for staff to record capacity assessments. If a patient lacked capacity, staff could complete a separate form to record care given in a patient's best interests.
- For patients receiving care under the Mental Capacity Act, staff liaised with the local children and adolescent mental health service. However there were limitations based on where a child lived. For example, patients in the Sefton area liaised with the local children's hospital for out of hours advice. Patients in the West Lancashire area did not have access to this service. For these children, staff could 'spot' purchase services out of hours. The staff were not in control of this arrangement because the trust was not responsible for commissioning this service.

Are urgent and emergency services caring?

Good

Following our latest inspection, urgent and emergency services have retained a rating of good for providing a caring service.

This is because:

- We spoke to people who said they were happy with the care provided, and that care was fully explained in a way they could understand.
- Careful checks were made prior to entering rooms, and the use of curtains around bays ensured that dignity and privacy was maintained in treatment and assessment areas.
- We observed compassionate care being provided by staff who engaged with children to ensure they were happy whilst care was in progress.
- Bereavement services were available so that those who had lost someone had support if required.

Compassionate care

- We spoke to three families in the PED during our inspection. All of them were happy with the care provided for their children.
- We observed staff treating patients with compassion and engaging with them to make the process of obtaining clinical observations as easy as possible. We saw one example where a healthcare assistant took the time to interact with a young child and family members, gaining trust and cooperation through engagement and play.
- In areas where children were receiving care we saw that curtains were drawn, ensuring privacy and dignity was maintained while receiving treatment in the PED. In the WLHC we observed the care staff took to ensure rooms were vacant prior to entering.

Understanding and involvement of patients and those close to them

- All the patients and carers we spoke with felt that staff communicated well with them, ensuring they were fully informed about their medical condition and what care or treatment was required.

Urgent and emergency services

- Patients told us that staff had responded in good time to their needs.

Emotional support

- We saw that staff invited those who had lost loved ones under distressing circumstances to meet with them and talk about the care provided. This provided extra support for people dealing with the loss of a loved one.
- Bereavement link and sudden infant death nurses were available to support those who had lost a loved one. Bereavement services were also provided by the local children's hospital through a joint initiative.
- Solution focused therapy was provided for patients with specific problems such as a history of self-harm. Here, staff helped children focus on future wishes rather than analysing the causes of harm.

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

Good

Following a rating of good in our previous report, we have again rated Urgent and Emergency services as good in the responsive domain.

This is because:

- Staff knew about populations in their local area and the reasons patients came seeking care or treatment.
- Waiting areas catered for the needs of patients, with enough seating, toilets, and hand washing facilities. Translation was available for patients whose first language was not English. A hearing loop and sign language facilities were also available.
- Specialist nurses provided specific care for certain conditions such as deep vein thrombosis and epilepsy.
- Wait times were not excessive and department of health targets were being met at both the PED and the WLHC.
- Low levels of complaints were received and learning was disseminated to staff following investigation.

However:

- Specialist nursing for epilepsy in children was not available for all patients. We noted that this was caused when commissioning teams funded care in different ways and was not something PED staff could control.

Service planning and delivery to meet the needs of local people

- Services were planned around the needs of local people. Whilst the PED and the WLHC had plans in place to care for very poorly patients, they knew that the majority of visitors came with more minor injuries or ailments. For example WLHC staff told us more patients attended with minor illness than injury. PED staff reported that 66% of children attended with minor problems, such as viral infections, or parents seeking reassurance.
- Two local commissioning teams worked to provide support services for PED patients. However, services were commissioned differently, resulting in service provision for some children but not for others. For example, epilepsy specialist nursing was provided for children living in one area but not in another. Staff found this challenging but were not in a position to change the arrangement. We noted that issue was recorded on the directorate risk register.
- There was enough seating for patients in the waiting areas. Whilst these were in close proximity to reception areas (which could impact on privacy for patients) we saw signs for visitors prompting them to inform staff if they would like to provide details in a more private setting.
- Waiting areas had toys for children to play with. The PED had an additional closed playroom, enabling younger children to roam freely.
- Neither the PED nor the WLHC had rooms designed specifically for mental health patients to await assessment, care or treatment. Children attending the PED with mental health needs were admitted to the adjacent children's ward or transferred for specialist care. Patients attending the WLHC were referred elsewhere, such as the trust's main ED at Southport.
- The PED had a dedicated room for loved ones to sit away from the main area. However, there was no dedicated area for adolescents to wait.
- Toilets and hand sanitising facilities were available throughout both departments.
- Vending machines were also available for visitors which were fully stocked with drinks and snacks.

Urgent and emergency services

Meeting people's individual needs

- Telephone or face to face translation services were available for those whose first language was not English. A hearing loop was installed for visitors with hearing loss and sign language was also available if required.
- Specialist nursing care was available. For example, patients had access to deep vein thrombosis nurses in the WLHC. For children attending the PED, specialist epilepsy or community nursing was available depending upon commissioning arrangements.
- Mental health care was available for children attending the PED. Patients with mental health care needs attending the WLHC were referred to more appropriate settings such as the main ED if required, following assessment.
- Although there were no designated rooms for mental health patients attending either the WLHC or the PED, there were quieter areas for patients to wait if they preferred. In the PED a treatment room was available which had dual exits and removable equipment.
- Staff were familiar with the needs of patients with learning disabilities, or complex needs. They explained that patients usually arrived with carers who could explain their needs. PED staff kept a file containing details of regular visitors to the department. This helped staff ensure tailored care was provided on a continual basis.
- In the PED, Healthcare Assistants and two play specialists used distraction techniques to help children receiving care or treatment such as x-rays. The majority of health care assistants were also nursery nurse trained.
- Transitional care was provided for children attending the PED regularly up to their 18th birthday.

Access and flow

- The Department of Health target for urgent and emergency services is to admit, transfer or discharge 95% of patients within four hours of arrival. Both the PED and the WLHC met this target with an average of 99% of patients admitted, transferred or discharged between February 2015 and April 2016.
- The average time taken to complete initial assessments was also reported by the trust. Between February 2015 and April 2016 patients were initially assessed within an average of ten minutes in the PED and seven minutes in the WLHC, which although being slightly higher than the England average of five minutes, was within the Department of Health target of 15 minutes.
- The number of patients waiting between four and 12 hours from the point of decision to admit and actual admission was low, with only five patients recorded as waiting in the PED and no patients in the WLHC between February 2015 and April 2016.
- The total time average time patients spent in the PED between February 2015 and April 2016 was one hour 41 minutes and one hour three minutes in the WLHC.
- The Department of Health target for time taken to provide treatment is 60 minutes. Between February 2015 and April 2016, the time taken by the PED ranged between 36 and 77 minutes, (an average of 52 minutes) and between 37 and 72 minutes (an average of 49 minutes) in the WLHC which was less than the England average.
- Senior managers told us that the number of children attending the PED had risen sharply (by approximately 20%) from the same time the previous year.
- Senior clinical staff told us the PED was busiest between 5pm and 10pm. Activity quietened at night with an average of five children attending after midnight.

Learning from complaints and concerns

- Senior staff from both the PED and the WLHC told us that the complaint rate was low and data supplied by the trust confirmed this. Between February 2015 and January 2016, 14 complaints were received by the PED and five were received by the WLHC. The majority of these (all but one) related to staff attitude or clinical care.
- Staff explained the process for managing complaints. If explanation at the time did not resolve the issue, staff referred complainants to the trust patient advice and liaison service (PALS). Leaflets were available explaining the process.
- PED staff told us that complainants were invited to visit the department and discuss their concerns face to face if appropriate. This provided an opportunity to clarify concerns with senior clinicians.
- Complaints were discussed during staff meetings or individually with the staff involved. Learning was shared

following complaints. For example, in the PED we saw that staff were reminded of good record keeping practice in order to reduce complaints and improve the investigation process.

Are urgent and emergency services well-led?

Good

Following our previous inspection where services were rated as good in May 2015, we have maintained this rating for the well led domain following this inspection.

This is because:

- Staff had visions about the future and how services would be improved for patients.
- Work had been done to strengthen governance and regular governance meetings took place.
- Risk registers were in place and captured the concerns described by senior managers during our inspection.
- Risks to staff were managed through the use of panic buttons
- We saw examples of staff engagement. Staff told us they felt happy to work for the trust and proud of the teams they worked with.
- Engagement with the public took place to help educate and familiarise people with the service.
- Innovative work for orthopaedic care and solution focused therapy was undertaken in the PED.

However:

- We noted that the WLHC services were undergoing a tender process at the time of inspection which limited their ability to make strategic changes to improve services. As a result of this process, staff felt morale was lowered during what appeared to be uncertain times.
- Staff did not always feel that executive managers were visible or listened to concerns raised.

Vision and strategy for this service

- Senior members of the PED team described aspirations to develop a service which was integrated with the community and where people received care regardless of where they lived. A 'trust vision day' was planned the week following our inspection.
- WLHC managers had visions for improving care which included revised staffing and further integration of the historical models of care for minor injury, ailments and illness. However they understood that many of their ideas could not be implemented until the outcome of the tender process in September 2016.
- In the urgent care strategy called 'urgent care – reducing the pressure,' objectives and outcomes were listed but the report also stated that, although WLHC and PED activity was included, the majority of performance improvement would take place at the main ED in Southport.

Governance, risk management and quality measurement

- Senior PED managers told us that, following the last inspection, work had been done to improve governance. We saw minutes of harm meetings, daily incident reports, governance and risk meetings and the introduction of 'read and sign' documents. Monthly governance meetings also took place where staff from the PED, risk, and audit departments discussed topics such as staffing levels, complaints, incidents, policy reviews and audit progress.
- The directorates had risk registers in place identifying risks within the department. Information such as the date the risk was first entered; responsible staff member, description, risk rating and mitigating actions were all included. Risks on the register tallied with concerns described by senior managers during our inspection.
- Directorate governance reports were completed monthly, with findings presented in a dashboard. Figures showed the frequency of identified infections each month such as clostridium difficile (C-Diff) and MRSA, patient falls, staff training figures, performance in relation to department of health targets, complaints and compliments.
- Staff meetings were held monthly and joint meetings with the children's and observation wards were held twice each year.
- At the time of our inspection security staff were not employed by the trust but were due to be commissioned in April 2016. Prior to this, staff were dependent upon police assistance via 999. An external review of security in December 2015 concluded that "relying on police support does not provide a viable long term solution".

- Reception staff had access to panic buttons should they require urgent assistance. These were in good working order and we saw help summoned quickly. However, until security arrangements improved they were reliant upon colleagues for support or police attendance should an incident occur.

Leadership of service

- WLHC staff had produced evidence of an increase in attendance but that when they showed this to executive leaders, 'no one listened'.
- The PED matron was named as a Nursing Times Inspirational Leader in 2015.
- Nursing staff in the PED felt managers were approachable.
- However some staff reported that more senior managers such as the executive team were rarely seen.

Culture within the service

- Staff described being happy to work for the PED and the WLHC.
- Staff in the PED felt proud to deliver what they described as a 'really good' service.
- However WLHC staff described a historical culture of division between staff due to job roles. Since moving to trust management in December 2015 managers were working to address the issues and demonstrated their visions for change, but felt restricted by the tender process which would not be complete until September 2016 which led to low morale.
- Staff in the WLHC also felt uncertain about the future given the tender process. This was exacerbated because private organisations were bidding in the process.

Public engagement

- The trust used web based information to explain the purpose of an ED and promote alternative care pathways such as the GP, 111 service or pharmacists. This formed part of the "A&E won't kiss it better" campaign.
- The WLHC displayed drawings done by local school children on the walls.
- The PED worked closely with a local school for children with learning disabilities, inviting them to the department to familiarise themselves should they need to attend in the future.
- The trust asked patients to rate their experience of the PED in the NHS Friends and Family test. The average results between January and March 2016 showed that on average, 77% of patients would recommend the PED to friends and family which was below the England average of 85%. However we noted that results changed dramatically between months (94% in March and 65% in February) and the response rate was low (on average 2.2%). Both these factors meant results were not robust.

Staff engagement

- The trust had only taken over management of the WLHC in December 2016, and efforts to engage with staff were therefore in their infancy. So far managers had identified the need for a shared drive on the trust IT systems to enable information sharing which was under development at the time of our inspection.
- WLHC staff worked to manage the feeling of uncertainty amongst staff in relation to the tender process that was in progress at the time of inspection. Drop in sessions and weekly briefings took place to ensure staff could raise questions about the future.
- The paediatric consultant in the PED used a blog to engage with staff as well as hosting meetings called 'compassionate conversations' which focused on positive elements of work before discussions about current issues took place.

Innovation, improvement and sustainability

- PED staff worked with other local hospitals to formulate an orthopaedic pathway and a protocol for administering ketamine in the PED. This enabled staff to manage the care of some children who would ordinarily have had to be transferred to another hospital for treatment.
- The PED provided 'solution focused therapy' for children with problems such as sustained fractures when angry, cyclical vomiting, anxiety or long term conditions such as diabetes. The therapy focused on what children wanted, how they would achieve it and what difference it would make. Children could also be referred to paediatric solution focused therapy clinics held at the hospital.

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

The only medical service provided at Ormskirk District General Hospital is a small rehabilitation service provided on H ward.

H ward had 14 beds, and provides longer term rehabilitation care and treatment for patients.

Summary of findings

At the last inspection in November 2014, we rated medical services at Ormskirk district general hospital as requires improvement overall. The service required improvement in the safe, effective and responsive domains and was rated good in the caring and well-led domains.

At this inspection we rated medical services at Ormskirk district hospital as requires improvement.

- A Resident Medical Officer (RMO) was employed to provide medical cover 9am to 5pm through the day and on call through the night for a whole two week period without a rest break. There was also a junior doctor who worked Monday to Friday 8am to 6pm. The RMO also covered other wards at Ormskirk hospital. This risked that if the RMO was called out that they would not receive adequate breaks leaving them overworked and exhausted.
- Overnight there were two qualified staff and no regular unqualified staff. Staff reported that having no unqualified staff to support patients with personal care caused some difficulties as it often meant that they were having to stop giving medication and attend to personal care tasks. It also meant that if trained nurses were attending to deteriorating patients then there were no staff to support patients with their personal care needs.
- The service was not equitable across the week. There was no routine medical cover on H ward at weekends

Medical care (including older people's care)

to see and treat any patients that required medical attention.A junior doctor on the ward worked Monday to Friday 8am to 6pm and any medical cover outside of this time was provided by the RMO on call. The therapy team worked Monday to Friday 8.30am to 4.30pm and there was no routine cover for patients to receive therapy over the weekend.

- Patients that were assessed as requiring a swallow assessment and were nil by mouth on a Friday would need to remain nil by mouth over a weekend due to there not being a service that covered evenings and weekends. This risked vulnerable patients who were already malnourished without access to diet and fluids over a weekend.
- Records on the ward were not stored securely in a lockable trolley on the ward. We found the trolley was stored next to the nursing station and nursing assessments were stored in a plastic box under the desk at the nursing station. This did not provide the security required to ensure the confidentiality of patient records.
- Compliance with core competency training was variable. The data provided by the trust showed that training compliance with medicines management and consent had been below the trust target of 90% for the whole period from April 2015 to March 2016.
- We found that there were no formal cleaning rotas in place to ensure that the environment remained clean. It was evident from the inspection that the ward was being cleaned, however from July 2015, there were no formal processes by managers to maintain standards as to the trust policies.
- We found from reviewing ward dashboards that matron checklists were not being completed formally since July 2015. The checklist included checking the ward environment, equipment, infection control and ward documentation. The matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures.

However,

- Medical care services were delivered by hardworking, caring and compassionate staff who treated patients with dignity and respect. Local leadership was good, and staff felt supported by their immediate managers.
- All patients we spoke with were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received.
- The rehabilitation facilities within H ward were responsive to the needs of the patients. We observed that all staff were aware of the rehabilitation needs of the patients in order for them to return home safely.
- The percentage of patients who returned back to their usual residence following rehabilitation was 77% and the average length of stay was17.3 days on the ward before being discharged.
- There was good communication and co-operation between the hospital staff and local community teams from both the NHS and local authority, which enabled safe, timely and effective discharge of patients.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

At the last inspection in November 2014 safe was rated as requires improvement because we found Medical Care Services to require improvement. The RMO (resident medical officer) provided medical cover around the clock for two week periods of time without a break. There were insufficient nursing staff with the appropriate skills and experience to provide safe and effective care to patients outside of normal working hours. Staff were confident in reporting incidents but did not always receive feedback, and lessons learned from incidents were not widely shared.

At this inspection we rated safe as requires improvement because:

- We found that there were no formal cleaning rotas in place to ensure that the environment remained clean. It was evident from the inspection that the ward was being cleaned, however there were no formal processes by managers to maintain standards as to the trust policies.
- Due to lack of storage, equipment was left out on the ward. This reduced the corridor space and made it more difficult for patients and staff to move about freely on the ward, and made the ward seem cluttered. This posed a risk to patients who were unsteady on their feet and could fall onto equipment.
- We were informed that the ward required specialist equipment to aid patients' transfers, however this equipment had not been made available to the ward, and so staff were required to use a hoist instead. The use of a hoist did not always maximise a patient's independence. Also the ward had falls alarms that were not being used due to staff not being trained. This posed a risk to patients who attempted to mobilise unaided as there were no observable beds on the wards. Since the inspection the ward has been relocated to A ward which has created two additional rehabilitation beds. The beds on A ward are now more observable.
- Records on the ward were not stored securely in a lockable trolley on the ward. We found the trolley was stored next to the nursing station and nursing assessments were stored in a plastic box under the desk at the nursing station. This did not provide the security required to ensure the confidentiality of patient records.
- A Resident Medical Officer (RMO) was employed to provide medical cover 9am to 5pm through the day and on call through the night for a whole two week period without a rest break. There was also a junior doctor who worked Monday to Friday 8am to 6pm. The RMO also covered two other wards at Ormskirk hospital. This risked that if the RMO was called out that they would not receive adequate breaks leaving them overworked and exhausted.

However,

- All patients that were transferred from Southport hospital were initially barrier nursed in side rooms for 24 hours until all infection screening assessments had been completed to ensure the ward remained free of infection.
- Upon admission to H ward staff carried out observations and risk assessments to identify patients at risk of harm. The risk assessments included falls, pressure ulcers, nutrition (malnutrition universal screening tool MUST) and use of bed rails.
- Training statistics provided by the trust showed that 100% of staff had received level 1adult safeguarding training.

Incidents

- Incidents were recorded and documented using an electronic incident reporting system to capture data on incidents or near misses. Staff could clearly demonstrate how to use the system, and identified the types of incidents that should be recorded and understood what constituted an incident. Examples given included patient falls, development of pressure sores or insufficient staffing levels on the ward. We reviewed incidents from January 2016 to March 2016 and found that H ward had reported incidents that included patient falls and staffing issues.
- Staff told us they were encouraged to report incidents to protect patients. Feedback from incidents was regularly fed back to the staff via team briefings and staff safety huddles. Staff were able to tell where the briefings were kept and were able to discuss incidents that had been highlighted, and the actions to be taken at ward level. Staff were able to tell us about serious incidents that

had occurred on the Southport site. The ward manager was able to explain that any risks identified by the trust were quickly acted upon and procedures changed. For example, there had been an incident relating to the use of IV potassium, within hours the trust had responded and produced new guidance that all wards were to follow.

- Once serious incidents were reported a root cause analysis was undertaken and feedback given with any actions for learning. We reviewed team briefing bulletins (Governance noticeboard) sent to the ward and found that incidents were highlighted, and information to staff given to prevent further occurrence. For example pressure ulcers were highlighted as a concern and so patients need to have pressure areas checked as part of the admission process. From records reviewed we found that patients were being routinely screened for pressure sores and staff we spoke with were aware of the screening process.
- The bulletins welcomed feedback from staff and provided them an e-mail and telephone number in order to make comments or suggestions.
- Staff at all levels we spoke with were aware of the duty of candour legislation, and were able to give us examples of when this had been implemented. 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.
- We reviewed minutes of governance meetings which showed incidents were discussed and actions identified.
- Mortality and morbidity reviews were held in a monthly mortality surveillance group and action plans developed to reduce mortality. The ward manager informed us that she did not attend mortality meetings held by the trust.

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 including falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was collected and performance monitored on a monthly basis.
- Safety thermometer information was prominently displayed on the wall outside the ward and was in date for March 2016. All staff we spoke with were aware of the NHS safety thermometer and actions were taken to reduce the likelihood of harm to patients.
- The ward had achieved 100% in assessment for VTE in February and March 2016, there had been no pressure sores for the period from April 2015 to March 2016, and reported an average of two falls per month from April 2015 to February 2016. There had been four falls in November 2015, and three falls in December and January and March 2016. We were told that falls alarms had been available on the ward for approximately four weeks, yet they were not able to use them as training had not been delivered. As there were no observable beds on H ward, then the use of falls alarms would alert staff quickly that a high risk of falls patient was attempting to mobilise without assistance.

Cleanliness, infection control and hygiene

- The H ward appeared visibly clean, and all patients we spoke with expressed that they thought the ward was clean. However, we found that there were no formal cleaning rotas in place to ensure that the environment remained clean. It was evident from the inspection that the ward was being cleaned, however there were no formal processes by managers to maintain standards in line with the trust policies.
- We observed staff hygiene practice and found that all staff were following the Personal Protective Equipment (PPE) guidance such as wearing gloves and aprons.
- There were sufficient hand wash sinks and hand gels, and soap dispensers were adequately stocked and we observed that all staff followed the' bare below the elbows' guidance.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk. There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room.
- Hand hygiene audits were completed in line with the world health organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. H ward had been 100% compliant from April 2015 to March 2016.

- Performance in infection prevention and control was monitored across the medical directorate and we were informed that infection control attended the ward regularly.
- All patients that were transferred from Southport hospital were initially barrier nursed in side rooms for 24 hours until all infection screening assessments had been completed to ensure the ward remained free of infection.
- Ward performance in infection control was monitored monthly. We saw from the ward dashboard provided by the trust that H ward had reported no cases of Methicillin-resistant Staphylococcus Aureus (MRSA), and only one case of Clostridium Difficile (C.Diff) in the period from April 2015 to March 2016.

Environment and equipment

- An intercom system was in operation outside of the ward to maintain the security of patients.
- There were systems in place to maintain and service equipment. The ward reported that they had no broken equipment. All equipment we inspected was in good working order and serviced. Electrical items were portable appliance tested (PAT).
- We observed that patients that required pressure relieving equipment were on suitable pressure relieving mattresses.
- We observed that bathrooms were accessible by wheelchairs and had wide opening to aid access. However, we saw that there were long pull cords situated near hand rails or hooks which meant they could be used to isolate the pull cord from the call bell and be used as a ligature point. These had not been risk assessed.
- The environment was set out on the ward that there were no observable beds. Any high risk patients would not be able to be observed whilst nursing staff were at the nursing station. We were told that any high falls risk patients had 1:1 support if required to minimise the risk of falls.
- Due to lack of storage, equipment was left out on the ward. This reduced the corridor space and made it more difficult for patients and staff to move about freely on the ward, and made the ward appear cluttered. It also posed a risk of patients who had poor mobility falling onto equipment.
- There was a large therapy room in order for therapists to carry out comprehensive assessments with patients. We were informed that they required a sam hall turner to aid patient transfers, however this equipment had not been made available to the ward, and so staff were required to use a hoist. The use of a hoist did not always maximise a patient's independence.
- We observed that all patients had call bells within reach to be able to summon help if required.

Medicines

- H ward had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identified the patient before medicines were given to the patient. Regular checks of controlled drugs balances were recorded. However, we saw no formal evidence that controlled drugs were being audited on a monthly basis by the ward managers or matron overseeing the ward. We were informed by a senior nurse that matron checklists were in the process of being recommenced.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges on the ward.
- We reviewed four prescription charts and found them to be accurate and up to date and allergies had been noted.
- The ward had a pharmacist to support with patients medication. Pharmacists covered the wards between Monday and Friday. The pharmacy was open over seven days and there was an on call pharmacist if required.

Records

- Patient records included a range of risk assessments and care plans that were to be completed on admission and reviewed throughout a patient's stay. All patients had an individualised care plan that was reviewed and updated.
- Records on the ward were not stored securely in a lockable trolley on the ward. We found the trolley was stored next to the nursing station and nursing assessments were stored in a plastic box under the desk at the nursing station. This did not provide the security required to ensure the confidentiality of patient records.

- We reviewed six patient records and found them all to be legible, included the name of the doctor reviewing the patient, and all contained a care plan.

Safeguarding

- Safeguarding policies and procedures were in place, and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team which staff reported was a valuable resource as they also offered advice and guidance if needed. Staff reported that guidance was also available on the trust intranet. Senior nurses and a safeguarding lead nurse were also available to give advice and guidance if required.
- There was a system for raising safeguarding concerns. Staff were aware of the process and the trust safeguarding team were accessible from Monday to Friday, however, did not offer a 24 hour service. Advice outside of Monday to Friday was provided via the bed manager or via senior nurses on the wards.
- Training statistics provided by the trust showed that 100% of staff had received level 1 adult safeguarding training. However, training in safeguarding level 2 was just below the trust target from October 2015 to February 2016, averaging 87%.

Mandatory training

- Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as health and safety, fire, manual handling, and infection and prevention.
- Training statistics provided by the trust showed that the H ward was 77% compliant with training in March 2016. The trust target was 90%. In the previous four months to February 2016, the ward had achieved the trust target.

Assessing and responding to patient risk

- The trust used an electronic system to record Early Warning Scores (EWS). The system was used to alert staff if a patient's condition was deteriorating using a set of observations including temperature, pain score and respiratory rate. Observations were increased if there were signs of a patient deteriorating. A full set of observations were only collected once daily on H ward due to patients being medically fit. However, we were told by patients that they were regularly asked if they experienced pain to ensure that they remained pain free.
- Upon admission to H ward staff carried out observations and risk assessments to identify patients at risk of harm. The risk assessments included falls, pressure ulcers, nutrition (malnutrition universal screening tool MUST) and use of bed rails. From the records we reviewed we found that all risk assessments were completed and reviewed.
- There were specialist nurses in tissue viability to support staff in grading pressure ulcers and a falls nurse to support with assessing risk of falls to patients. Patients at risk of falls wore a yellow wrist band to highlight to staff the patient was at risk.
- Patients at risk of harming themselves or at severe risk of falls were protected by having one to one support in order to maintain their safety. However, at the time of inspection one patient who was at high risk of falls that did not have 1:1 throughout the day and night due to not being able to cover all the shifts required. This posed a safety risk to the patient. A senior nurse reported that it had not been possible to provide the extra staff needed.

Nursing staffing.

- H ward displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- H wards reported that its current vacancy rate was low at 1.78 WTE for qualified nurses. The real time staffing report showed that between November 2015 and February 2016 the staffing ratio was correct at 100% of shifts filled for qualified and unqualified nurses. The use of temporary staffing in the February 2016 staffing report was high at 20% for qualified nursing staff and 64% for non-qualified staff. The sickness rate for February 2016 was 7%.
- Overnight there were two qualified staff and no regular unqualified staff. Staff reported that having no unqualified staff to support patients with personal care caused some difficulties as it often meant that they were

having to stop giving medication and attend to personal care tasks. It also meant that if trained nurses were attending to deteriorating patients then there were no staff to support patients with their personal care needs.

- From reviewing the incidents reported from February 2015 to March 2016 we found that there had been 14 occasions where staff had reported that there was only one qualified nurse on duty and would not be adequate to care and treat patients safely.

Medical staffing

- A Resident Medical Officer (RMO) was employed to provide medical cover 9am to 5pm through the day and on call through the night for a whole two week period without a rest break between. There was also a junior doctor who worked Monday to Friday 8am to 6pm. The RMO also covered two other wards at Ormskirk hospital. This risked that if the RMO was called out that they would not receive adequate breaks leaving them overworked and exhausted. We requested the number of call outs the RMO had received in the past 12 months, however this information was not available. The trust supplied a snap shot of call outs for one day from the 15/03/2016 to 16/03/2016. The data showed that the RMO had been called out four times in this period one of which was out of hours after 10pm.
- A senior review by a consultant took place every Wednesday, and if required the RMO was able to contact the consultant or two medical registrars at the Southport hospital if advice was required.

Major incident awareness and training

- There were documented major incident plans within medical areas with action cards to follow in the event of a major accident.
- Staff were aware of the actions to take in the event of an emergency and knew how to find the trust policy and access key documents and guidance.
- Staff were aware of the procedures to follow in the event of a fire.
- In the event of staff shortages a staffing escalation plan detailed the responsibilities of the managers to ensure that staff shifts were covered on a daily basis to ensure patient safety.

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Are medical care services effective?

Requires improvement

At the last inspection in November 2014 effective was rated as requires improvement because 7 day working was not in place. There was no routine medical presence on H ward at weekends. Patients who were not acutely ill and did not require a daily review of their condition were not routinely seen by a doctor at weekends.

At this inspection we rated effective as requires improvement because:

- Compliance with core competency training was variable. We were informed that none of the nursing staff apart from the ward manager were able to deliver blood transfusions, which meant that patients would need to transfer back to the Southport site to receive this medical care.
- The data provided by the trust showed that training compliance with medicines management had been below the trust target of 90% for the whole period from March 2015 to February 2016. In February 2016 the training compliance was at 61.5%.
- There remained no dedicated medical cover on H ward at weekends to see and treat any patients that required medical attention. A junior doctor on the ward worked Monday to Friday 8am to 6pm and any medical cover outside of this time was provided by the RMO on call. The therapy team worked Monday to Friday 8.30am to 4.30pm and there was no cover for patients to receive therapy over the weekend. We were also told that patients that were assessed as requiring a swallow assessment and were nil by mouth on a Friday would need to remain nil by mouth over a weekend due to there not being a service that covered evenings and weekends. This risked vulnerable patients who were already malnourished being without access to oral diet and fluids over a weekend.

However,

- Staff on H ward used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to determine the treatment they provided. We observed from the records we reviewed that patients were screened for infection and appropriate measures were put in place to best care and treat patients.

Medical care (including older people's care)

- The average length of stay for rehabilitation services at Ormskirk in September 2014 to August 2015 was 24.8 days which was lower (better) than the England average of 26.6 days. We were informed by staff and managers that patients usually stayed for approximately three weeks and then their rehabilitation potential was re-evaluated. Length of stay performance for March 2015 to March 2016 had improved significantly with the trust showing that H ward length of stay had been reduced to 17.3 days.
- From March 2015 to March 2016, 77% of patients returned to their usual residence which showed that patients were receiving appropriate treatment in order for them to return home safely.
- Multidisciplinary teams worked well together to ensure coordinated care for patients. We saw that staff across all disciplines genuinely respected and valued the work of other members of the team.

Evidence-based care and treatment

- Staff on H ward used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines to determine the treatment they provided. We observed from the records we reviewed that patients were screened for infection and appropriate measures were put in place to best care and treat patients.
- There were examples of local audits that had taken place with regards to infection control and the information disseminated through the use of ward dashboard performance
- From the records we reviewed there was clear management plans and evidence of reviews from the medical team.
- Patient assessment documents were to be completed by nursing staff when patients were admitted to the ward and reviewed regularly. This formed the basis of the patient overall care plan. All patients had an individualised care plan that was reviewed and updated.

Pain relief

- Pain relief was managed on an individual basis, and was regularly monitored. Pain scores were routinely collected by nursing staff due observation rounds and recorded. We saw that levels of pain was recorded with early warning scores and observed this information being discussed at nurse handovers.
- There was a pain team based within the trust to provide support and advice to staff and patients as needed and referral could be made for follow up by the community pain team.
- Patients we spoke with told us that they had access to regular pain relief.

Nutrition and hydration

- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking.
- In the Patient Led Assessment of the Care Environment survey for 2013, 2014 and 2015 the hospital scored 83% in the quality of the food provided, which was below the England average 88%. All patients we spoke with reported that they enjoyed the food provided by the hospital
- From the records we reviewed we found that they all contained a completed Malnutrition Universal Screening Tool (MUST). The MUST is a simple 5 step screening tool which helps to identify adults who are underweight and at risk of malnutrition.
- We observed that patients had access to fluids as they required on tables in front of them

Patient outcomes

- The average length of stay for rehabilitation services at Ormskirk in September 2014 to August 2015 was 24.8 days which was lower (better) than the England average of 26.6 days. We were informed by staff and managers that patients usually stayed for approximately three weeks and then their rehabilitation potential was re-evaluated. Length of stay performance for March 2015 to March 2016 had improved significantly with the trust showing that H ward length of stay had been reduced to 17.3 days. Performance data also showed that 77% of patients in the period from March 2015 to March 2016 returned back to their usual residence demonstrating that patients were receiving timely care and treatment in order for them to return home safely.

Competent staff

- Staff told us that they received an annual personal development review (PDR) and data supplied from the

trust showed that PDR compliance was in line with the trust policy (90%) from March 2015 to February 2016. The ward manager informed us that all PDR's had now been completed (100%).

- In the 2015, national staff survey the trust scored 2.88 out of five for staff response to the quality of the staff appraisal. This was below the national average of 3.03.
- There was no system in place for the ward to have regular team meetings. However, important information was passed to staff through team briefings and daily safety huddles to ensure all staff on shift were aware of any important events or happenings on the ward or within the trust.
- Staff were provided with relevant information throughout the day through daily safety huddles. Information with regards to trust learning points were shared. These included highlighted risks and things to remember such as patients with the same or similar names.
- Staff we spoke with confirmed they had an adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- In the 2015, national staff survey the trust scored 3.97 out of five for the staff response to the quality of non-mandatory training, learning or development. This was below the national average of 4.15.
- Compliance with core competency training was variable. We were informed that none of the nursing staff apart from the ward manager were able to deliver blood transfusions. Ward dashboard performance also showed no data from July 2015 to March 2016 for the compliance with training with regards to blood transfusions. This meant that any patients who required a blood transfusion would need to transfer back to Southport hospital. Data provided by the trust showed that between April 2015 to March 2016, 38 patients transferred back to Southport Hospital of which 17 patients were admitted to the observation ward due to requiring treatment.
- The data provided by the trust showed that training compliance with consent and medicines management had been below the trust target of 90% for the whole period from April 2015 to March 2016. We reviewed medication incidents on the ward as part of the inspection and found that there had been a total of seven medication incidents from April 2015 to March 2016. Four of these incidents were in February 2016. Medicine management training performance in February 2016 was low at 61.5%.
- Managers informed us that poor performance of staff was monitored and the trust capabilities policy was followed to ensure that all staff were capable and competent in carrying out their role and responsibilities. Managers were able to give examples of where poor performance had been addressed.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, and review of records, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- Multidisciplinary team (MDT) working was well established on the ward. MDT meetings took place regularly and were attended by the medical staff, nursing staff and therapy staff such as a physiotherapist and occupational therapist and social services.
- Safety huddles took place daily on the ward. We observed that patient safety issues were part of the safety huddle, and important information exchanged to ensure the safety of patients and any organisation issues disseminated.
- Consultant ward rounds were held once a week on a Wednesday and the RMO completed a ward round every Monday.
- Pharmacy visited the ward on a daily basis and there was attendance by the dietician as required.
- The chaplaincy team from Southport hospital visited once weekly to provide support and friendship to patients.

Seven-day services

- Patients on H ward only received a senior medical review once a week. This was due to the fact that patients on the ward were deemed medically fit.
- There was no dedicated medical cover on H ward at weekends to see and treat any patients that required medical attention. A junior doctor on the ward worked Monday to Friday 8am to 6pm and any medical cover outside of this time was provided by the RMO on call.

Medical care (including older people's care)

- The therapy team worked Monday to Friday 8.30am to 4.30pm and there was no cover for patients to receive therapy over the weekend.
- Patients that were assessed as requiring a swallow assessment and were nil by mouth on a Friday would need to remain nil by mouth over a weekend due to there not being a service that covered evenings and weekends. This risked vulnerable patients who were already malnourished without access to diet and fluids over a weekend.

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.
- Trust policies were available via the trust intranet.
- There were sufficient computers available on the ward which gave staff access to patient and trust information.
- The ward displayed information with regards to patient safety, training, and upcoming events. Newsletters with current changes in ward performance and actions were readily available for staff to read.
- We observed that there were files containing minutes of meetings and protocols available to staff, and in managers office there was current information displayed on notice boards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty and ensuring adjustments such as access to specialist support, and flexible visiting. We looked at patient records and found that documentation was completed with regards to mental capacity where required.
- Staff had knowledge and understanding of procedures relating to Deprivation of Liberty Safeguards (DoLS). 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 interests of the person, and there is no other way to look after them. This includes people who may lack capacity. In one patient record we observed that the DoLS documentation was completed fully and sent to the local authority.
- 100% of the staff on H ward had received training in MCA and DoLS.

Are medical care services caring?

Good

At the last inspection in November 2014 caring was rated as good.

At this inspection we rated caring as good because:

- All six patients we spoke with were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received. Patients reported that staff were 'brilliant' and they were 'lovely'.
- We observed staff being open, friendly and helpful to patients and each other.
- The ward was busy but the atmosphere was calm, and we observed staff taking time to speak to patients to address their needs.
- The nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Patients we spoke with were complimentary about the care and attention received from the therapy staff. Patients told us that the therapy teams were 'excellent', and they were 'helping them to get back on their feet'.

Compassionate care

- All six patients we spoke with were positive about their interactions with staff. They told us that the staff were kind, polite and respectful, and they were happy with the care they received. Patients reported that staff were 'brilliant' and they were 'lovely'.
- We observed staff being open, friendly and helpful to patients and each other.
- All patients we spoke with reported the overall view of the quality of the service was good, and they were happy with the service received.

- We observed staff attending to patient's needs, and closing curtains or doors to protect the privacy and dignity of the patients.
- Patients reported that they had pain relief as required to ensure they were not in any discomfort.
- The ward was busy but the atmosphere was calm and we observed staff taking time to speak to patients to address their needs.
- Patients reported that the ward appeared clean and thought the food was good.
- The friends and family test (FFT) average response rate was 19.1% which was lower than the national average of 25.1%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. Results from the FFT were excellent with a score of 100% in December 2015.
- The trust performed better than the England average in three of the five areas of the Patient Led Assessment of the Care Environment (PLACE), these were in cleanliness scoring 99%, facilities (93%), and privacy and dignity (87%).

Understanding and involvement of patients and those close to them

- Patients said that staff usually introduced themselves before care and treatment took place and we observed that nurses knew the patients and involved them in discussions.
- Patients said they had been involved in their care and were aware of the discharge plans in place.
- Patients we spoke with said they had received good information about their condition and treatment.
- Patients who required extra support to make their needs known had a 'patient passport' document in their records. This was completed with the patient and those close to them to ensure it expressed their preferences. We observed that the ward used the booklet.
- We observed staff speaking to family members keeping them informed of progress in care and treatment.
- Patients we spoke with were complimentary about the care and attention received from the therapy staff. Patients told us that the therapy teams were 'excellent', and they were 'helping them to get back on their feet'.

Emotional support

- Staff reported that they felt they did not always have enough time to spend with patients due to the level of staffing on the wards, especially at night when there were only two staff to care and treat patients.
- Visiting times on the wards were open to meet the needs of the relatives and patients. This allowed relatives to support patients if they wanted to.
- The nursing staff carried out regular patient safety checks to ensure that the needs of patients were being met. We observed staff asking patients if they were in pain to ensure they remained comfortable.
- Chaplaincy services were available to patients as required and the chaplaincy team visited the ward weekly.

Are medical care services responsive?

Good

At the last inspection in November 2014 responsive was rated as requires improvement because at certain times there were insufficient members of staff to meet the needs of patients for example when there was only two members of staff and medicines were being administered it left only one member of staff available to support patients other needs and when the majority of patients required two staff to support them they had to wait for basic care. There was also no adequate provision for patients who needed a blood transfusion without transferring them out of the hospital.

At this inspection we rated responsive as good because:

- The rehabilitation facilities within H ward were responsive to the needs of the patients. We observed that all staff were aware of the rehabilitation needs of the patients in order for them to return home.
- There was good communication and co-operation between the hospital staff and local community teams from both the NHS and local authority, which enabled safe, timely and effective discharge of patients.
- We observed that all patients on the ward had rehabilitation needs and the service did not screen patients out of rehabilitation based upon their cognitive function.

- There had been no complaints raised by patients or relatives in the period from March 2015 to February 2016.

However,

- No leaflets were available on the ward to inform patients and their families. The manager informed us that they were available to hand out to patients and their families if they requested them.

Service planning and delivery to meet the needs of local people

- The rehabilitation facilities within H ward were responsive to the needs of the patients. We observed that all staff were aware of the rehabilitation needs of the patients in order for them to return home.
- The nursing and allied health professionals worked hand in hand next to each other on the ward, which enabled good communication and effective multidisciplinary working.
- There was a bright, roomy and a therapies room attached to the ward. However, the therapy team did not have access to all the equipment they needed. For example, we were told that a sam hall turner was required to aid patients to be able to regain their independence.
- There was good communication and co-operation between the hospital staff and local community teams from both the NHS and local authority, which enabled safe, timely and effective discharge of patients.

Access and flow

- Patients were assessed before admission to H ward and were not moved within the hospital, once admitted to the ward, unless there was a clinical need to do so. The admission process was based upon the rehabilitation needs of the patient prior to returning home.
- We observed that all patients on the ward had rehabilitation needs and the service did not screen patients out of rehabilitation based upon their cognitive function.
- Data supplied by the trust showed that patients were not routinely placed on ward H as outliers. (Outliers are patients who are placed on a ward that is not appropriate to their needs). The data supplied by the trust showed that only a total of four patients had been placed on ward H in the period from October 2015 to March 2016.
- We saw that the multidisciplinary team met at various times throughout the day, both formally and informally, to review patient care, and plan for discharge.
- Multidisciplinary team decisions were recorded, and care and treatment plans amended to include changes.
- We were informed that patients usually stayed on the ward for up to three weeks before re-evaluations were made as to the rehabilitation potential of patients.
- We reviewed the length of stay for each patient on the ward at the time of inspection, and saw that the longest length of stay was 39 days. Only a total of four patients had been on the ward for more than three weeks.
- Between January 2015 to December 2015, bed occupancy rates for H ward were good averaging 90.4%. The figures showed that H ward beds were protected and kept only for those patients who were suitable for rehabilitation and not used to free beds in other areas of the trust. We saw at the time of inspection that all patients on the ward were suitable for rehabilitation and had not been transferred to the ward inappropriately.
- There was a focus on discharge planning on the ward. Following multi-disciplinary meetings discharge plans were made for each patient based upon their progress.

Meeting people's individual needs

- The trust used a yellow wrist band to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- On admission people living with dementia or with a learning disability were given patient health passports to complete supported by carers or nursing staff. This enabled staff to know more about the person including preferences. We saw that the patient health passport was being used on the ward at the time of the inspection.
- Helping hand stickers were used for patients that required extra assistance from the staff. We saw that the stickers were placed on the patient name board and patient records and any additional support needs required were discussed at the board round and nurse hand over.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the online service

- Leaflets were available around the hospital about services that were offered in hospital and in the community. However, we found that no leaflets were available on the ward. The manager informed us that they were available to hand out to patients and their families if they requested them.
- Call bells were available on the ward and we observed that every patient had access to a call bell.
- There were a range of specialist nurses who provided specialist advice to staff, patients and their relatives. These included tissue viability, palliative care and diabetes. We observed that for those patients that needed specialist support with their nutrition had been referred to a dietician. We observed a dietician on the ward providing nutritional advice and support.
- There was a chaplaincy team that visited weekly.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would signpost patients to the Customer Services team if they were unable to deal with concerns directly.
- Patients would be advised to make a formal complaint if their concerns remained.
- There had been no complaints raised by patients or relatives in the period from March 2015 to February 2016. We were informed by the manager that complaints about the ward were seldom and had only received three complaints in two years. Ward dashboard performance confirmed this.

Are medical care services well-led?

Requires improvement

At the last inspection in November 2014 well-led was rated as requires improvement because there was no local vision for the service, and although risks within the medical directorate were discussed regularly but the system in place to communicate risks and changes in practice to nursing staff was not robust.

At this inspection we rated well- led as requires improvement because:

- The trust had a vision and strategy for the organisation, however this was not clear to all staff we spoke with. The trust had several interim executive board leaders and so a new change in direction was being developed and had yet to be cascaded to the staff teams.
- In the trust wide 2015 NHS staff survey the trust performed worse than the national average when staff were asked if they would recommend the organisation as a place to work or receive treatment. The trust scored 3.57 out of 5 compared to a national average of 3.71. The trust performed worse in 14 of the 32 key findings of the NHS staff survey and scored higher (better) in 10 of the key findings.
- There were no formal matron checklists in place to ensure that senior managers monitored and ensured that all policies and procedures of the trust were being adhered to. For example there were no formal processes from July 2015 to April 2016 that matron checklists were being completed and reported back to the medical directorate. A new accreditation scheme had been implemented, however this had not yet been rolled out across all medical wards and could not replace matrons walking the wards and completing formal assurance procedures on a monthly basis.
- Staff reported that not all members of the senior management were visible and approachable. However, they felt well supported by their immediate managers.
- We saw no formal evidence that all key improvement identified at the last inspection in November 2014 had been acted upon to improve the care and treatment for patients. For example, there was also no adequate provision for patients who needed a blood transfusion as staff did not have the necessary competencies.

However,

- Risks within the medical directorate were discussed regularly at both ward and divisional level and escalated where necessary. We saw that the risk register reflected the concerns of managers.
- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. The ward managers reported that they had good relationships with their immediate matron.
- Managers reported that they had an open door policy to ensure that staff were adequately supported. There was

no formal meeting structure, but staff reported that they could speak to their manager at any time they wanted and information was cascaded to staff through newsletters and daily safety huddles.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, however this was not clear to all staff we interviewed and staff were unclear of the direction of the trust. The trust had several interim executive board leaders and so a new change in direction was being developed.
- Staff we spoke with were clear on the values of the trust and their responsibility of delivering quality care. The values were based upon 5 areas, Supportive, Caring, Open, Professional and Efficient (SCOPE).
- In the trust wide 2015 NHS staff survey the trust performed worse than the national average when staff were asked if they would recommend the organisation as a place to work or receive treatment. The trust scored 3.57 out of 5 compared to a national average of 3.71. The trust performed worse in 14 of the 32 key findings of the NHS staff survey and scored higher (better) in 10 of the key findings.

Governance, risk management and quality measurement

- Risks within the medical directorate were discussed regularly at both ward and divisional level and escalated where necessary. We saw that the risk register reflected the concerns of managers, the risks were reviewed and a level of risk assigned. For example, the risk register reflected that there were no observable beds on the H ward and provided guidance to avoid potential harm to patients who were of high risk of falls.
- We saw no formal evidence that key improvement identified at the last inspection in November 2014 had been acted upon to improve the care and treatment for patients. For example, there was also no adequate provision for patients who needed a blood transfusion as staff did not have the necessary competencies.
- Although senior nurses attended several of the senior meetings, they did not attend the governance meetings.
- The trust did not have an onsite security team, and so if violence from patients or visitors occurred there was a reliance on the Police to respond quickly if required. From the incidents we reviewed from February 2015 to March 2016, we found two incidents where a security team may have needed to respond. On one occasion a patient went missing from the ward and another occasion where a patient had become aggressive. Data provided by the trust showed the Police had only been called out once to the Ormskirk hospital on between March 2015 and March 2016.
- In the trust wide NHS staff survey 2015, 17% of staff reported that they had experienced physical violence from patients, relatives or the public in the last 12 months. This is higher than the national average of 14%. Violence to staff and having no security team was not on the medicine risk register as of the 30 March 2016.
- Senior staff knew that there was a risk register and the ward manager was able to tell us what the key risks were for their area of responsibility.
- Senior staff were able to tell us how their ward performance was monitored and the ward manager had copies of the ward dashboard performance.
- We saw no formal evidence that daily/weekly matron quality ward rounds took place to ensure that all areas of the ward were compliant with trust policy and procedure. For example, we saw no evidence in the controlled drug medicine book that this had been checked by a senior nurse or environmental checks had been completed and reported back through the medical directorate. We found from reviewing ward dashboards that matron checklists were not being completed formally since July 2015. The checklist included checking the ward environment, equipment, infection control and ward documentation. The matron checklists are an important inspection of each medical ward to ensure that ward quality is maintained and provides evidence that wards are compliant with all policy and procedures. As these were not being formally completed then no formal assurances could be provided to the executive board that the ward was fully compliant with all policy and procedures.
- A new accreditation scheme had been implemented, however this had not yet been rolled out across all medical wards and could not replace matrons walking the wards and completing formal assurance procedures on a monthly basis.
- The ward managers informed us that alignment between the ward dashboard performance did not always match the actual figures of compliance. For example staff training compliance dashboard data did not reconcile with what the ward manager reported had been completed.

- In the trust wide NHS staff survey 2015 the trust scored 3.57 out of 5 which was lower (worse) than the national average (3.71) when staff were asked regards to the fairness and effectiveness of procedures for reporting errors, near misses and incidents.

Leadership of service

- Nursing staff spoke highly of their immediate managers and felt supported by them to carry out their role. The ward managers reported that they had good relationships with their immediate matron. However, we were informed that the matron only usually visited the ward twice monthly.
- Staff reported that some members of the senior management were visible and approachable.
- We saw good leadership at ward level. We observed senior nurses working alongside staff providing support and guidance where necessary.
- In the trust wide 2015 NHS staff survey 21% of staff reported good communication between senior management and staff. This was below the national average of 30%.

Culture within the service

- Nursing staff said they felt supported and able to speak up if they had concerns. Most staff reported that the trust was a lovely place to work, and all the staff helped each other to ensure that patients received the 'best care and treatment'. Staff were proud of the work they achieved, but felt under pressure due to staffing shortages.
- Managers reported that they had an open door policy to ensure that staff were adequately supported. There was no formal meeting structure, but staff reported that they could speak to their manager at any time they wanted and information was cascaded to staff through newsletters and safety huddles daily.
- In the trust wide 2015, NHS staff survey, the trust scored 4.08 out of 5 for staff satisfaction with the quality of work and care they were able to deliver. The national average was 3.94 out of 5.

Public engagement

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed that the majority of medical wards scored over 95%of patients who would recommend the hospital to friends or a relative.
- The trust had news releases on its website pages to keep members of the local community up to date with current events. We observed that the news releases on the website were current and up to date.
- The Trust had undertaken a number of events titled "In Your Shoes" where patients and carers were invited to share their journey with the trust. The trust event highlighted a number of positive aspects of the care and treatment on the wards as well as a number of negative findings. We saw that the positive findings included good support from allied health professionals, openness of staff and good food. Negatives findings included slow discharge planning arrangements and lots of chaos around the wards.

Staff engagement

- The trust held a staff engagement programme in 2015, holding 48 sessions with approximately 900 staff to listen to their views.
- Staff we spoke to felt that they were equipped for their role and had clear roles and responsibilities
- In the trust wide 2015, NHS staff survey 90% of staff reported they had an appraisal in the last 12 months which was higher (better) than the national average. However, the same survey reports that staff scored the quality of the appraisals lower (worse) than the national average, scoring the quality 2.88 out of five compared to the national average of 3.03 out of 5.
- The trust celebrated the achievements of staff at an annual event. At the last event, medical services had a number of staff recognised for their hard work and commitment.

Innovation, improvement and sustainability

- In the trust wide 2015, NHS staff survey, 70% of staff felt they were able to contribute towards improvements at work. This was a similar result to the national average of 71%.
- The trust was improving the quality standards across the wards using Southport & Ormskirk Nursing Accreditation Scheme (SONAS). The accreditation

scheme was based on the trust's 'Care as care should be' approach to service delivery and was modelled around the CQC five domains. Ward H had not yet received its SONAS at the time of inspection.

- Medical wards used an electronic early warning score system to record information as to deteriorating patients.

Surgery

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

Information about the service

We visited Ormskirk District General Hospital (ODGH) from the 12 to 15 April 2016, as part of our announced visit of Southport and Ormskirk Hospitals NHS Trust. The hospital carries out a range of elective surgical services, including orthopaedics, urology, general surgery and ophthalmology.

On this inspection we visited G ward, which was a 23 bedded elective orthopaedic unit. There was also a treatment centre, which was a planned surgical and medical procedures day ward, with nine beds and nine trolley bays. There were also four theatre areas. We spoke with four patients, 10 members of staff and reviewed 10 records.

The trust provided 18,724 episodes of surgical care from July 2014 to June 2015. Of these 12,300 were carried out at ODGH. Ninety per cent of these procedures were day case and only 1% of all procedures were emergency procedures. Surgical services were a part of the planned care division.

This hospital was last inspected as part of a comprehensive inspection in November 2014.

Summary of findings

The previous inspection in November 2014 found all domains of surgical services at ODGH to be good apart from safe. Safe was found to require improvement because of the large number of vacancies in theatres, the lack of approved schedule for replacing older equipment used in theatres and that the only medical cover was provided by a resident medical officer (RMO).

- This inspection identified that surgical services still required improvement in safe. We also found that it required improvement in well-led. For effective, caring and responsive we rated it as good.
- Surgical services at ODGH required improvement in safe because there were still a large number of staff vacancies in theatres and there was still no approved schedule for replacing older equipment. There were 10 vacancies in theatres and although it was reported that five new members of staff had been recruited, they had not commenced in post and no start date had been identified. The situation was not very different from the last inspection.
- There was still no approved schedule for replacing older theatre equipment. The issue appeared on the risk register of the planned care division, but there was no funding attached to it and it was clear that it would not be addressed until funding was identified.
- In well-led, the situation had deteriorated from the last inspection because there was no clear vision for the future of surgical services at ODGH. There was

Surgery

extra capacity at the hospital, which contrasted sharply with the situation at Southport and Formby District General Hospital (SFDGH). We saw a business case for all urology procedures to be transferred to ODGH.We found that no decision had been made about the future, but could only be made as part of a decision in the wider healthcare economy.

- In addition to there being no clear vision for surgical services, staff morale was mixed at the hospital, with some sections of clinical staff reporting poor morale. Staff reported concern about the length of time that disciplinary investigations took and that clinical staff were suspended for lengthy periods of time. Staff reported that this approach created a culture of fear. There were high rates of sickness in some important areas of the service. Staff based at ODGH felt isolated from the rest of the trust and reported that they did not see executive directors.

However, we also found that:

- Since the last inspection a foundation year two doctor had been recruited to support the RMO at ODGH.
- The standard of documentation was good, with evidence of all risk assessments being carried out and reviewed.
- Services were effective, implementing national and local guidelines.
- There were planned pre-operative assessments taking place.
- Surgical services provided care with compassion and empathy.
- Services were also responsive, in that they were planned to meet the needs of the local population and took into account the complex needs of individual patients.

Are surgery services safe?

Requires improvement

Surgical services at ODGH require improvement because:

- There were high levels of staff vacancies in theatre, which remained unchanged since the last inspection.
- Theatre equipment was old and had not been replaced. This was identified during the last inspection. It was on the trust risk register, but no funds had been identified to undertake the refurbishment of old equipment.
- We observed two instances where the World Health Organisation safer surgery was not properly completed. When we challenged a member of staff about one instance we did not provide assurance that the importance of the checklist being completed was fully recognised. This was also identified as an area for improvement during the last inspection.

However we also found that:

- There had been improvements in medical cover since the last inspection, with a foundation year 2 doctor being recruited to supplement the registered medical officer covering ODGH.
- Care at the treatment centre for day patients was highly organised, all risk assessments were undertaken across the service and the standard of documentation was high.
- We also observed a robust system of infection control monitoring and reporting across surgical services.

Incidents

- One serious incident occurred at ODGH between February 2015 and January 2016. This incident involved a missing surgical pack. This incident was fully investigated using a root cause analysis methodology and an action plan was developed with lessons cascaded.
- All staff we spoke with were aware of how to report incidents on the electronic incident reporting system.

Staff were aware of what constituted an incident and the types of incidents that required reporting. Staff understood the term duty of candour, which was evident in the incidents we reviewed.

- Five hundred and fifty-five incidents were reported to have occurred at ODGH between February 2015 and January 2016. Five hundred of these incidents were designated as low or no harm, 22 as causing moderate harm, with 25 of the remaining 33 being recorded as a near miss to patients.
- Staff reported that they didn't always receive feedback from the incidents that they reported, but incidents were discussed in team meetings and at morning safety huddles.
- Surgical services reviewed mortality and morbidity, across the trust, as part of the regular audit meetings in each specialty. Although minutes were taken of these meetings they were not part of the trust governance structures. We were told that mortality and morbidity was reported at the planned care governance meetings and fed into the mortality surveillance group, but on review of the minutes of the planned care governance meeting, we were unable to identify an agenda item which discussed mortality and morbidity for each speciality on a regular basis. There was a trust wide mortality surveillance group which had various task and finish work streams which were ongoing. However, from a review of the minutes of the mortality surveillance group there appeared to be no in-depth review of deaths in each surgical specialty. We were unable to identify a route by which trust board were informed of in-depth mortality and morbidity issues arising across surgical services.

Safety thermometer

- The NHS safety thermometer is an assessment tool which, once a month, measures a snapshot of a range of possible harms. These harms include the incidence of falls, pressure ulcers, blood clots and urinary catheter infections. All surgical services collected data by ward and theatre area and prominently displayed the information at the entrance of the ward.
- The data provided showed that there were no infections arising from catheters in the past year. It also showed that incidence of falls, pressure ulcers and blood clots were low.

Cleanliness, infection control and hygiene

- We were provided with very detailed monthly infection control reports. Each monthly report identified the number of meticillin-resistant staphylococcus aureus (MRSA) bacteraemia (blood-born) infections, clostridium difficile (C diff), infections arising from in-dwelling devices, hand-hygiene audits, incidence of contagious infections such as influenza and antibiotic prescribing behaviour. From these reports we were able to see that annual targets were being set and progress towards these targets was monitored on a ward, clinical area basis. Any infectious event was investigated using a root cause analysis methodology and lessons were cascaded across the trust. The reports also identified annual trends and provided monthly performance comparison against last year's infection rates by ward. This monthly reporting process provided us with assurance that there were robust systems in place to monitor infection control practices across surgical services. The data provided demonstrated that infection rates across surgical services were very low
- The data provided to us by the hospital indicate that there were no C.diff infections from April 2015 to January 2016.
- The hospital monitored surgical site infection rates on a monthly basis and prepared an annual report for the trust board. Between April 2015 and March 2016 there were four instances of surgical site infections in total hip replacements.
- The hospital monitored each clinical area's compliance with hand hygiene policies. From the data that we were given there was almost 100% compliance with trust policy for G ward and the treatment centre when they submitted an audit, but both areas did not submit audits on every occasion.We observed staff complying with hand hygiene policy on all wards we visited.
- The cleanliness of commodes was audited on a weekly basis and compliance with trust policy was high across surgical wards.
- We observed that staff wore personal protective equipment such as gloves and aprons when providing personal care to patients.
- Staff in theatres adhered to gowning policy and all infection control policies and good practice.

- The ward areas we visited were visibly clean. Theatres areas were also visibly clean, however, we observed that there was obvious dust on a piece of theatre equipment and on the latex free trolley. This was escalated to senior ward staff and dealt with immediately. There was a cleaning schedule in place, which was regularly monitored. We observed regular cleaning taking place throughout the day.

Environment and equipment

- It was identified during the last inspection that theatre equipment was old and required replacing. Although this was placed on the CQC action plan and was on the trust risk register, funds have not been identified to complete this refurbishment.
- There was a system in place for the servicing of theatre equipment. All theatre equipment that we checked was in date and regularly serviced.
- There was a system in place to monitor the completeness of resuscitation equipment. The resuscitation equipment in the ward areas was in order and checked daily as verified by the regular signing of documentation.

Medicines

- All the wards we visited had appropriate storage facilities for medicines. Ward areas were visited by staff from pharmacy department on a daily basis Monday to Friday and were available on-call outside of these times.
- Controlled drugs were appropriately stored in a metal, double locked cupboard. There was a system in place to check that controlled drugs were being managed in a secure and safe manner.
- All drug fridges were in working order. Maximum, minimum and actual temperatures were recorded daily and signed in accordance with trust policy.

Records

- We reviewed five ward patient records and five theatre records. All records were legible, complete and signed by appropriate staff.
- Risk assessments for falls, VTE, fluid balance and nutrition were completed in full.
- We saw evidence of comprehensive pre-operative assessments taking place, which included reviewing patients' past medical history and establishing meticillin resistant staphylococcus aureus (MRSA) status. Staff reported that if any abnormalities were identified at pre-operative assessment the anaesthetist was alerted and the patient further reviewed.
- A complex system of documentation was being used by nursing staff. Nursing care plans and communication sheets were held in a large lever arch folder at the nursing station and organised according to ward bay. Other parts of the nursing documentation, such as fluid balance charts, 2 hourly patient comfort checks and records relating to pressure area care, were kept at the end of the patient's bed. There was also a separate, electronic recording of early warning of medical deterioration scores.
- Medical records were stored securely in a locked trolley, but risk assessments were kept in a folder at the bottom of the bed.

Safeguarding

- Safeguarding policies and procedures were in place across surgical services. The trust had a safeguarding team, which was available during normal business hours Monday to Friday, to provide advice and guidance to staff if required. All safeguarding policies and procedures were available on the trust intranet and all staff we spoke with knew how to find them.
- The staff we spoke with knew how to identify safeguarding concerns and some staff were able to discuss occasions when they had raised a safeguarding concern.
- The trust had a target of 90% of staff receiving safeguarding training. All nursing and medical staff at ODGH had completed safeguarding adults level one this year.
- All medical and nursing staff had completed children's safeguarding training levels one and two this year.

Mandatory training

- The trust provided annual training for all staff on an annual rolling programme basis. The modules provided by the trust covered a wide range of areas. The trust had recently introduced the prevent module, which is part of the government's counter terrorism strategy.

- Information provided by the trust indicated that the completion of all mandatory training modules was variable according to professional group. Medical staff had low rates of completion for some modules such as moving and handling and fire safety, but better rates for infection control and information governance.
- Ward nursing staff had much higher rates of completion for all modules (85-100%), apart from basic life support training, hand hygiene and conflict resolution. Data provided by the trust indicated that only 33% of nursing staff hand completed hand hygiene modules, although ward staff we interviewed disputed this low figure.
- All the staff we spoke with reported that they had completed all their mandatory training modules apart from prevent.

Assessing and responding to patient risk

- In the treatment centre the staff completed all risk assessments at the bedside. A 23 hour patient pathway was in use and contained all risk assessments, venous thromboembolism (VTE), hydration and nutrition. There was also a separate falls assessment. All the assessments were completed in full.
- On G ward five records were reviewed and risk assessments for falls, VTE, fluid balance and nutrition were completed in full.
- The trust used an electronic system to record patients' vital observations such as temperature, rate of respirations and pain. This system aggregated each observation to one score, which formed an early warning score (EWS). This system was used to alert ward staff when a patient was medically deteriorating and required increased observations and further medical input. If a patient scored above four, this was escalated to medical staff.
- The trust undertook monthly audits to identify whether the EWS observations were being completed in line with trust policy, which is as the early warning score increased the frequency of observation should be increased.The information provided to us indicated that G ward was recording observations in line with trust protocol on a consistent basis.
- We observed patients being brought into theatre, procedures immediately prior to surgery commencing and the recovery process. As part of the safety procedures we observed theatre staff implementing the World Health Organisation (WHO) surgical safety checklist. The WHO safer surgery checklist is a set of safety checks to improve safety performance at critical points in a patient's surgical pathway. We found that on two occasions the checklist was not performed in the recommended way for each point of the pathway. On one occasion an anaesthetist did not perform the required sign in checks in the anaesthetic room. When challenged by us, the anaesthetist replied in a manner indicating that the value of the WHO was not fully accepted. The second omission involved a failure to complete the sign out procedure.
- There was a policy governing the transfer of critically ill patients to SFDGH, which could be found on the trust intranet.

Nursing staffing

- We were provided with monthly data detailing staffing levels on all surgical wards in the hospital for the months of October 2015 to January 12016.The data provided told us about the planned number of staff and the fill rate of staff for the months October 2015 to January 2016. A matron for surgical wards reported that acuity and dependency for each ward was assessed on a six monthly basis, but when we discussed this with senior ward staff, they appeared to be unfamiliar with the concept of acuity and dependency assessments. We were unable to see any evidence of daily acuity and dependency levels of patients being considered to support daily review of staffing levels. Sickness was monitored for each ward on a monthly basis.
- The staffing in the treatment centre was sufficient to deliver safe care and treatment to patients having day case surgery. From the data we were given G ward had 4 whole time equivalent vacancies for qualified nurses. It was reported to us that the ward had recently recruited 4 band 5 staff, who were waiting for their start date. The nurse rotas for G ward indicated that the ward was struggling to fill shifts with qualified nurses. In January 2016, there was a sickness rate of 3.9% on G ward. Agency nurses were used to fill these shifts where possible, but staff reported that it was difficult to fill shifts with agency staff.
- From the data we were provided with there were 10 vacancies in theatres. When we spoke with the theatre

manager, we were told that it was very difficult to recruit theatre staff and there was a national shortage, but 5 staff were waiting to commence employment. As a result of the high vacancy levels, theatres used a high level of agency staff

- We did not observe any gaps in care or treatment during our inspection and all ward documentation was completed appropriately.

Surgical staffing

- There were regular consultant ward rounds during the week. Medical cover was provided by a RMO and a recently appointed foundation year two doctor.

Major incident awareness and training

- There was a major incident plan and business continuity plan for surgical services. All staff that we spoke with knew how to access the major incident plan and this was included on agency staff induction.

Are surgery services effective?

Good

Surgical services at ODH are effective because:

- Patients received care and treatment in line with recommended national guidelines. The surgical services actively participate in national programmes for each surgical specialty, such as the national joint register. We were able to see evidence of a programme of local audit which included all surgical specialties.
- Nutrition and hydration needs were assessed and reviewed according to national guidelines in every patient record we reviewed. Staff complied with the trust fasting policy, which was based upon national guidelines, when preparing patients for surgery.
- Patients were assessed pre-operatively and post-operatively for pain needs. From the records we reviewed patients received the required pain relief when they needed it.

However,

- Surgical services at ODG did not carry out World Health Organisation (WHO) safer surgery checklist in full consistently. Audits demonstrated this, with all parts of documentation being carried out only 75% of occasions that were audited in January 2016.

Evidence-based care and treatment

- Patients received care and treatment in line with recommended national guidelines from NICE and the Royal College of Surgeons, which was regularly audited by the trust's involvement in a wide range of national and local audits.
- There was a trust wide annual audit plan, in which surgical services had strong representation. Each specialty had its own annual audit programme based on national and local priorities. We were provided with the minutes of monthly audit meetings for urology, orthopaedics, anaesthetics and general surgery. These minutes demonstrated that there was a programme of clinical audits in each specialty which was based on national and local policies.
- Enhanced recovery pathways were in use for surgical procedures such as joint replacements. Enhanced Recovery is an evidence-based approach to delivering care in a way that promotes a better surgical journey for the patient and delivers a quicker recovery. Evidence has shown that patients on an ER pathway are involved with the planning of their operation, receive smoother rehabilitation and return to normal activities more quickly.
- Monthly audits were undertaken to assess theatres compliance with WHO safer surgery checklists. We reviewed a selection of recent WHO audits from theatres at ODGH. These audits demonstrated that not all parts of the WHO safer surgery checklist were being carried out consistently, with all parts of documentation being carried out only 75% of occasions that were audited in January 2016.

Pain relief

- Staff assessed patients' preferences for pain management pre-operatively. The pain of in-patients was assessed as part of vital sign electronic assessment. There were also 2 hourly intentional comfort rounds. However, surgical services did not use formal pain

scoring to assess pain. In addition, there was no formal tool used to assess pain in patients that had cognitive impairment or were not able to communicate their pain levels verbally.
- There was a dedicated pain team based within the hospital to provide support and advice to staff dealing with patients' complex pain requirements.

Nutrition and hydration

- There was a system in place to assess the nutritional requirements of all patients. The hospital policy required all in-patients to undergo a malnutrition universal screening tool (MUST). Those patients requiring extra support or assessment were either referred to a dietician for further assessment or identified for extra support during mealtimes. There was a red jug and tray system in place to identify those patients who required extra support eating and drinking.
- In the five records we reviewed fluid balance charts and MUST screening was completed in full and reviewed regularly.
- The trust had a policy for fasting patients prior to surgery and we observed that this was implemented in full, with patients being given fluids up to 2 hours prior to surgery.

Patient outcomes

- Hospital episode statistics data measures the relative risk of readmission for all hospitals against an England average of 100. Data provided to us indicated that between June 2014 and May 2015 the relative risk of readmission for all elective surgery was 73, which was better than the England average. For elective general surgery it was much better than the England average at 57. The relative risk of readmission for oral surgery was around the same as the England average at 105. However, for elective orthopaedics the relative risk of readmission was 131, which is higher than the England average.
- Surgical services participated in national audits such as the national joint registry database. Surgical services also participated in a programme of local audits.
- Out of the 12,300 surgical procedures carried out at ODGH, 90% of them were day case surgery.

Competent staff

- All staff we spoke with reported having annual appraisals. However, we were told that only about 65% of theatre staff had annual appraisal this year. Trust data showed that 83% of nurses and 100% of medical staff in surgical services at ODGH have received an appraisal in the past year.
- Staff reported that the training budget had been cut and that it was more difficult than it had been previously to access training.

Multidisciplinary working

- We observed evidence of strong multidisciplinary working at ODGH. There were therapy staff based on G ward and they were an integral part of the ward team.
- We saw evidence of communication between disciplines in the medical notes, where treatment plans and progress were communicated between professions.
- Nursing staff reported that they were able to refer patients to a wide range of professionals and receive a timely response. Staff also reported that they were well supported by diagnostic services and patients were able to receive investigations such as scans and blood tests easily.
- Nursing staff reported that medical support was easily accessible from the RMO.
- Staff reported that there was effective working between sites and patients could be transferred very easily to Southport and Formby for emergency surgery, if required.

Seven-day services

- The treatment centre and the maxillofacial unit were not seven day services, but only open Monday to Friday during normal working hours.
- Out of hours medical cover was provided by the RMO, supported by on-call consultant.
- Patients were seen at the weekend by either a consultant or the RMO.
- All support and diagnostic services were available at the weekend. This included radiology support such as x-ray, pharmacy on-call cover and physiotherapy.

Access to information

- Staff had access to the necessary information to make decisions and care appropriately for patients. Staff we spoke with reported that test results and other diagnostic services reported in a timely manner and reports were secured in patient notes.

- We noted that there was evidence in the medical notes of regular senior review and a robust clinical decision making processes.
- All pre-operative assessments were contained within the medical notes, containing risk assessments, allergies and social information about the patients.
- Information boards were visible in staff areas and these displayed audit information, link nurse details and trust wide correspondence.
- Staff had access to the trust intranet and access policies and procedures when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for obtaining consent to carry out a surgical procedure from surgical patients, which was based on national guidelines. This policy was based upon national guidelines. We saw evidence of consent to surgical procedures being obtained in two stages; during the pre-operative stage prior to admission, and on the morning of admission.
- We observed consent being obtained prior to surgical procedures and other treatment procedures. It was obtained in the correct manner according to trust policy.
- In November 2015 there was a trust wide audit of surgical services compliance with the consent policy and found that full compliance was achieved in only 50% of cases. An action plan was developed to address the where the shortfalls in compliance lay but we were not provided with details of a re-audit.
- The staff we spoke with understood issues relating to capacity and the need to assess capacity. Staff reported that if a patient didn't have capacity they would discuss matters with a relative in order to make a decision in the best interest of the patient.

Are surgery services caring?

Good

Surgical services at SFDGH were caring because:

- We observed a range of care and treatment activities being delivered to patients with kindness, consideration and respect.
- We observed staff actively considering the privacy and dignity of patients in all areas of surgical services.
- Patients and relatives told us that they were happy with the care they received from nurses. They also told us that on most occasions nurses had comforted them when they were distressed and needed emotional support. This was confirmed by the level of positive responses to the NHS Friends and Family Test.#

Compassionate care

- We observed staff delivering compassionate and caring treatment to patients across all areas of the service. Theatres and recovery staff were observed being kind and reassuring to patients following their surgery. We had the opportunity to observe nursing auxiliary staff, therapy staff and student nurses delivering a range of care and treatment to in-patients and they all delivered this care with kindness and respect. All patient/staff interactions that we observed were positive, caring and respectful.
- The Friends and Family Test is an NHS tool that enables patients to give feedback on their experience of NHS care and is collected at ward level. The percentage of ODGH patients from G ward that responded during the period August 2014 to July 2015 was 12.6%, which was significantly lower than the national average of 35.5%. However, the level of satisfaction was high with over 90% of patients confirming that they would recommend the surgical services at ODGH to friends and family. These results were confirmed by the more recent monthly data that the trust collates for the same survey. In January 2016 100% of respondents for the same survey gave a positive response.

Understanding and involvement of patients and those close to them

- Staff demonstrated that they were focussed on putting patients at the centre of the care delivered and we observed staff explaining procedures and care to patients in a straightforward and caring manner.
- We saw pre-operative assessments and day case notes which indicated that staff considered patients preferences.
- Leaflet information was provided for patients coming into hospital for elective procedures, outlining what people could expect throughout the process.

Emotional support

- We observed staff providing emotional support to patients when they were distressed. This was particularly the case for patients who were confused and agitated.
- We observed that patients' dignity was maintained at all times across surgical services. Curtains were drawn around bed areas, when privacy was required. It was possible to transfer patients to a side room if extra privacy was required.

Are surgery services responsive?

Good

Surgical services are responsive to the needs of the local population and individual patient needs because:

- Services were planned and delivered in a way that meets the needs of the local population. ODGH provided mainly elective procedures, the majority of which were day case procedures. These were planned efficiently and included efficient admission and discharge procedures.
- The needs of different patients were taken into account when services are planned and delivered. We observed how patients with complex needs such as dementia and learning disabilities are fully considered when planning services.

However we also found that:

- Surgical services did not use complaints as an opportunity to learn and improve the delivery of care and treatment provided to patients.

Service planning and delivery to meet the needs of local people

- Surgical services at ODGH were planned to meet the needs of the local population by providing a range of elective surgical procedures. This included orthopaedics, ophthalmology, urology and general surgery. There was a very small amount of non-elective surgery being carried out at the hospital but only one percentage of all procedures.

Access and flow

- There was an efficient admission and discharge process in place for the treatment centre. This was based upon a thorough pre-operative assessment. Patients who were admitted for day case procedures were given morning or afternoon appointments. There were nine bed areas and nine trolley areas in the treatment centre and it was organised to ensure an efficient flow through the service.
- The discharge process from the treatment centre was efficient and organised. On discharge staff completed a discharge checklist to ensure that every aspect of discharge was addressed. This included medication, communication with health professionals in the community and a patient information leaflet.
- Patients were admitted directly to G ward, the elective orthopaedic ward. There were also non-elective orthopaedic patients, who had been transferred from Southport and Formby DGH, on this ward. There was a forward waiting area in theatres at ODGH and patients could be taken down on the morning of surgery to wait. This assisted patient flow.
- The trust wide target for percentage of cancelled operations was 0.6%. Over the previous 12 months, this was met on only two occasions which were July 2015 and January 2016 across surgical services. For the months when the target was not met, performance varied considerably, with the highest percentage of cancellations occurring in October 2015, when 2.04% of all operations were cancelled. In February and March 2016 the percentage of operations that were cancelled was 1.23% and 1.57% respectively. Compared to the England monthly average of 1%, the trust's performance was worse. However, for quarter 4 of 2015/2016 the trust performed about the same as the England average of 1.2% because of the trust's strong performance in January 2016.
- We were provided with additional data providing the reason for all operations that were cancelled. Out of 450 operations that were cancelled, only five were cancelled because of lack of a ward bed, indicating that bed capacity was not a problem at ODGH. The remaining patients were cancelled due to illness, their operation was no longer required or cancelled at patients' own volition.
- The bed occupancy rates for G ward ran at between 34-38% between October 2015 and January 2016. This is another indicator identifying spare capacity at ODGH.
- Between August 2014 and July 2015, the average length of stay at ODGH for all elective surgery was 2.4 days,

which is better than the England average of 3.3. For elective trauma and orthopaedics the average length of stay was 3 days, which is around the same as the England average of 3.4.
- The percentage of patients starting treatment within 18 weeks of referral was below 90% for all specialities, which was a trust wide figure.

Meeting people's individual needs

- Surgical services at ODGH were responsive to individual patient's needs. If patients attending the treatment centre had dementia, this was noted on pre-operative assessment and the service was adapted to better meet the needs of the individual. Relatives were asked if they wished to accompany the patient at all times. This was also the case if a patient had a learning disability.
- The trust had interpretation and translation services for those patients whose first language was not English.
- We were told about a dementia passport for patients living with dementia. This was completed by the patient or their representative and included key information about the patient, such as important likes and dislikes. We did not see a passport in operation during our visit.

Learning from complaints and concerns

- Information relating to how a patient could complain about their treatment was displayed for patients. This was not always as prominent as it could be.
- Staff we spoke with understood the process for complaints and understood that complaints could improve the service.
- Between February 2015 to January 2016 G ward received 14 complaints and the treatment centre received 4 complaints. The information we received from the trust relating to complaints demonstrated that surgical services did not use complaints to drive service improvements. The outcome was frequently no action and there did not appear to be any urgency in how the service cascaded learning points back to nursing and medical staff. An example of this attitude is that following a complaint by a patient who complained that he was discharged too soon and had to be readmitted as an emergency to another hospital, the service responded that it would be brought up at the next team meeting. Whereas a more rapid cascading of the learning actions would have be an opportunity to improve the service. In addition most complaints had no action taken next to them, again demonstrating a missed opportunity to use complaints to improve the service.

Are surgery services well-led?

Requires improvement

Surgical services at ODGH in the well-led domain require improvement because:

- There is no clear vision about the future of surgical services at ODGH. Senior managers and clinicians were unable to articulate a clear strategy for future development of surgical services. Ward staff were also unable to articulate a clear vision of services.
- Morale within the service was low, with staff articulating concern about senior clinical leadership. All staff complained about the unfairness of lengthy suspensions of clinical staff while undergoing protracted disciplinary investigations for clinical errors. Staff reported that it bred a climate of fear.
- Staff did not feel engaged with trust managers and did not feel that their concerns were listened to by senior staff.

However we also found that:

- The management in the treatment centre, G ward and theatres was very strong.
- There were robust governance structures in place and risks were appropriately identified.

Vision and strategy for this service

- The senior members of surgical services were not able to clearly articulate a vision and strategy for services at ODGH. Ward staff had no idea as to the vision or strategy for surgical services.
- There was extra capacity at ODGH, which contrasted sharply with the situation at SFDGH. However, any permanent decisions about a change in the way services were organised was impossible at the current time because of the situation that existed within the wider trust.

Governance, risk management and quality measurement

- There were structures in place to identify and report on risk and quality measurement. Risks for surgical services were identified and placed on a risk register, but didn't always progress forward. An example of this is the lack of a plan to replace old theatre equipment.
- There were regular business and governance meetings of throughout the unplanned care division. Minutes were taken and cascaded throughout the service. Ward meetings took place on a regular basis and minutes were made available for us to review. We saw a good standard of communication from these minutes.

Leadership of service

- There were clear lines of accountability across surgical services. However, there had been a lot of recent management changes which had caused instability.
- Staff at ODGH reported that they did not see the senior leadership of surgical services or the trust executive directors. They reported that they felt isolated from the rest of the trust.
- Ward and treatment centre leadership was strong at ODGH. The ward managers gave clear direction on a daily basis and communicated well with staff.
- In the 2015 NHS staff survey 21% of staff reported good communication between senior management and staff. This was below the national average of 30%.

Culture within the service

- Medical staff reported significant difficulties with senior clinical leadership. It was also reported that other medical managers did not meet with senior medical staff on a regular basis. Medical staff reported that a combative approach to dealing with disciplinary matters permeated relationships between clinicians and clinical managers.
- The same issue was also raised by other clinical staff. We were given three examples of where mistakes had resulted in lengthy suspensions. This approach to clinical mistakes was seen as harsh and not getting to the root of issues. Clinical staff were unhappy with the length of time that disciplinary investigations took and that clinicians subject to the investigatory processes were suspended during this time. It was reported to inspectors that this approach led to a culture of fear amongst clinical staff.
- The morale within the treatment centre was very positive and forward looking.

Public engagement

- The trust board minutes were available to the public online.
- The trust reported that it had undertaken a number of events designed to understand the patients' experience of its services. These events were called "In Your Shoes" and patients and carers shared their experience of services. They highlighted good experiences including good support from allied health professionals and good food. They also highlighted negative experiences such as slow discharge planning and chaos on the wards.

Staff engagement

- Staff reported that they did not feel engaged or listened to by trust management.
- The trust held a staff engagement programme in 2015, holding 48 sessions with approximately 900 staff.
- In the NHS staff survey 90% of staff reported that they had an appraisal in the last 12 months, which was better than the national average. The survey also reported that staff rated the quality of appraisal lower than the national average.

Innovation, improvement and sustainability

- There was little innovation across surgical services at ODGH as there was confusion about the future development and sustainability of surgical services at this site.
- We were told about an innovative new service being developed for pelvic floor surgery and that preliminary discussions had taken place.

Maternity and gynaecology

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

Information about the service

The trust offers pregnant women and their families antenatal, delivery and postnatal care at Ormskirk District General Hospital. The department delivered 2091 babies from January 2015 to January 2016. A range of gynaecology services and termination of pregnancies are also provided.

The Women's unit occupies three floors of one wing of the hospital. There is a consultant led delivery suite with eight rooms, three of which are for low risk pregnancies and one has a birthing pool. There is no midwifery led birthing centre. The obstetric theatre was situated within the delivery suite. The single maternity ward has 22 beds used for either ante-natal or post natal care including 8 single rooms. An induction of labour suite with five beds opened 14 February 2016 in the maternity assessment suite. The triage area of two rooms and an early pregnancy service of four beds are situated in this same area. An ante-natal clinic is on the ground floor of the women's unit.

One ward of 18 beds is specifically for gynaecology patients. There are three side rooms two of which have en-suite facilities. In this area there is a gynaecology emergency bay.

There are two community midwifery teams. One covers the West Lancashire area and the other the Southport area which includes South Sefton and Formby.

We visited the maternity department during the announced inspection between 12 and 15 April 2016 and the unannounced inspection 29 April 2016. During our visits we spoke with 45 staff, seven patients and four family members. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 15 patients. We also looked at six medication charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

At the last inspection we found maternity and gynaecology services to be inadequate overall. They were rated inadequate in safe and well led, requires improvement in effective and responsive and good in caring. Improvements had been made and at this inspection we rated them as requires improvement in safe, effective, responsive and well led and good in caring.

In August 2015 the Royal College of Obstetrics and Gynaecology (RCOG) completed a review of the obstetric care provided. This was commissioned by the trust to "review the obstetric services at Ormskirk District General Hospital based on the findings of the CQC report dated November 2014 with an emphasis on patient safety and clinical governance". As a result of this review 26 recommendations were made which included immediate changes to procedures to improve patient safety, review of staffing arrangements and improvements in governance.

At this inspection we found managers and staff had accepted the outcome of that report, identified the changes required and implemented an improvement plan to change practices and develop the service. Whilst some of this work was ongoing a vast majority had been completed and both midwifery and medical staff spoke about the positive changes which had taken place. There was acknowledgement that some changes were in their infancy and results could not yet be measured and others were still to be implemented. However there were examples of service improvements which had resulted in positive changes to patient care and improvements in staff culture.

- Whilst improvements had been made to the investigation and system for learning from incidents there were some delays in the production of reports and sharing of information.
- Some practices did not meet national or local policy guidance this included infection control practices, medicine management and checking of emergency equipment.
- There were risks of safeguarding information not being shared due to issues with the new patient electronic record system.
- There were environmental concerns with the second obstetric theatre and the administration area for community midwives in Southport and Formby District General Hospital.
- Some of the risks to patients of not receiving blood products in a timely way remained the same as the last inspection.
- The issues with access to the patient electronic record system for community midwives meant they could not easily access information for community visits they had to complete.
- Not all patient outcomes were benchmarked against available national data.
- 84% of nursing and midwifery staff were up to date with their mandatory training which did not meet the trusts' target of 90%.
- Appraisal rates for gynaecology nursing staff and midwives were below the trusts' target.
- There was a lack of understanding of the deprivation of liberty safeguards on the gynaecology ward.
- The hospital scored worse than other trusts in three questions in the labour and birth section of the 2015 CQC survey of Women's experiences of maternity services. An action plan was in place to address this.
- Environmental constraints limited partners ability to be as involved as they would like during the hospital stay.
- There was a lack of specialist midwives and a lack of facilities for bereaved parents.

However;

- Changes to the risk assessments for patients at risk of a post-partum haemorrhage had been introduced with a process for meeting the RCOG recommendation of transferring those patients to other units.
- Improvements had been made to mortality and morbidity reviews.
- An electronic patient information system had been introduced although there were some issues with lack of compatibility with the other systems in use.
- There was a full audit programme and changes were made as a result where necessary.
- There were sufficient maternity, nursing and medical staff on duty.

Maternity and gynaecology

- Most guidelines were up to date and in line with relevant National guidance.
- The referral to treatment times for gynaecology patients met the national recommendations.
- Changes to the clinic environment meant gynaecology patients had a contained outpatient area.
- Changes to the termination of pregnancy service meant those patients no longer came into contact with pregnant women.
- A comprehensive information system for monitoring patient outcomes had been developed and monthly exception reports meant trends were identified, monitored and where necessary investigated.
- There had been improvements in the training of midwives to assist in the operating theatres which increased their competence in this role.
- We observed staff in the maternity and gynaecology services to be kind, caring and respectful. The privacy and dignity of patients was protected.
- Changes to the maternity admissions system meant improvements for patients through triage and induction of labour.
- Since the last inspection there had been significant and numerous changes to the management of the maternity services. This included improvements in the governance, risk management systems, development and implementation of a maternity improvement plan and increased staff and public engagement. The sustainability of these improvements would be vital to the continued success of the service.

Are maternity and gynaecology services safe?

Requires improvement

Summary

At the last inspection we rated maternity and gynaecology services as inadequate in safe; however improvements had been made and at this inspection we have rated them as requires improvement for the following reasons;

- In the maternity services the system for reporting, investigation and learning from incidents had improved and included weekly meetings to review any incidents which resulted in harm. However there were some delays in the investigation of incidents and the production of reports and sharing of learning.
- Some practices did not meet with infection prevention and control guidance.
- Not all emergency equipment had been checked in line with the trusts' policy.
- There was a potential risk of delay in the transfer of a patient between floors in an emergency which was brought to the attention of managers during the inspection.
- The second obstetric theatre and the administration area for community midwives were not fit for purpose.
- Not all storage of medicines met with current guidance on the labour ward or in obstetric theatre.
- Documentation of medical staff training was inaccurate due to poor recording of data by the trust. Issues with the collation and reporting of data for both trust and maternity specific training had been identified and escalated.
- An electronic patient information system had recently been introduced. Staff had worked hard to put this into practice; however there were concerns that the various systems were not compatible and specific information was not easily accessible, especially for community midwives.
- There was a risk of information not being shared including that with regard to safeguarding of adults and children.
- Some of the risks to patients of not receiving blood products in a timely way remained the same as the last inspection.

However

- Multidisciplinary meetings to review incidents, risks and complaints had been introduced since the last inspection. Action plans resulted when required and these were monitored.
- Since the last inspection specific procedures to reduce the risks to patients following a post-partum haemorrhage included assessments for transfers to other hospitals, changes in blood product availability and detailed reviews of all cases to learn any lessons.
- Mortality and morbidity meetings took place and when potential themes were identified more in depth reviews were completed.
- Some resuscitation equipment was moved between the announced and unannounced inspection to improve access.
- In maternity and gynaecology services medicine administration and storage records were accurately kept.
- Patient records included risk assessments and care plans, were clearly documented and securely stored.
- Staff had a good understanding of safeguarding issues and their role in the protection of vulnerable patients.
- Maternity staff were up to date with safeguarding training for adults and children.
- There were sufficient midwifery, nursing and medical staff on duty.

Incidents

- There were 629 incidents reported in the maternity services between February 2015 and January 2016 of which 10 had an outcome of severe harm. These had all been investigated with a resulting action plan in place, or the investigation was ongoing.
- There were 141 incidents in the gynaecology department within the same period. None resulted in severe harm and eight were of moderate harm.
- A weekly multidisciplinary meeting was held to review incidents, risks and complaints where there had been moderate or severe harm or death. These had been introduced in September 2015.
- There was a planned process of escalation to the assistant director for integrated governance, the head of risk or the executive team within 72 hours if a serious incident occurred. However in the January 2016 minutes of the Women and Children's Divisional services governance committee meeting it was noted the executive level harm review meetings had not yet commenced.
- Managers reported some delays in the investigation of incidents and production of reports. We were told there were several reasons for this which included delays in reporting on the information system, conflicting priorities by the investigators and concerns by staff from the previous culture of blame. Changes to the incident investigation system had resulted in more rigor and an increased number of investigations. The new risk management structure was designed to assist this process.
- There had been improvements in feedback to staff following an incident since the last inspection. Lessons were shared verbally and in writing and discussed at the shift changeover safety huddles. Any staff involved had a debrief with a manager although for a serious incident which occurred in September 2015 discussions with relevant staff had not taken place in January 2016.
- If there were immediate lessons to be learnt from a serious incident a "flash report" was produced. This was shared with staff to ensure any immediate changes took place before the full investigation report was available.
- The lesson of the week was shared with staff via e-mail and displayed in the staff area of the ward. This was visible in the areas we visited.
- Not all staff were aware of the procedure for investigating an incident and those who were not involved in investigations did not have root cause analysis records shared with them.
- Improvements in the systems to learn from incidents included increased awareness for the medical staff. They had four safety huddles per day which were multidisciplinary when required such as including the anaesthetist.
- Procedures were changed as the result of learning from incidents. Examples included all patients who attended triage with reduced fetal movements being rated as high risk and having immediate care and treatment. Also staff were allocated roles in case of emergency situations during shift changeover.
- There was a system to ensure all staff on the gynaecology ward had received any safety messages and feedback from incidents. They signed the team brief to indicate they had read and understood the information.

- For gynaecology services serious incidents any resulting actions were discussed at the monthly gynaecology management forum. This included any reviews of morbidity and mortality within the service.
- There was no document to prompt staff as to what should be reported and not all were aware of what to report as an incident. One example was community midwives not having reported an inability to access vital information for their visits with the introduction of the new computer system.
- Medical staff completed informal discussions regarding duty of candour as part of the weekly harm review meeting. These were recorded on the minutes with the allocation of this task to a specific consultant where applicable. There was no specific training for staff about their role and responsibilities.
- Mortality and morbidity in the maternity department were reported on the dashboard, discussed as part of the weekly harm review meetings and at executive level in the performance and finance meetings. These discussions included identification of themes, agreement for further investigation and feedback to relevant parties.
- A rise in perinatal mortality had been identified. From April 2014 to March 2015 there were nine perinatal deaths and from April 2015 to January 2016 there had been 12 deaths. When this had been identified a specific review of the deaths had taken place. Actions required to prevent recurrence were identified which included changes to practice, additional training for staff and review of guidance.
- A retrospective audit into neonatal deaths from 2013 to 2015 was underway to assist in the identification of any themes. Additional work to reduce mortality included a multidisciplinary meeting with the Perinatal Neonatologist from Alderhey to review all perinatal mortality cases in 2015.

Safety thermometer

- The maternity specific safety thermometer had been introduced on the maternity ward. Due to this being introduced in November 2015 staff were unaware of how this information would be used to change practice. It had not yet been used to identify trends in the care and treatment outcomes.
- The gynaecology safety thermometer showed harm free care had been provided between March 2015 and March 2016 for catheter infections and pressure ulcers. There had been two falls with harm in June 2015 with none since.

Cleanliness, infection control and hygiene

- Areas of the maternity and gynaecology services we visited were visibly clean. There were positive comments from patients about the cleanliness of the maternity areas.
- There had been two cases of clostridium difficile on the gynaecology ward between December 2014 and December 2015.
- There was 100% compliance with the hand hygiene audits throughout 2015 on the maternity and gynaecology wards.
- The availability of hand hygiene gel did not meet the trusts' target of 95% - 100% on the maternity and gynaecology wards in December 2015. Measures put in place included wall mounted dispensers at the side of patient's beds. We saw these in place and all those we used contained hand gel.
- The doors to the dirty utility room on the maternity ward and the delivery suite were wedged open. This posed a potential risk of the spread of infection of airborne organisms. This had been noted as not acceptable in the health and safety audit of October 2015 as waste materials were not securely stored.
- Assessments of the cleanliness of clinical areas took place by a team of staff including infection control nurses. The gynaecology ward scored 88% in November 2015 which was within acceptable limits. The labour ward scored 75% which rated them as a two on a scale of zero to four. The areas which were not compliant on the labour ward included inappropriate storage and cluttered areas.
- Not all equipment met with infection prevention and control guidance. One example was rusty portable oxygen trolleys which could not be adequately cleaned.
- Personal protective equipment was available on all the wards and departments we visited. We observed staff to use this appropriately.
- There was no robust system for ensuring the curtains between beds were changed at regular intervals to prevent the spread of infection. They were linen and had no stickers to record when they had been changed. Housekeeping staff had hand written records which

showed some were changed six monthly; however these records did not specify the exact curtains which had been changed. There were also no spare curtains available therefore if they needed to be changed due to a spillage of bodily fluids there were no replacements.

Environment and equipment

- Storage of expressed breast milk was not secure. The fridge used to store this milk for patients on the maternity ward was in the neonatal unit. This fridge was on an open corridor, accessible to the public, was not locked and the milk was not in tamper proof bottles. No risk assessment was available for this storage. At the unannounced inspection this fridge had been moved to the clinical storage room and was behind a locked door.
- The temperature of this fridge had not been checked at the time of the announced inspection. The ward manager had introduced a checklist which started on 14 April 2016. Since then the checks had been documented twice daily and had been within acceptable limits.
- On one ward the cupboard which contained cleaning fluids was not secure.
- The container to store cannulation equipment which was taken to the patient was broken which meant this equipment could be accessed when used in the ward. At the unannounced inspection this had been replaced.
- There was a potential risk to patients in the system to transfer them from the maternity ward to the obstetric theatre and delivery suite in an emergency. During a test of the system the lift failed to go up a floor, but went to the ground floor due to maintenance. This would cause a delay for the patient. The system had worked well in a real life situation earlier in the day. At the unannounced inspection action had been taken which included written information being provided to all other hospital departments regarding the 24 hour per day and seven day per week need for access to this lift. A risk assessment had been documented and circulated to other relevant departments including maintenance, housekeeping and porters.
- The room used as the second obstetric theatre on the delivery suite was a converted patients' accommodation room with an en-suite bathroom including a toilet. It had no diathermy and no specialist theatre flooring. There was no annexed changing and scrubbing facilities. This meant theatre staff had to move across an open corridor once ready to enter the operating theatre which did not meet the National Institute for Clinical Excellence (NICE) guideline CG74 for the prevention of surgical site infections. As this was the second theatre it was not used frequently and records showed it had only been used twice in the past 6 months.
- The checks on the anaesthetic machine in the second obstetric theatre had not been consistently completed. For week commencing 21 March 2016 the check was recorded once, for week commencing 28 March 2016 it was recorded four times. We were told by one doctor it should be done daily and by others that it was only when the equipment was used. This meant the policy for checking this equipment was unclear to staff.
- There was a lack of facilities on the maternity ward for partners wishing to stay overnight. This included only one recliner chair in working order and no toilet facilities on the ward.
- Although most equipment was repaired in a timely way two recliner chairs for use by partners wishing to stay overnight had not been repaired for two months.
- Replacement of the floor and worktops in the maternity ward had taken place since the last inspection.
- The resuscitation equipment checklist records showed most had been checked daily in line with the trusts' policy, including that on the gynaecology ward. Those on the maternity assessment unit had not been checked for three consecutive days during the week prior to our inspection.
- Access to the infant resuscitaire in the maternity ward was restricted. This emergency equipment was kept in the small staff handover room which contained chairs, record storage trolleys, a photocopier and other administrative equipment. At the unannounced inspection this had been moved to a side room specifically allocated for that equipment.
- The portable appliance testing for most electronic equipment was within the recorded review date; however one set of frequently used weighing scales in the antenatal clinic were out of date.
- The equipment required to evacuate a patient from the pool in an emergency was present in the pool room. This procedure had been tested.
- There was no record of the equipment available in the maternity assessment suite. This included fetal heart monitors of which there were insufficient for the number of patients in the area. One patient and staff told us there could be delays and long waits due to equipment not being readily available.

- Specialist equipment for bariatric patients was available such as that required in the obstetric operating theatre.
- There was a lack of storage space on the gynaecology ward which led to the corridors and bays being cluttered with equipment. This was stored as safely as possible; however did present a potential hazard to patients.
- A bladder scanning machine and an ultrasound scanner were available on the gynaecology ward. This meant patients could have these scans in a timely manner without the need to return if a competent staff member was available.
- There was a gynaecology waiting room, treatment room and recovery area in the gynaecology out patients department. All the necessary equipment was available for patients to receive gynaecology treatment in a specialist area.
- In Southport hospital the office space for community midwives was not fit for purpose. The 10 community midwives had desk space in the trust management offices which was insufficient for their computer equipment. There was limited confidential storage and we saw patient files insecurely stored. There was no area for confidential telephone conversations which were held in this open office environment.

Medicines

- Medicines including controlled drugs and intravenous fluids were securely stored. Records were kept which included disposal of medicines and a twice daily stock check of controlled drugs.
- On one ward the same controlled drug from two boxes had been mixed up which meant the expiry date and batch number on the box did not correspond with the vials of medicines. This does not meet safe medicines management guidance.
- Records of medicine administration had been completed. These were very large forms and were not part of the electronic records system but needed to be scanned into the notes.
- The maternity and gynaecology wards had weekly visits from a pharmacist who checked the stock and gave advice and support with any complex or new medicines.
- The temperatures of medicine fridges had been checked and recorded. Most had been done daily as per the policy; however on the assessment suite there was no record for nine days.
- There was no medicine storage including for controlled drugs in the main obstetric theatre. The anaesthetist gathered the medicines they would need prior to going into theatre. Should they need something in addition either they would leave theatre or the nurse would check the medicine with a midwife on the ward and take the record for the anaesthetist to check and sign. This does not meet safe administration of medicines guidance.
- Entonox and oxygen were stored in an unlocked cupboard in the open office environment provided for the community midwives in Southport hospital. These medicines were not recorded as stored there, not regularly checked and stored with flammable items. This was discussed with the pharmacy manager during the inspection and alternative arrangements were to be found.
- Other medicines stored in a locked cupboard in the community midwives office were securely stored and checked regularly.
- The community midwives carried oxygen and Entonox in their cars. They were unaware of any risk assessment or actions required to meet safety standards. The risk assessment was forwarded following the inspection; however it lacked control measures to ensure adequate safety precautions were in place.

Records

- An inpatient electronic maternity information system had been put into place in the past three months. This had been recommended following the RCOG review. Staff had received training and two midwives had worked as trainers and provided on-going support. This had mostly replaced the paper records. Staff had embraced this change, seeing it as positive, but were still getting used to the practicalities of its day to day working.
- This electronic information system did not link with the other electronic systems used for blood results, gynaecology, children's records and neonatal patient records. That resulted in staff having to access various systems to ensure they had viewed all pertinent documentation.
- We reviewed 15 records with staff including the midwife information technology trainers. Some records such as evidence of fresh eyes having been used for CTG monitoring was difficult for staff to find and was identified in four out of nine records.
- There was a recommendation from the RCOG review that every midwife who delivered care to a patient

should record the care they provided. We reviewed five relevant patients' notes with the information technology training midwife and could not see any evidence that this had been done.

- The records used by the community midwives did not contain the required data set to comply with NICE guidance "Antenatal care for uncomplicated pregnancies" (NICE CG62) With the introduction of the electronic records they no longer used the perinatal institute antenatal notes. The new records were less comprehensive, were poorly photocopied, not referenced and presented as individual loose papers.
- Antenatal patients had no hand held documentation for approximately the first three weeks of their pregnancy. This was because the electronic records were not printed until after a patient attended for their 12 week scan. This meant midwives had limited information about the patient during antenatal clinic appointments. Should a patient attend any hospital outside the one where they had booked their pregnancy staff would have no information.
- There was an increased risk that vital antenatal documentation may not be readily available and safely kept due to the new documentation system. The new hand held notes for the patients were loose leaf papers put into a folder by the midwife. This included printed documents from visits to antenatal clinics, scans and risk assessments.
- The manual recording of blood test results for patients in the community could lead to incorrect results being documented. Community midwives copied results by hand from the computer screen then re-recorded them onto the patient's computer record.
- The neonatal early warning scores were still recorded on paper documents although all maternal observations were recorded on the electronic system.
- The patient information board on the gynaecology ward did not meet confidentiality of information guidance. Patient identification and clinical information was in the general ward area accessible to all patients and visitors to the ward. We were told patients had been asked if this was acceptable; however staff were unclear what the system would be for any patient who declined their information to be recorded in this way.
- On the maternity ward and delivery suite the patient information boards met confidentiality of information guidance.
- Telephone calls to the triage area were recorded in detail. This included the personal information, the reason for the call, information provided to the patient and any other pertinent details such as safeguarding issues.
- The patient records on the gynaecology ward were stored on a different electronic system than the maternity system. Specific staff members scanned in the documents so that all records could be seen on the computer screen. Doctors described this as simple to use and easily accessible.
- The gynaecology records we reviewed contained all relevant information including risk assessments and were up to date.
- Infant health record books were introduced on the maternity ward.

Safeguarding

- 94% of staff in maternity services had completed safeguarding adults training to level 1 and 96% for safeguarding children to level 1. For level 3 safeguarding children 76% of staff had completed this training which did not meet the trusts' target of 90%.
- Staff in the gynaecology ward and clinics had met the trusts' target for safeguarding adults training; however had only achieved 75% for safeguarding children level 3 against the trusts' target of 90%.
- The safeguarding structure across the trust was being changed. This included the introduction of a lead midwife for safeguarding in maternity services rather than it being part of the consultant midwives role.
- Staff received training in female genital mutilation as part of their safeguarding training. There had been no reported cases at the trust.
- The electronic maternity record system contained safeguarding information which could be accessed online. In order for this to be present in the patients' notes should they present at another unit the patient had to give consent.
- Community midwives had visited patients when safeguarding concerns were present without knowing this prior to the visit. They could not access any safeguarding information on the new electronic system unless they were at their hospital base. If they were asked to attend a patient's home at short notice or whilst already on their visits they would not be able to access this information.

- Systems to protect patients should they not attend for antenatal appointments were in place. These included informing the safeguarding midwife, child protection lead nurse and alerting other maternity units in the area.
- Referrals to specialist midwives, social services and other health professionals were made if a staff member identified safeguarding concerns. Community midwives described good working relationships with children's centres and health visitors.
- Systems were in place to protect babies from abduction. This included locked doors to the ward areas which required staff to allow access and exit. A baby tagging system was in place and staff had completed a simulation exercise. Learning from this had resulted in changes to the procedure to strengthen the protection to babies.
- The entrance to the neonatal unit was secured with staff only access from the maternity ward.
- Nursing staff on the gynaecology ward knew their responsibilities for safeguarding patients and had made appropriate referrals to other agencies. However there had been a lack of action being taken in a timely manner for one patient with specific safeguarding concerns present.

Mandatory training

- 84% of nursing and midwifery staff in the maternity services were up to date with their mandatory training. This did not meet the trust's target of 90% with the exception of neonatal life support where 100% of staff were up to date.
- 61% of staff were up to date with training in blood transfusion which did not meet the trusts' target of 90% and was of concern due to issues identified at the last inspection and this inspection with regard to this treatment. Other areas where the percentage of staff up to date with training was low included fire safety at 55.45%, infection control at 65.35%. and mental capacity act at 65.35%.
- Doctors and clinical leads told us the mandatory training information provided by the trust was incorrect. They kept their own records since the data provided showed less staff had completed training than had actually done so. For medical staff this information showed 13 doctors were not up to date with some aspect of their mandatory training; however much of this would have been completed during the induction training which was not recorded in this data.
- Online annual training in the understanding of the Mental Capacity Act and deprivation of Liberty safeguards was mandatory. However information provided by the trust showed 65.35% of staff were up to date with this training which did not meet the trusts' target.
- Maternity mandatory training took place over three consecutive days covering topics such as skills and drills, GROW, infant feeding, resuscitation, screening, smoking cessation, child protection, mentorship and supervision.
- 85% midwives were up to date with their maternity skills training**.** This included community midwifery staff. By April 2016, 88% of midwives were updated with CTG training.
- Medical staff compliance with CTG training was 85% and compliance with skills and drills training was 80%. However, there was some discrepancy about exact figures as recording of data for medical staff was inconsistent.

Assessing and responding to patient risk

- Following the last inspection and an external review by the Royal College of Obstetrics and Gynaecology (RCOG) there was a system in place to assess the risks of a patient having a post- partum haemorrhage. If this risk was deemed to be high then the patients were offered transfer to another local hospital which had additional on site facilities including supply of blood products and an intensive care unit. Between August 2015 and April 2016 there had been 15 patients transferred and eight identified as high risk had declined transfer.
- All patients who met the criteria identified in the RCOG report were offered the opportunity to transfer. The discussion which took place with the patient was not consistently recorded and it was not clear how the risks had been presented. A document to clarify this, including signing by the patient to record they understood the information provided, had been developed before the end of the announced inspection.
- Patients' risk factors were reassessed at every antenatal appointment. One consultant had taken the lead for those patients assessed as having the RCOG identified risk factors present. They saw the patients at antenatal

clinic and recorded a delivery plan as it was recognised even if they were to transfer to another hospital they could present at this unit in labour. The plan included the preparation of blood products to be available.

- Between August 2015 and April 2016 three patients had been transferred to other maternity units in an emergency. These were patients who had not been identified as high risk under the RCOG recommendations.
- All maternity staff were aware of the current plans for the transfer of high risk women to other units. They would discuss any concerns about a patient with a consultant to make sure their risk was identified if appropriate.
- Medical and midwifery managers were concerned about the potential delay in receiving blood products in an emergency out of hours. Although actions had been taken this remained their major concern for patient safety. This was on the risk register and actions to reduce the risk were under review.
- Whilst there were plans for changes to the availability of blood products there was no agreement between clinicians and haematologists that they would improve the current situation. Solutions discussed included increased cell salvage, bar coded samples being available on site and purchasing equipment to identify patients at increased risk of bleeding.
- Investigations into two incidents where there was a delay of over one hour in the provision of blood products showed multiple factors were involved. These included delays in ward staff sending blood samples, delays in collecting samples from the lab and a 30 minute delay in being transferred from the blood fridge in obstetric theatre to the patient. These incidents had been investigated by the blood bank manager; however medical staff were unaware of the outcome and no actions had been put into place to prevent recurrence. At the unannounced inspection a multidisciplinary meeting had taken place, the issues identified discussed and possible solutions presented.
- Blood products were transferred from the Southport and Formby DGH to the Ormskirk DGH by taxi. This had remained unchanged since the last inspection and the RCOG review. At the unannounced inspection there was discussion that motorbike transport may be made available to assist a more timely transfer in future.
- Cell salvage was used in theatre. There was discussion about increasing the use of this to improve the availability of blood products.
- Patients in the community may not receive timely treatment due to a delay in midwives accessing their blood test results. Community midwives told us there was a lack of accessible medical review and it could be up to two weeks before a patient received their test results.
- The maternity early warning scores we reviewed had been fully completed. These were recorded on the electronic system which calculated the score and prompted questions dependant on the outcome.
- There was a clear escalation plan as to when a medical review should be sought and we observed this to take place.
- Risk assessments including for venous thromboembolism had been completed on the inpatient records.
- We observed the five steps of safer surgery was used in the obstetric theatre. All steps were completed with all staff present.
- The system to assess blood loss in theatre had been changed since the last inspection and now all swabs used were weighed in line with practice in the main theatres in the trust.
- There was a system for clarifying the roles of specific staff should a patient's condition suddenly deteriorate on the maternity ward. The roles of all staff were documented at every shift change to include who would take the lead, access the emergency lift and summon assistance. This had resulted from learning from an incident.
- There was a sepsis pathway and the equipment required to manage this situation was present on the delivery suite and the gynaecology ward.
- Telephone calls to the maternity triage area resulted in a risk assessment being recorded.
- On the gynaecology ward the early warning scores had been completed. Nursing staff had a clear escalation policy to follow and discussed that doctors were readily available to review a patient if required.
- Staff on the gynaecology ward could access medical assistance for any patients who were from another speciality (outliers). They told us they could raise a concern and would receive a timely response including out of hours.

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Midwifery staffing

- During both the announced and unannounced inspections the actual numbers of staff on the maternity ward and the delivery suite met the required number. These were displayed at the entrance to the ward.
- The midwife to birth ratio target for the trust was 1 to 29. They had achieved a better average of 1 to 26 in the past 11 months.
- Midwives told us they achieved one to one care in established labour. This was measured on the dashboard provided by the trust for one month only (January 2016) and it had been achieved in that month.
- The midwife sickness rate averaged 7.63% from January 2015 to December 2015. This was higher than the trusts' target of 3.7%.
- The turnover rate for midwives from January 2015 to January 2016 was 13.39% which exceeded the trusts' target of 9%. This had reduced from April 2014 to April 2015 when it was 16%.
- The delivery suite shift co-ordinator would either ring the ward or visit to check the activity and staffing in the area. If necessary they would then move staff to ensure the numbers met the needs of the patients. This may include cover for staff for their breaks.
- Electronic rostering was in place. This was reviewed by a midwifery manager to ensure the skill mix to specific areas of the maternity service was appropriate.
- One midwife with a health care assistant could be working in both the triage and pregnancy assessment unit should the second midwife accompany a labouring patient to the delivery suite and remain with them. We observed this to occur without a further midwife being made available from another area. The manager in the maternity assessment suite had been in post only one week and they had reviewed these staff numbers and presented a case for increasing the midwives to two.
- Since the last inspection five experienced band six midwives had been recruited as the number of newly qualified band five midwives had been disproportionate. This had increased the support less experienced midwives received.
- Community midwives were unaware of the numbers of patients they had on their caseload. They told us this was not monitored or discussed.
- The introduction of the computer system for community midwives had increased their workload in that they had to complete longer records, input records onto the computer in the office and complete some documentation in their own time due to lack of online access during working hours. This had been raised with their manager.
- The community midwives could not be used as part of the escalation procedure at busy times as they had not received training in the use of the inpatient maternity information system. This meant they would be unable to access or document patient records.
- At shift change on the delivery suite there was a multidisciplinary handover of care. Medical staff of various grades and midwifery staff were present.
- Two midwives had worked 22.5 hours each per week to introduce the electronic records system. The other midwives were very complimentary about their work and the support they had offered.
- Midwives described the role of the health care assistants as very helpful. They carried out a variety of tasks including meal provision, supporting breast feeding, completing clinical observations and giving demonstrations of care to new mothers such as bathing their newborn.
- Since the last inspection operating department personnel worked in the obstetric theatres. One staff member from the main theatres was assigned to assist in the obstetric theatres 24 hours per day and seven days per week.
- A "scrub" nurse from the main theatres worked Monday to Friday 8.30am to 4.30pm. This was due to continue until the end of April when 30 midwives would have been trained by them to continue this role. Some clinicians identified there may be times when a trained midwife may not be available; however this was a risk they would continue to assess.
- We were told nurse staffing on the gynaecology ward usually met the required numbers. The use of bank and agency staff was one of the lowest in the trust with an average of 1.8% from April 2014 to March 2015.
- The sickness rates in the gynaecology service for 2014 to 2015 were 3% on the ward and 5% in the clinic. The staff turnover rate for the same period was low at 9%.

Medical staffing

- There were 60 hours of consultant cover on the labour ward. One consultant was resident from 9am to 8pm Monday to Friday with a consultant on call from 5pm to 9am seven days per week. This consultant was also on call for any gynaecology emergencies.

Maternity and gynaecology

- Consultant obstetricians worked a one week in eight rota as the consultant of the week. This increased continuity of care for the patients.
- Information provided by the trust showed there had been no locum cover between April 2014 and April 2015.
- There were some issues with the medical staffing rotas whereby doctors received short notice to cover for the gaps. They told us this could be a request for next day cover including weekends and evenings. This had been escalated to the medical director; however the situation remained unchanged.
- The consultant of the week attended the maternity and gynaecology wards for at least two and a half hours on Saturday and Sunday. They did a ward round and would review any patients who required their care.
- There was a middle grade and junior doctor available to provide medical cover 24 hours per day seven days per week.
- Midwives told us medical support for the maternity assessment unit was sufficient to ensure patients were seen in a timely way. This included out of hours.
- Gynaecology specialist consultants, registrars and junior doctors were available Monday to Friday 9am to 8pm. Outside these hours there was a specialist gynaecology doctor on call and staff said there was no delay in them attending the ward.
- We observed paediatricians were present when required at delivery where neonatal complications could arise. Midwifery staff told us there were never delays in obtaining paediatric support.
- There was appropriate anaesthetic cover for the maternity services including out of hours. A resident consultant anaesthetist was present from 8am to 6pm Monday to Friday. They also covered other areas of the hospital. There was a duty middle grade anaesthetist specifically for maternity who was resident 24 hours per day and seven days per week. Between 6pm and 8am there were two anaesthetist consultants on call to support the middle grade doctor if required
- Information provided at medical handover was documented and this included any safety messages which needed to be distributed.
- Junior doctors were well supported and told us they could request assistance at any time, including out of hours and be assured of a prompt response.

Major incident awareness and training

- Since the last inspection some staff had received training about their role in a major incident. Information provided by the trust showed 37% of staff had completed this training.
- An action card had been developed for the labour ward shift co-ordinator who was the only staff member in maternity services with an active role to play. Staff in this position knew their role and the tasks they would need to complete.

Are maternity and gynaecology services effective?

Requires improvement

Summary

We rated maternity and gynaecology services at Southport and Ormskirk hospital requires improvement for effective because:

- Where patient outcomes were worse than the trusts' target actions had not always been taken to identify the reasons for this or improve the outcomes.
- There was a lack of a midwifery led care model which had resulted in the trusts' homebirth rate not being met.
- Breastfeeding rates were not part of the trusts' data collection which meant it was not possible to identify good practice or the need for improvements.
- Not all information gathered on the dashboard was used to benchmark performance against other trusts or National targets. Where national data was available and had not been used staff were unaware of actions to improve the outcomes for patients.
- For some policies and procedures it was not possible to see that they were up to date with relevant guidance and had been reviewed. Staff confirmed that the information in one policy did not meet their current practice.
- Only 35% of midwives were trained in the care of a deteriorating patient. Staff informed us that there had been difficulties in them attending this training.
- Not all midwives or nurses in gynaecology services were up to date with their annual appraisals.
- On the gynaecology ward there was a lack of understanding and working within the Mental Capacity Act and the Deprivation of Liberty safeguards.

- The introduction of the patient electronic record system for community midwives had resulted in them not having access to all necessary records when they were providing care to patients in the community.

However

- The majority of policies and procedures were up to date, 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).
- Audits took place to monitor the quality of the service provided. Where improvements were required action plans were in place and up to date.
- Since the last inspection an audit of post partum haemorrhages and their management had been completed. Changes had been made to reduce the risks for patients associated with this potential complication.
- There was a comprehensive maternity information system in place for collecting and monitoring patient outcomes. This included a monthly exception report to monitor trends and assess the quality of service delivered.
- A thorough system for assessing and maintaining the competence of midwives assisting in the operating theatre had been introduced since the last inspection.
- Patients received timely pain relief.
- Systems were in place to offer good support for mothers who wished to breast feed.
- There were examples of effective multi-disciplinary working in obstetrics and gynaecology services.
- Access to services seven days per week included emergency gynaecology and maternity triage.
- Improvements to the consent to care and treatment in maternity services had been made since the last inspection.
- Concerns were raised at the last inspection regarding a higher than average number of forceps deliveries. Since then, forceps and ventouse deliveries were monitored through the maternity dashboard, practices had been audited and additional training provided.

Evidence-based care and treatment

- Policies and procedures were in line with National Institute for Health and Care Excellence (NICE) guidance. This included examination of the newborn, induction of labour, and post-partum haemorrhage. However, current version numbers and dates were not always present or correct, for example “obstetric high care policies” and “operative vaginal delivery policy”. However the guideline for the admission of a neonate to the neonatal unit was last reviewed March 2012.
- Staff in all areas knew how to access policies and procedures and they were available in both written form and on the intranet.
- Senior medical staff confirmed that the current policy “Obstetric High Dependancy Care Polices” did not reflect the current practice. Patients with an arterial line were not cared for in the High Dependency Unit (HDU) room on delivery suite (as stated in policy) but transferred to Intensive Care Unit (ITU) at Southport and Formby DGH.
- There was a system for monitoring guidelines. Updates were presented at the multi-disciplinary maternity care forum, women and children’s governance committee, consultant meetings and staff forum meetings. A patient group was also reviewing the recently revised high risk of bleeding proforma.
- Midwives attended the North West network for normality, breast-feeding and bereavement to share good practice and learn from others.
- The percentage of women who had seen a midwife by 12 weeks and six days of pregnancy were not met in nine of the 12 months between January 2015 and January 2016. This did not meet NICE guideline (CG62) 2016, which recommends women should ideally be booked for care around 10 weeks of pregnancy.
- The trust was taking part in the four elements of the ‘Saving Babies Lives’ (DOH 2016) programme, which included smoking cessation intervention, fetal 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 fetal 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.
- Staff said that most patients who reported reduced fetal movements had a scan within seventy-two hours, in line with RCOG guidelines 2013. If scan appointments were not available, plans were made for the patient to return to the Pregnancy Assessment unit (PAU) for daily baby heart monitoring.

- Staff and consultants had concerns that there was increased workload demands on ultrasound scans slots, antenatal clinic appointments and numbers of inductions due to the introduction of the GROW package. However, the package was introduced to reduce the number of stillbirths so staff were supportive of it.
- The trust had a policy of 'opt-out' of referral to smoking cessation services. Patients were referred for additional support and advice on smoking cessation at booking. All patients had carbon monoxide monitoring at booking.
- An audit of combined screening prior to a booking appointment was completed in November 2015. Actions included the implementation and documentation of a telephone discussion offering screening for patients who did not attend their allocated booking appointment, prior to their scan. This was included in the Standard Operating Procedure (SOP) "Follow up of non-attendance for antenatal care"
- Following the previous CQC inspection and RCOG review, concerns had been raised about the management of post-partum haemorrhage (PPH). Since then an audit of PPH had been completed. 28 cases of PPH greater than 1500mls between July and December 2015 were reviewed. This showed some good practice such as improvement of assessment of blood loss. However, consultant anaesthetist attendance was low with the consultant haematologist rarely involved. The Major Obstetric Haemorrhage (MOH) protocol was only activated in 57% of cases.
- Lessons learnt from the PPH audit included improvement in communication, documentation, management of antenatal anaemia, management of PPH and use of blood products.
- Because of the PPH audit, an action plan was developed which included additional multidisciplinary training, review of the induction of labour policy guideline and revising the PPH risk assessment proforma. All required actions were within the agreed timescales.
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- There were four induction of labour time slots per day offered to patients. These were 9am, 10am, 9pm and 10pm. The evening time slots do not meet with NICE guidelines 2008 stating that inductions should be carried out in the morning because of higher maternal satisfaction. However, staff informed us that patients requested these times slots to fit around family life.
- Audits of the maternity WHO Safer Surgery checklist were completed in November 2015 to January 2016 and April 2016. These consisted of low numbers of forms reviewed with two in the first audit and six in the second. The post list briefing only scored 50% in the November to January review. This increased to 83% in the April 2016 review. The main reasons were staff leaving the theatre before the post briefing period.
- A newborn and infant physical examination audit of 60 patients was completed between August and September 2015. Of the three standards that were reviewed, only one met the required standard of 90% or above. Recommendations included mandatory questions to be included in the new computer system that requires the recording of family history.
- The Trust underwent a Screening Quality Assurance (QA) visit in June 2015.. Work towards the completion of the actions was on-going in the trust.
- Medical staff informed us that a specific raised body mass index (BMI) clinic was to start in May 2016. Current BMI pathways and guidelines were seen and were in accordance with national guidelines (RCOG 2010).

Pain relief

- An induction of labour patient satisfaction audit, February 2016, showed 94% of patients had access to and were satisfied with the pain relief they received.
- There was one pool on the delivery suite, which staff said was used regularly as a form of pain relief. However, staff were unable to say how many times it had been used, as data was not recorded.
- Community midwives had access to pain relief for home births including medical gases.
- Assessment and documentation of pain on the Modified Early Warning Score **(**MEWS) on the new Maternity Information System for the women was seen. Methods of recording the score for the babies were recorded on paper versions.
- A 24-hour epidural service was available on the delivery suite. There were no reported delays in receiving an epidural due to the availability of anaesthetic cover.
- Pain relief, its effectiveness for individual patients and changes to prescriptions were discussed at handover on the maternity ward.
- Patient controlled analgesia (PCA) was offered to patients within risk assessment guidelines on the gynaecology ward.

- Staff on the maternity ward reported that they did not use PCA as a form of pain relief. They reported offering voltoral, paracetamol, oral oramorphine or morphine prescribed by the anaesthetist.
- Midwives could prescribe certain drugs under the midwives patient group directions policy, which meant patients who attended could have analgesia in a timely fashion. A list of these drugs was on a list on the controlled drug (CD) cupboard in the locked storeroom.

Nutrition and hydration

- The trust had achieved Stage 1 Baby friendly accreditation and was working towards the stage 2 assessment. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and were supported in their chosen feeding method.
- Breastfeeding (BF) rates were not included separately on the dashboard of maternity measures and no target was presented. Therefore, it was not possible to understand if the rates were declining, improving or meeting the trust's target.
- Staff informed us that the initial BF rate was 61%, however this was not documented on the dashboard. This target was below the Infant Feeding Survey UK (2010) rate of 81%.
- Breast feeding peer support volunteers were available daily on the postnatal ward from 9am-12am to assist and support patients.
- Midwives and health care assistants (HCA) on the ward provided post-natal support for breastfeeding.
- Mothers who chose to bottle feed were also supported and given help and advice. Demonstrations for making up bottles feeds were given by an HCA.
- There was no dedicated staff member to perform a frenulotomy, which is the removal of a small fold of tissue in the mouth, which restricts infant feeding, to treat tongue-tie. We were informed that staff were aware of how to recognise tongue-tie and how to make a referral to another hospital.
- On the maternity ward, there was a patients' kitchen on each ward where patients and partners could make hot and cold drinks and snacks. Hot meals were provided for patients who remained in hospital, which could be ordered by a menu or online by staff.
- Patients reported they received tea and toast immediately following birth. Meals or snack boxes were readily available when requested.
- Breakfast was available in the day room and those with mobility problems were assisted. One HCA said the quality of food was good and had received minimal complaints about it.

Patient outcomes

- The trust maternity dashboard contained comprehensive information. However, trust targets were not recorded for some areas, for example in utero transfers, instrumental deliveries, postpartum haemorrhage (PPH) and maternal readmissions within 30 days.
- There were no national targets recorded on the dashboard. However, staff informed us that the key performance indicators on the dashboard were in line with the Cheshire and Merseyside regional dashboard. The trust did not provide evidence of this.
- The maternity dashboard was on display in the clinical areas for staff to view. Key issues were fed back to staff via the staff forum meetings and the recently introduced safety huddles. These included emergency caesarean section audit review and post-partum haemorrhage audit and learning points.
- The trust had a monthly maternity exception reporting dashboard, which was concise. Current risk, actions taken and performance trend graphs were documented. This report was used to identify trends, such as an increase in forceps delivery. Senior medical staff told us such trends would be audited in order to ensure necessary improvements were made.
- The trust homebirth rate of 2% of all births was not met in 11 of the 13 months between January 2015 and January 2016. Community midwives reported that this was due to the lack of a midwifery led care structure.
- A trust target of 24% was set for all caesarean sections (CS) between January 2015 and January 2016.The rate was above this target for eight of the 13 months recorded. However, it was below the national target of 26.2% (NHS Maternity Statistics England 2013-14) in eight of the 13 months.
- Of the 13 months from January 2015 to January 2016, the trust was above their own target of 6% on five occasions for third and fourth degree tears following

assisted vaginal births. For three months 0% was recorded. However the highest was 15% in November 2015.The rate had reduced to 8% in January 2016 but still above the trust target.

- The rate for third and fourth degree tears following unassisted births were within the trust target of 3% from January 2015 to January 2016 apart from October 2015, where it rose to 7%.This increase was discussed at the November 2015 staff forum meeting where it was agreed to carry out an audit to monitor the increase.
- Concerns were raised at the last inspection regarding a higher than average number of forceps deliveries. Since then, forceps and ventouse deliveries had been added to the maternity dashboard in order to monitor rates accurately.
- However, there was no trust or national targets recorded for this on the dashboard. From January 2015 to January 2016, the highest monthly forceps rate was 11.54% in December 2015.The lowest month recorded was 3.59% in September 2015. It was documented in the staff forum meeting, January 2016, that in order to improve these figures, normal deliveries needed to increase.
- Combined forceps and ventouse delivery rates on the dashboard were above the national average of 12.9% (NHS Maternity Statistics - England, 2013-14).
- Concerns were raised at the previous inspection regarding safety in terms of use of forceps and lack of confidence amongst trainees with performing ventouse deliveries. An audit of trials of operative vaginal deliveries (OVD) had been completed between October 2014 and March 2015. Since then, medical staff had attended ROBuST (RCOG Operative Birth Simulation Training) and training on how to use the ventouse equipment for delivery.
- There was an increase in the number of cases of stillbirth and neonatal death with nine cases between August 2015 and January 2016. This followed a period from January 2015 until July 2015 when there were no stillbirths.
- The national average of stillbirths is 4.7 per 1,000 births (Office of National Statistics 2014). The perinatal mortality trust target was set at 7.7%. This was within target from January 2015 to January 2016. However, 17.94% was recorded in September 2015 and 17.94% in January 2016 .As a result of this increase a multi-disciplinary perinatal mortality review of all cases from August 2015 to January 2016 took place. Actions from this included individual feedback and training for staff, review of policies such as the attendance of paediatricians at multiple births and review of antibiotic prescribing.
- Induction of labour trust target was 33.25%. Six out of 13 months on the dashboard were above the target. Current national average is approximately 14.9 %(NHS Maternity Statistics England 2014-15). This was not an indicator on the exception-reporting dashboard.
- Data on the maternity dashboard showed that the number of maternal readmissions within 30 days was higher than expected for the trust. During the inspection and the unannounced visit, staff and management were unaware of the reason for this. This data was reviewed by the trust post inspection and it was identified that there were issues with the way the data was collected onto their system.

Competent staff

- A recommendation following the RCOG review August 2015 was to employ a full time practice development midwife specifically to ensure preceptorship and educational opportunities. A band 7 practice development midwife had been recently appointed. Staff had reported that this was an effective post and had been encouraged to arrange one to one meetings with the practice development midwife to discuss personal training and development needs.
- Skills and drills training for 22 gynaecology staff, up to March 2016, showed that 16 were up to date.
- Maternity appraisal rates from April 2015 to January 2016 were 64%. additional clinical services staff achieved 81%.
- In the same period for the gynaecology department, appraisal rates for nursing staff achieved between 60-73%. Gynaecology cancer service achieved 100%. However additional clinical services staff only achieved 67%.
- This meant not all midwives and nurses had had the opportunity to discuss their performance and development in the past 12 months.
- The maternity training needs analysis report was out of date since August 2015.
- Due to concerns from the last inspection and RCOG recommendations regarding competency of midwives scrubbing in obstetric theatre, a new robust comprehensive training system was in place.

- 30 midwives were trained to scrub in theatre. This met with the Association of anaesthetists of Great Britain and Ireland Guidance 2013 which states "the person assisting the anaesthetist must be trained to a nationally recognised standard and must work regularly and frequently in the obstetric unit".
- All scrub competencies were seen and complete. Theatre induction training packs were given to newly trained scrub midwives.
- There were no immediate plans to train any more midwives. The aim was to consolidate skills and ensure trained midwives had enough scrubbing experience to keep their skills up to date.
- A scrub nurse audit to ensure relevant trained midwives were on duty at all times took place between February and March 2016.The result showed 100% compliance
- The consultant in on call for the week facilitated unexpected skills and drill sessions on the delivery suite that involved input from anaesthetists and the operating department practitioners(OPD).
- A simulation-training doll had also been ordered to enable obstetricians, anaesthetists and midwives to demonstrate various, realistic birthing scenarios including high risk situations such as a difficult shoulders delivery or haemorrhaging.
- There was one full time infant feeding midwife. She worked closely with the consultant midwife, providing yearly breast feeding training on the three-day mandatory training programme. Monthly breast feeding study days were also provided.
- Staff informed us that midwives rotated between the maternity ward and the delivery suite to maintain their skills and competence. However, there was no formal process for this.
- 35% of midwives were trained in the care of a deteriorating patient. Staff informed us that there had been difficulties in them attending this training. Only staff trained in the last three years were identified within the off duty and allocated to patients requiring additional care.
- Approximately 10 midwives were trained in the examination of the newborn. However, apart from a small number of patients requesting an early discharge from delivery suite, most examinations of the newborn were performed on the postnatal ward by the paediatricians.
- The Local Supervising Authorities (LSA) annual audit, July 2015, reported that the Supervision of Midwifery (SOM) team had an average caseload ranging from twenty-three midwives to eight midwives thereby giving a ratio of supervisors to midwives as 1:13. NMC (2012) recommends 1:15; therefore, the trust is within the national recommendations.
- However, SOM ratio had only been recorded from November 2015 to January 2016 on the maternity dashboard. Two of these months were recorded at 1:18 which was above the recommendation.
- The audit standards were assessed within four domains for auditing purposes. The trust met three of the four domains.
- The current Head of Midwifery (HOM) held one to one meetings with midwives undertaking their preceptorship course and student midwives.
- The gynaecology department had gynaecology specific trained nurses to work in clinic and on the wards.
- Some nurse's had specialised in areas such as colposcopy, smear, gynaecology oncology and uro-gynaecology. This meant they had increased their competencies through specific training to be able to provide nurse led clinics and treatments.
- Gynaecology nurses had also specialised in fertility management and provided two nurse led fertility clinics.

Multidisciplinary working

- A theatre nurse, from the main general theatre, led the training for the midwives to scrub in obstetric theatre. She was on a six-month secondment, which ended in May 2016. There was a plan to rotate general theatre nurses to continue the supervision of trained scrub midwives. Transferrable standards and ideas from the main general theatre had been introduced into the obstetric theatre by the theatre nurse such as the ordering of an electronic information board and a diary to record samples sent to the laboratory.
- The first multidisciplinary meeting to discuss blood transfusion issues was held the week before our inspection. Those attended included an obstetric consultant, transfusion staff, and an anaesthetist. The plan was for these meetings to take place on a regular basis.
- A multidisciplinary safety huddle took place on the delivery unit four times a day, between incoming and outgoing shift changes, to discuss workload and lessons

learnt. Senior and junior doctors, anaesthetist, shift leader and midwives attended these short meetings. The key points were recorded and stored in a dedicated folder for all staff to review.

- A staff forum had been established to improve communication, escalate issues, take forward staff ideas and embrace change as a team. This was chaired by a band 6 midwife and had representation from staff side, clinical areas and management. Human resources had also been invited to some meetings.
- Multidisciplinary CTG training sessions were held on a Monday and Friday mornings, Staff reported that this was well attended and very informative.
- Junior gynaecology doctors reported they felt very well supported by consultant gynaecology consultants. Medical staff reported having a good working relationship with the midwives and felt the executive team were visible.
- Gynaecology ward staff worked closely with the specific palliative link nurse to give extra support and advice.
- There was a midwife with an interest in mental health who led a weekly mental health clinic. Pathways and care plans were evident in the obstetric notes. Staff informed us that the mental health nurse from the general mental health team was also supportive to staff on the wards.
- A diabetic consultant leads a diabetic clinic, there was no diabetic nurse involved in this clinic; however midwives could access the trusts' diabetic specialist nurse for advice and support.
- The consultant midwife led a weekly vaginal birth after caesarean (VBAC) clinic.
- A medical disorders clinic also ran weekly to care for patients with various medical disorders in pregnancy.
- Consultants told us they worked well with the midwives and there was good cooperation and communication.
- Consultants in obstetrics and gynaecology had weekly-protected time for multi-disciplinary meetings.
- Nurses in the gynaecology services told us the doctors were supportive of the expansion of the nurse led services. They provided the necessary medical input such as signing consent forms and worked collaboratively to make sure the patient's journey was efficient.
- Senior management told us that there was a better skill mix since the last inspection and many new staff posts had been created and filled. This included a practice development midwife.
- Maternity services had quarterly meetings with the smoking cessation advisors to identify areas for joint working and improvements for practice. Smoking cessation advisors provided annual training updates to staff on the maternity mandatory training.
- The trust had midwifery and consultant obstetrician representatives on the Cheshire and Merseyside special interest group for stillbirths, the focus being on sharing practice, developing joint guidelines and reducing stillbirth rates across the region. All cases of stillbirths were reviewed via the serious untoward incident process and included external representation from other maternity units within Cheshire and Merseyside, arranged by NHS England, to support objective review and shared lessons learnt.
- The maternity services work collaboratively with newborn hearing screeners as part of the delivery of national screening programmes.
- The maternity services were actively participating in the Cheshire and Merseyside special interest groups –pre-term delivery, medical co-morbidities and perinatal mental health to engage with partner agencies in the development and implementation of best practice.
- Community midwives told us that communication with GPs was not good recently. They felt this was partly due to them having difficulty accessing up to date "live" information from the maternity information system. They also reported that GPs use a different information system, which could lead to lack of relevant information immediately.

Seven-day services

- The gynaecology assessment unit was open 24 hours per day and seven days per week for patients up to 18 weeks pregnant. Referrals were taken from the emergency department, minor injuries, GP, midwives and patients could self-refer to the unit.
- The triage area had two rooms and was open 24 hours per day, seven days per week. This meant patients had both telephone advice and physical assessment services when required.
- PAU, a five-bedded bay, was open Monday to Friday 7.30am to 8pm, seven days per week. This was for booked appointments such as blood pressure checks and glucose tolerance tests. Overnight patients were seen in triage. During the day, if triage were busy, PAU beds would be used.

- The induction of labour bay consisted of a five-bedded bay and was open 24 hours per day, seven days a week.
- Community midwives provided 24 hours a day, seven-day on call service.
- There was no pathology service on site at Ormskirk hospital overnight. This meant that blood products had to be accessed from Southport DGH.

Access to information

- The Maternity Information System, introduced in January 2016, met the RCOG recommendation from August 2015. However, there remained issues with access to information such as blood results and up to date patient information for community midwives. During our inspection, there were also difficulties in accessing specific records for example CTG records, to see if individual staff had recorded in the notes.
- In the maternity unit, forms of communication between staff were circulated at the maternity care forum, weekly harm review meetings, staff forum meetings, core huddles at handover times, emails, noticeboards and a communication diary.
- Gynaecology ward staff used various forms to aid communication such as a communication book, which they read and signed, team briefs and verbal communication. Staff attended the gynaecology forum meeting.
- Equipment for the new patient electronic record system was good and accessible. There were computers in all delivery rooms and in theatre. Therefore, all stages of labour were documented and recorded directly onto the new system.
- Coordination and links between the different trust computer systems was limited. Staff said they have to log onto and review different systems to access blood result, the evolve (gynaecology) and badger systems (contains baby information).
- Obstetric staff continued to use some paper documents, such as consent forms, scan results and prescription charts. These all had to be scanned into the new system by them once completed. Staff reported that this was time consuming.
- Community midwives reported that they could not access the information needed to deliver effective care and treatment in a timely way. They had no “live” access online once they left the hospital grounds. Therefore, they often did not have the most up to date information for their patients.
- Community midwives reported that the off-line system created an inability to access maternal records prior to antenatal appointments. This meant there was a failure to identify risk factors, for example safeguarding. This was on the risk register, which reported that community midwives had access to a central safeguarding file and that additional communication, verbal and written was required.
- Some community midwives were linked to GP practices for their clinics. However, due to the new electronic system, they reported that GP access and flow of information was now on a separate system. This resulted in either duplication of information or the possibility of lack of information, leading to a poor inter-relationship between community midwives and GP.
- There was no formal robust system of communication to share patient information. The community midwives said they had raised this with management but there was no other mechanism put in place to improve this. At the band 7/8 focus group, senior staff were aware that the new electronic system has raised some challenges. They were planning to meet with the system company to ensure the system is working effectively for all staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the last inspection, consent forms were incompletely filled in. This was audited in October 2015. 20 surgical consent forms were reviewed. Actions from the audit showed that the trust had developed procedure specific consent forms. These were pre-printed documents, which explained the procedure and potential risks for elective caesarean section, for example.
- The consent policy had been updated to reflect that verbal consent for Category 1 caesarean sections was acceptable as long as it was accurately recorded. (RCOG 2015)
- There was a lack of understanding of the Mental Capacity Act (MCA) and how it applied to a patient cared for on the gynaecology ward. This patient had been accommodated on the ward for five weeks and there was a lack of clarity about their mental capacity in order to ensure a safe discharge. Although staff had tried to involve other professionals to facilitate a safe discharge failures in that system had resulted in an unnecessarily long hospital stay.

- A Deprivation of Liberty safeguard application (DoLs) had expired on the 6 March 2016. The manager was made aware of this during the inspection. We were told that there was a DOLS in place however, there was no record of any further applications. At the time of the unannounced inspection, staff had made contact with other external agencies and a best interest meeting was planned.
- Information for staff about DoLs and mental health was seen on the delivery suite, which was accessible to the staff. Resources to help staff care for patients with a learning disability were also present which included written information and picture prompts.

Are maternity and gynaecology services caring?

Good

Summary

We rated maternity and gynaecology services at Southport and Ormskirk hospital good for caring for the following reasons:

- Midwives and nurses on the gynaecology ward were respectful, caring and considerate to patients and their families.
- Patients and relatives were complimentary about staff and the care they had received and we saw their privacy and dignity was respected.
- There was inclusion of patients in their own care where this was appropriate.
- Patients were accommodated for an extended period if their baby was being cared for on the neonatal unit.
- There was recognition by staff of patients who may need additional emotional support and this was available from other specialists if required.

However

- The hospital scored worse than other trusts for three questions in the CQC survey of maternity services in 2015. This included concerns being taken seriously, women being left alone at a time when it worried them and partners not being involved as much as they would like. An action plan had been developed to address these concerns which included the involvement of patients. Practices around these issues were under review.

Compassionate care

- We observed midwives and doctors speak to patients in a calm, caring and professional manner. On the gynaecology ward nursing staff spoke respectfully to patients, protected their dignity and were seen to be proactive in assisting patients.
- One patient we spoke with had chosen to have their maternity care at this hospital following disappointment with the standard of care at another local hospital. They said in comparison their experience had been better, much more relaxed and had improved interaction with staff.
- Maternity and gynaecology patients said they were treated with compassion, care and respect throughout their care.
- The Friends and Family Test (FFT) showed the percentage of women who were likely to recommend the antenatal and postnatal care was similar to the England average. However the percentage who would recommend during birth was below the England average from January 2015 to December 2015 rising above the England average in January 2016.
- The hospital scored worse than other trusts in three questions in the labour and birth section of the 2015 CQC survey of Women's experiences of maternity services. These included concerns raised not being taken seriously and women being left alone at a time when it worried them. The group of staff responsible for promoting normality were reviewing practices to improve these survey results. This had begun in January 2016.
- An action plan to address these concerns had been developed and included as part of the maternity improvement plan to monitor ongoing progress.
- One of the actions was to introduce 'Tell the Midwife' meetings to invite women and their families to meet with maternity staff monthly to discuss any issues and offer feedback regarding the service. The plan was for a 'Womens Forum' to be developed where women could help lead on maternity & gynaecology improvements in quality and patient experience.

- Patients were accommodated on the ward for a longer period if their baby was on the neonatal unit despite the fact they may be fit to return home.
- If a baby was on the neonatal unit the staff from that unit and midwives on the ward would ensure the patient saw their baby as often as possible. Where this wasn't possible a diary and photographs would be kept.

Understanding and involvement of patients and those close to them

- Patients were given choices such as having skin to skin with their baby after birth.
- Partners of patients we spoke with told us they had been involved in the care if they wished. This included being present in theatre during a caesarean section and being included in the care of the newborn baby.
- Despite these limited facilities for partners to stay at the hospital. Staff tried to ensure anyone with specific needs for extra support would be accommodated in a single room so this could be available.
- Staff proactively encouraged patients and others to provide feedback via the friends and family test surveys.
- Written information was provided for patients and their families and some was given to them on discharge. This included safety information such as how to ensure a baby was sleeping safely as well as general care of the newborn information.
- Patients were supported to continue their own care where possible. This included management of diabetes including medication.
- Health care assistants and midwives held education sessions for patients such as how to safely bath their baby, breast and bottle feeding support and information about health and welfare needs of both mother and baby.

Emotional support

- Staff discussed the emotional wellbeing of patients in a sensitive and dignified manner. This included information being exchanged at shift handover which may impact on the emotional health of a patient.
- There was good recognition of behaviours which may indicate a patient was anxious or distressed. These concerns were appropriately escalated, support offered and where appropriate other agencies contacted.
- Staffing on the induction of labour suite was organised such that the same midwife could accompany a patient to the labour ward and assist them to deliver if there were complications such as an intrauterine death.
- There was no midwife with a specific role in the support of bereaved parents; however there was one midwife with an interest in bereavement who provided support and advice to staff and parents when available.
- Bereaved parents and their partners could remain in the unit as long as they required. The specialist bereavement midwife offered one to one support and provided the necessary information.
- The hospital chaplain was available to visit and offer comfort to bereaved parents should they wish.
- A patient support group for bereaved parents was set up in January 2016. A trained counsellor facilitated these monthly meetings which were held away from the hospital setting.
- There were plans for all staff in the women's and children's directorate to be trained in the care of bereaved parents. Four training days had taken place.
- Follow up support was available for those patients who had a termination of pregnancy. They were provided with information of how to access support from ward staff and other agencies. There was proactive support offered by staff on the ward when necessary.
- A case for gynaecology nurses to complete training in counselling had been identified. This would mean they could offer additional specialist support to patients who had a termination of pregnancy.
- The gynaecology nurses had good links with the palliative care nurses and could request their assistance with specific patients should they need it.
- Free yoga sessions were held to assist patients' health and wellbeing.

Are maternity and gynaecology services responsive?

Requires improvement

Summary

We rated maternity and gynaecology services at Southport and Ormskirk hospital requires improvement for responsive for the following reasons:

- Changes to the service had been made to improve the access for patients. This included the introduction of a maternity assessment suite for planned antenatal care, triage of unplanned care and support and the induction of labour.
- There was a lack of specialist midwives and a reliance on staff to provide a lead in areas such as perinatal mental health and bereavement within their roles.
- There were insufficient facilities for partners to stay with patients if they wished.
- It was acknowledged the facilities for bereaved parents were not suitable and fund raising was underway to make improvements.
- There were delays in the management of complaints especially when complex issues were involved.

However

- There had been no closures or diversions from the maternity services in the past 12 months.
- Gynaecology referral to treatment times met the national recommendations with rapid access clinics available.
- Patients could access scanning facilities in a timely way and test results were available quickly.
- Support and education was planned in a way which allowed patients with conflicting responsibilities to attend.
- Since the last inspection changes to the termination of pregnancy service meant patients were separated from pregnant women.
- The gynaecology clinic area had been improved with a separate waiting area provided.
- The waiting times for gynaecology clinics and procedures were within or better than national and local targets most of the time.
- There was timely access to emergency gynaecology services.
- There were examples of where service improvements had been made as a result of learning from complaints.

Service planning and delivery to meet the needs of local people

- The community midwives worked in clinics which were spread across the geographical area covered by the hospital. This provided most patients with antenatal care close to their home.
- Education sessions for expectant parents were flexible to encourage and enable parents with other responsibilities to take part. Parent craft sessions were held both during the week and on two Saturdays per month and between various locations on a rotating basis.
- Since the last inspection the termination of pregnancy service had been moved to Southport and Formby DGH. This meant there was no possibility of pregnant women and those requiring a termination of their pregnancy waiting in the same area as each other.
- Partners of patients who had an induction of labour could stay with them between 9am and 9pm. There was no current plan to extend these hours and allow partners to remain overnight although staff said they would try to be flexible.

Access and flow

- A five bedded induction of labour bay had been introduced on 14 February 2016. This was situated next to the delivery unit and within the maternity assessment suite. This had improved the patient experience in that the area was calmer than the general maternity ward and within easy access to the delivery suite and obstetric theatre.
- The development of one area for triage, early pregnancy and induction of labour had improved the flow through the maternity unit. This area was used flexibly to accommodate those patients in early labour, those who had concerns about fetal movements and those who required assessment for other concerns raised by them or the community midwife. The area was open 24 hours per day and seven days per week.
- There were two examination rooms for the assessment of patients who attended the maternity triage area. Should they need to remain in the unit they would be transferred to a bed in the pregnancy assessment unit.
- The pregnancy assessment unit was open seven days per week 7.30am to 8pm. Patients attended this area to have observations and diagnostic tests completed, usually booked in advance.
- Patients who attended the pregnancy assessment unit for blood glucose tests received their results the same day and saw a specialist midwife within the week and often the next day.
- Waiting times in the triage and pregnancy assessment unit were not monitored. The arrival time was not recorded on the patient's documentation.

Maternity and gynaecology

- We were told by one patient that they had waited five hours in the pregnancy assessment unit due to lack of monitoring equipment. They had been kept informed throughout this wait.
- Patients who attended the pregnancy assessment unit could access a scan the same day if required. There were two slots daily specifically for scans for patients from this area, with others available if they were required. These slots had been increased to 30 minutes to allow for discussions if anomalies were observed.
- The capacity for scans for patients was being increased by the training of two midwives to complete third trimester scans. An ultrasound machine was purchased in October 2015; however this was not in use due to environmental changes being required.
- Ten midwives were competent in completing the examination of the newborn. However this resource was used only for early discharges from the delivery unit. Usually a paediatrician performed this examination.
- Gynaecology patients could be seen quickly in an emergency 24 hours per day and seven days per week. There was one bay of four beds on the gynaecology ward which was allocated for emergency patients. They could be referred from the emergency department, minor injuries or the midwives.
- There was a rapid access gynaecology clinic. Patients on a two week referral pathway could be seen by a consultant and have their scan on the same day. If the patient required a hysteroscopy this was completed within one week and the results provided.
- The two week cancer waiting time targets had met the trusts' target of 93% in 9 of 11 months April 2015 to February 2016.
- The trust had met the 18 week referral to treatment times in the non- admitted pathway from between 98% to 100% monthly from September 2015 to February 2016. In the admitted pathway it had been achieved between 97% and 99% monthly.
- Gynaecology patients who were having a surgical procedure attended a specific weekly nurse led pre-operative clinic. They were provided with information about the procedure, arrangements for their stay in hospital and their discharge.
- There had been 50 gynaecology operations cancelled between October 2015 and March 2016. 18 of these had been cancelled by the patient and 14 due to emergency procedures being performed.
- The average length of stay on the gynaecology ward was two days.
- Patients with hyperemesis were seen on the gynaecology assessment unit on the ward and could have rapid rehydration without the need to be admitted if that was suitable.
- Medical and surgical patients were often accommodated on the gynaecology ward. The manager stated there were usually two to four patients from other specialities. They had daily assessment by the doctors from the appropriate speciality and could obtain a prompt review of their condition if required.
- The Termination of Pregnancy (TOP) service was based at Southport site. Staff reported that TOP's were performed within the recommended 2-week time scale.

RGOC (The care of women requesting induced abortion, 2011) advise the total time from seeing the abortion provider to the procedure should not exceed ten working days.

Meeting people's individual needs

- Community midwives had patients with complex needs as part of their caseload. There was no specific team who provided support to these patients.
- There was one midwife seconded from Surestart to provide additional support for vulnerable women in the community.
- Midwives could access a specialist learning disability nurse from within the trust who would provide specific support for patients and advice for staff.
- There was no specific perinatal mental health midwife or bereavement midwife; however there were midwives with an interest in this area who were the designated lead. They provided a link to other services and support and advice for staff.
- Staff on the gynaecology ward had liaised with the specialist learning disability nurse, social services and family members to support a patient on the ward.
- Written information such as post natal guidance was available in English only. This information had been recently introduced with a change in the records system and we were told it would be developed in other languages.
- Translators were available if required for example to assist during the talks given to patients about the care of their baby prior to discharge.

Maternity and gynaecology

- The trust scored worse than other trusts in the survey of maternity care for partners being involved as much as they wanted. Managers thought the main reason for this was a lack of facilities for partners to be accommodated on the ward. There were no temporary beds for partners, only one recliner chair in working order and no toilet or bathroom facilities on the ward. This lack of accommodation was under review.
- The facilities for bereaved parents required development. They did not provide a non-clinical area where parents could be accommodated in comfort. This had been recognised by the trust and proactive fund raising was ongoing.
- The number of antenatal visits a patient would have was dependant on their individual needs and circumstances. There would be an increased number if there were concerns for their health and wellbeing either physically or emotionally.

Learning from complaints and concerns

- Some complaints had not been managed in a timely way. There were nine complaints with open investigations the longest of which was from May 2015. Those which were more easily investigated, such as attitude of staff, had an investigation completed and the complainant received feedback within four to six weeks. However others had taken several months for a response to be finalised and an action plan to prevent recurrence developed.
- The system for managing complaints had been changed to assist a more timely response. There was now a more integrated approach with the clinical governance co-ordinator which it was hoped would improve the response times.
- We saw good examples of where practice had changed as a result of complaints. The introduction of the induction of labour bay in the maternity assessment suite was the result of complaints about the hectic nature of the maternity ward. The complaints were said to have reduced in the two months since it opened and an audit was ongoing.
- One midwife told us they had met with managers to discuss a complaint which had been made; however there was no resulting action plan and they did not know what was going to be put into place to make any improvements.

Are maternity and gynaecology services well-led?

Good

Summary

We rated maternity and gynaecology services at Southport and Ormskirk Hospital good for well led for the following reasons:

- The changes which had been put in place were not embedded as many had been developed in the past few months.
- There were concerns by all staff we spoke with that some proposed changes to the leadership of the service could mean a return to a less open culture. Whilst this was acknowledged by managers the plans for these potentially negative changes were in place.
- Many of the developments for the service were in the planning stage and not all management personnel were in place at the time of the inspection.
- Not all risks we noted during the inspection had been identified, included on the risk register or had management plans in place.
- Whilst there were good examples of effective multi-disciplinary working we were told by midwives and managers there was room for improvement in working relationships between them and some medical staff.
- There was poor attendance at ward meetings and no system to engage the community midwives in service development.

However

- Since the last inspection there had been significant and numerous changes to the management of the maternity services. This included improvements in the governance, risk management systems, development and implementation of a maternity improvement plan and increased staff and public engagement. The sustainability of these improvements would be vital to the continued success of the service.
- There was a vision for the service which managers were aware of; however the focus for medical and midwifery

staff and managers was to continue the improvements to the services which had been ongoing since the Royal College of Obstetrics and gynaecology external review in August 2015.
- Improvements to the new risk management structure meant identification of risks had improved and action plans were put in place with timely reviews being carried out.
- There were mechanisms in place for the governance of both the maternity and gynaecology services to be managed in a multidisciplinary way.
- There were regular meetings some of which were specific to reviews of harm.
- The culture had improved since the last inspection following an external review and changes to staff engagement.
- Midwives told us there were "very good" improvements and they were more involved in the services and could openly discuss any concerns which were listened to.
- There had been an increase in public engagement and involvement in the development of maternity services.
- Medical staff spoke about improvements to the service which included more positive involvement and support from the trust board.

Vision and strategy for this service

- The managers described options for the future strategy of the service; however none of these changes were being developed at present. There was discussion about the regional reconfiguration of services, the development of a vanguard or movement of facilities within the trust to develop a "hot site".
- The maternity managers discussed how their focus was to continue the improvements which had been put into place following the last inspection and the RCOG review. They told us they needed to demonstrate that maternity services were safe.

Governance, risk management and quality measurement

- A risk register for the women's' and children's services was in place which had 20 risks documented. These had been reviewed within the past month and all had action plans in place to mitigate the risks. These had been updated and the necessary changes had taken place.
- A new risk management structure had been devised which included a risk management nurse, a risk co-ordinator and a governance officer. The manager had been appointed but not started work at the time of the inspection. They were going to "remove the punitive process" around incidents by offering support and develop a focus on patient safety.
- There was a consultant with the clinical lead for risk management and the labour ward lead had included risk management in their work.
- Managers in the maternity service told us they were not being heard previously when they highlighted risks to the service. They stated this had now changed and they were involved in the identification and management of risks and presentations at the performance meetings. This included midwifery leads who had presented their five key risks to the board and discussed what actions were required to mitigate these. These actions were part of the maternity improvement plan.
- The maternity improvement plan had been developed following the RCOG report publication in August 2015. This was a "live" document which was updated as additional areas for improvement were identified, such as through patient surveys. There was a system in place for multi-disciplinary discussions and agreement for completed actions and next steps on a monthly basis.
- The recommendations from other maternity reports such as the Kirkup enquiry had been linked into the maternity improvement plan to provide one overarching development plan
- Multi-disciplinary risk management had taken place for the identified patient safety concerns regarding the lack of on-site availability of blood products. This had included the haematologists, pathology laboratory staff, blood bank managers and maternity staff. This group completed multi-disciplinary investigations into incidents and any delays in the provision of blood products.
- A weekly multidisciplinary harm review meeting took place where all incidents of a level 3 or above were reviewed. The investigations and learnings were discussed at these meetings and at the monthly divisional governance meetings.
- Monthly governance meetings for the Children and families division took place. These were attended by managers and medical, nursing and midwifery senior staff. Topics discussed included audit outcomes and resulting changes in practice, learnings from incidents and complaints, health and safety issues and training and development of staff.

- Multidisciplinary gynaecology management forum meetings were held monthly. Updates on the risk register were discussed as well as general issues such as the environment, day to day working of the clinics and treatment areas and outcomes of audits.
- Managers were concerned about the electronic patient information system and the difficulties for community midwives to access necessary records. This was not on the risk register and there were no plans to improve the issues.
- Not all community midwives were aware of measures in place to protect them during their working day. Only one midwife of seven was aware of the lone worker policy and had a functioning lone worker alarm.

Leadership of service

- The leadership of the maternity and gynaecology services had been reviewed and additional posts put into place. There would be two matron's posts with one taking ownership for maternity only and the other for gynaecology and sexual health.
- The head of midwifery had increased their working hours since the last inspection; however they were still the manager for both the women and children's departments. The matron for paediatrics had also been the matron for maternity services for the past several months as an interim measure.
- Midwifery managers discussed an increase in support for maternity services from the trust board since the last inspection. They said maternity services had not been on the agenda for improvement and development previously; however that was not now the case.
- Concerns were raised that there would be a negative effect on the leadership of the service with the possible return of some managers. Since the last inspection the structure for the leadership of maternity services had been reviewed. Some managers had moved to different posts whilst the An external review into the culture of the service had been completed and they were due to return to their posts.some changes were due to take place as a result.
- There were plans in place to support those leaders of the service who were returning to their posts following the external review. This included one to one support, increased supervision and agreed objectives.
- Midwifery staff of all grades spoke of improvements in the leadership of the service since the last inspection. This included increased support and better communication from managers with them being more visible in the maternity service.
- All maternity staff spoke highly of the interim matron for the service. They described them as "very supportive", "visible" and that they listened to and acted upon their concerns.
- The leadership of the community midwives had been changed with the introduction of one band 7 midwife to manage both Southport and Ormskirk community midwifery teams. This may lead to an increase in team working within community services.
- Some of the band 5 midwives stated they were unsure how they would progress to a band 6. The merging of the wards led to fewer opportunities and senior managers did not manage progression in a timely way. A band 7 had recently been appointed to a developmental post which made the band 6 midwives concerned they would not progress into these roles.
- There had been a proposed change in the clinical leadership of the women's services. Due to recruitment difficulties this had not occurred; however the current clinical lead discussed they had good support from the executive team and were continuing in their role.
- Succession planning for the clinical lead roles was underway in some areas of management. For others there were difficulties in identifying the right people.
- The RCOG report recommended that the dual role of clinical director and head of school should be separated. This had taken place.
- A manager who had been in post one week told us they could suggest and make changes easily and they had the opportunity to discuss their ideas and developments with their line managers and above.
- The gynaecology specialist nurses reported good support from the matron for their service. They were approachable and helpful with any concerns or queries.

Culture within the service

- Since the last inspection there had been an external review into the culture of the maternity services. This had consisted of staff interviews and focus groups to discuss and understand negative influences and

recommend changes as a result to continue the improvements within the service. Whilst staff described this process as "uncomfortable" they recognised improvements had resulted from it.
- Medical staff told us there had been improvements in the culture within the service. This included acknowledgement from the trust board that they had not been listened to, improved engagement and a more open approach to communication.
- There were mixed opinions as to the culture of multi-disciplinary working within the service. Midwifery leaders discussed there remained work to be done to improve the multidisciplinary approach, particularly between the medical and midwifery staff. We were told there had been some resistance to changes; however this was improving.
- Midwives described how the culture had changed since the last inspection. They stated there was a proactive approach to change and development of the service with a more open atmosphere.
- Midwives told us they would now speak out if they had any concerns and felt they were listened to. However there were concerns from most band 5 and 6 staff that planned changes, including the return of some absent staff members, could prove detrimental to this positive change. They stated the changes were not embedded enough to ensure the change in culture would continue.

Public engagement

- Those patients who had been transferred to another unit due to the risk assessment process had been consulted on their experience. It was too soon for the results of this were not available at the time of the inspection but they would be used as part of the process review.
- Patients had been involved in organising a large ball in order to raise funds for the bereavement suite. This had been very well supported.
- There was good involvement of patients in the development of the environment on the maternity ward. One staff member was exploring the thoughts and ideas of patients in changing the ward environment with re-decoration and seating in the patients' day room area. This was being expanded to other areas along with fund raising ideas.
- There was protected use of social media to involve patients in the service, obtain feedback and share ideas. This was actively used by staff and patients were encouraged to join in.
- There was a maternity services liaison committee which met every two months. They discussed national strategies and how these would be implemented, local initiatives and updates on changes such as the perinatal mental health pathway.

Staff engagement

- Midwives reported a change in the engagement by managers since the last inspection. This included focus groups having taken place, monthly staff forums and more visibility of managers.
- Managers noted attendance at the monthly ward meetings was poor. Of the 21 potential representatives in September there were 4 attendees, with 7 in November and 10 in December. They had discussed how to improve this and work was ongoing.
- The monthly staff forum meetings were run by the staff for the staff. These were used as a place to discuss and influence changes within the unit.
- Staff could present ideas which, where possible, they were given the opportunity to develop. Managers told us staff were more willing to make suggestions and get involved in the development of the service.
- One staff member had introduced a communication system to make sure all staff received the same message from the safety huddles and other meetings. All staff used this as a positive example of where they had been able to instigate change.
- The interim matron and other managers noted a change in the way the band 7 midwives worked. They were taking more ownership for their work than previously.
- One of the learnings by the leadership of the maternity service since the last inspection was they needed a greater understanding of why staff members left employment. A new mechanism had been introduced whereby staff leaving the organisation were interviewed on exit in order to understand the reasons. 10 midwifery staff had left since April 2015. No themes had been identified through this process.
- There was a lack of communication between the community and inpatient midwives. There were no joint meetings or other ways of joint working, sharing practice or developing the service.

Maternity and gynaecology

Innovation, improvement and sustainability

- The managers discussed how they were pleased with the progress the maternity service had made since the last inspection, both clinically and culturally. They told us they would challenge any practices or developments which may jeopardise this progress.
- Managers told us the systems now in place for improved communication would continue beyond the implementation of the current maternity improvement plan.
- Midwifery managers participated in general discussions about the sustainability of the service and encouraged other staff to do the same.
- Managers and staff understood that there were possible changes at the trust which may affect the maternity services. They were working to develop the service in order to provide one which was sustainable through future changes.
- There was representation from the maternity services on the strategic clinical network subgroup. This improved partnership working with other trusts in the region.
- Some managers had visited maternity services in other trusts to learn how they had made changes and developed their service.
- Maternity and gynaecology clinical leads were involved in discussions about sustainability of the trust and the requirements for future development.
- There were some concerns about the sustainability of the gynaecology service especially having a specific ward due to reduced admissions. There was some discussion about urology sharing the ward in the future although there were no plans for this.
- As part of the improvements required to the availability of blood products one consultant was working with a local trust to evaluate different systems.

Services for children and young people

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

Information about the service

The children and young people service at Southport and Ormskirk Hospitals NHS Trust delivers care to children at Ormskirk District General Hospital. Between September 2014 and August 2015, 3,994 children aged between 0 - 16 years old were seen by the children's services.

The ward uses a flexi bed system that allows it to increase or decrease the number of beds according to demand. In summer, the ward becomes a 12 bedded inpatient unit, this increases to 17 beds in winter. There is one high dependency unit bed and a six bedded paediatric observation and assessment unit. The ward also accommodates four day case beds that treat patients who attend for minor procedures. An outpatients department is situated near the ward and holds a number of clinics throughout the week such as the blood clinic but the department is closed on Fridays.

The service offers a wide range of clinical services to children. In paediatric medicine there are services in epilepsy, diabetes, cystic fibrosis, allergy and neonatal services. The surgical team performs surgery of certain specialities such as ear, nose and throat (ENT), orthopaedics and dental. Any complex surgery is transferred to neighbouring tertiary centres. Children are also offered care at home, the community outreach team administrators medication such as antibiotics at home to avoid unnecessary admissions and a prolonged length of stay. The service also has access to child psychiatry services; this service was split into teams; Sefton and West Lancashire. The input from CAHMS and the community outreach teams is heavily dependent on the area the child resided within. The ward provides a child friendly playroom which meets the needs of children between the age of 1-8 years old, older children are offered game consoles and DVD's.

We inspected Southport and Ormskirk Hospital between 12 and 15 April 2016 and an unannounced inspection took place on the 26 April 2016. As part of the inspection we visited the ward, paediatric assessment and observation unit (PAOU), daycase unit, the neonatal unit and surgical theatres. We observed care and treatment and reviewed 10 nursing and medical records on the ward and seven on the neonatal unit. We spoke with 35 members of staff including nurses, junior doctors, consultants, ward managers, play specialists, domestic assistants, health care assistants, administration staff and senior managers. Prior to our inspection we reviewed comments from people who had contacted us about their experience at the hospital and we also reviewed the trust's performance data.

Services for children and young people

Summary of findings

The hospital was previously inspected by the Care Quality Commission in November 2014 and Children's and Young people's service received a good rating across the all domains. During this inspection, the Children's and young people's services received a rating of 'good' for being safe, caring and well-led however the overall rating was deemed requires improvement because the effective and responsive domains were rated as requires improvement. This was because;

- Although Staff knew what constituted as an incident and regularly reported them in categories of; no harm caused, low harm, moderate short term harm need further treatment / procedure or severe harm caused, we found 57 incidents relating to medication during February 2015 – January 2016. Discrepancies relating to medicine management had been addressed and involvement from the pharmacist was sought to improve practice.
- Patient records on the ward and neonatal unit were kept in unlocked trolleys across the service; this meant that they were accessible to visitors.
- There was no robust major incident planning, staff were not aware of their roles and responsibilities if a major incident was declared.
- Policies, pathways and procedures were out of date or available. This meant they did not reflect current guidelines and best practice. Reviewed pathways used by staff on a day to day basis were not referenced and therefore we could not determine which guidance they were taken from.
- Multidisciplinary team working was evident during ward rounds and handovers. However there was a lack of communication across other services such as theatres. Children attended pre op clinics alongside adults without informing clinical leads of the children's and young people's service.
- The public, parents of children and babies using the services were not involved in developing the service, however diabetes patients were offered meetings to share experiences and learn how to self-care for their condition.
- Dissemination of actions from complaints required to being more robust, complaints were not addressed in a timely manner and there was no evidence of learning from complaints.
- Leaflets were not responsive to the needs of children's visiting the ward. Information was available in English but was not available in different languages. Patient information was not in a child friendly format, leaflets contained long descriptions of conditions such as bronchiolitis or febrile convulsion.
- The 2014 CQC inspection identified that the children and adolescence mental health service was limited, which often meant that children were not assessed during the weekend. CAHMS support from West Lancashire team out of hours for patients who presented with psychosis or severe intent to self-harm was restricted due to financial provisions. The ward did not have an isolated room available for CAMHS patients but side rooms were used if available. Staff carried out risk assessment before patients were placed in rooms. . However senior managers were aware, side rooms were not always available when the ward was busy and patients would be placed with other patients.
- Senior managers did not involve children and their families to develop and plan the children, and young people's,
- The service did not have an executive or non-executive lead, and therefore was not represented at board level.

However,

- The service actively audited hand hygiene practice and environmental checks were regularly recoded. Hand gels were readily available across the ward and neonatal unit.
- Safeguarding referrals were appropriately escalated, clinicians, nursing and social services staff met regularly to discuss concerns.
- Mandatory training arrangements were in place; staff who had not attended mandatory training were identified and given protected time to complete.

Services for children and young people

- We reviewed a sample of staffing rotas between January – April 2016 whilst on inspection. Staffing reflected the British Association of Perinatal Medicine (BAPM) on the neonatal unit and the Royal College of Nursing (RCN) standards on the ward.
- Pain and nutritional and hydration needs of children was routinely assessed. The ward used the paediatric early warning score system to assess poorly children. A pain rating scale was used to help children communicate information about pain alongside assessments and observations. Fluid charts contained the weight and the child's age so that staff could calculate the appropriate levels of fluids
- The service participated in local and national audits; we found that staff actively reviewed patient outcomes to improve their service. Actions from audits were documented and timescales were set appropriately. The neonatal unit actively collected data for the Bliss audit and were awarded a prize of monetary value which was used to furnish the parent's room.
- Staff were competent in their roles and given opportunities to upskill themselves. We saw a number of competency frameworks to support staff when staff were rotated across the service or sent to help busy areas such as a paediatric nurse sent to alleviate staffing pressures on the neonatal unit. Annual appraisals were regularly completed and personal development opportunities were identified and supported.
- The transition pathway was clear and supported by a three step guide to transitioning children. Children and their families were supported by clinicians and nursing staff, who coordinated care.
- Staff sought appropriate consent from patients and those close to them before delivering care and treatment. Gillick competency guidelines were used to decide whether a child or young person had the mental capacity to understand information about their care and treatment.
- Staff delivered compassionate care to children, the privacy; dignity was respected and maintained when care was provided. Families were informed about their child's care and actively participated in developing their child's care plan. Staff recognised when children and their families required additional support such as the need for an interpreter. Staff demonstrated an empathetic and considerate attitude towards children and their families.
- The local leadership on the ward and unit was visible and leaders were approachable.
- Staff received information about changes to practice and policies through staff meetings and emails. The trust wide newsletter was sent to staff, this announced achievements to other services.
- Senior managers recognised the need to consider innovative ways to develop their service. Senior managers had written a business case to employ two more Advanced Paediatric Nurse Practitioners to increase the workforce because the senior managers believed there would be a shortage of junior doctors in the future.

Services for children and young people

Are services for children and young people safe?

Good

Summary

We rated the safe services for children and young people as good because:

- Incidents were reported on a central electronic reporting system as they were during the 2014 inspection. Staff were knowledgeable about the types of incidents to report and were familiar with what constituted an incident. Incidents were proactively reported lessons were learnt and documented.
- Cleanliness and hygiene was of a high standard throughout all areas and staff followed good practice guidance in relation to the control and prevention of infection. The unit achieved 100% compliance rate in the trust hand hygiene audit. The environment on the ward was vibrant and child friendly, posters and paintings of familiar characters were displayed across walls in all areas. The children's ward still displayed their planned and actual staffing numbers on the ward, as noted in 2014. Nurse staffing levels on the paediatric ward reflected Royal College of Nursing (RCN) standards (August 2013). The neonatal unit also met the British Association of Perinatal Medicine (BAPM) whilst on inspection. We were assured that when staffing levels did not meet these standards, senior managers were informed and appropriate actions taken. Staffing on the paediatric observation and assessment unit was covered by Paediatric A&E nursing staff overnight. However staff told us that it was difficult to manage the activity on the unit during the evenings because activity in the Accident and Emergency department was high. This was supported by five incidents that had been reported as "insufficient nurse staffing" between February 2015 – January 2016.
- Medical rotas showed staffing was appropriately managed but we noted that the percentage of consultants (25%) working in paediatrics was less than the England average (35%) but this was compensated by higher percentage of middle grade doctors (32%) compared to the nationally (7%) and junior doctors 18% compared to 7% nationally.
- The resuscitation equipment was regularly checked by staff throughout 2015/16, the trolley and equipment was readily available. During the 2014 inspection, we found no problems with the resuscitation equipment and also noted that it was checked on a daily basis.
- Safeguarding policies and procedures for children were in place; staff were aware of their roles and responsibilities and knew how to escalate any safeguarding concerns appropriately. The service operated a flagging system in the paediatric A&E department to make staff aware of issues that related to safeguarding. A health visitor was based on the ward and worked closely with the safeguarding named nurse to review any child who was referred. Staff received safeguarding training, 91% of staff across the service had completed safeguarding level three.
- Mandatory training uptake varied from 5% in clinical record keeping to 97% in safeguarding level 3.
- The ward and the unit assessed patients using the paediatric early warning score system and a modified safety thermometer was used on the ward. The unit and the ward closely measured hospital acquired harms and the proportion of patients that were 'harm free', data included the number of complaints, safeguarding training rates and sickness rate The ward had a clear major incident plan; however not all staff were familiar with their roles and responsibilities. However,
- Despite medication, including controlled drugs, being stored appropriately in locked cupboards and the keys being held by a designated member of staff the service had reported 54 incidents relating to medication between February 2015 and January 2016. Incidents were categorised into different subheadings; the highest number of medication related incidents was reported as omissions (14), Wrong Storage of Medicine (7) and Faulty equipment that has an impact on care (7). In 2015 a new medicines preparation and storage room was installed on the ward to reduce interruptions and ensure safe storage of medicines.
- We found gaps on medication fridge temperature recording sheets in April 2016 where the fridges had not been checked. The temperature of the fridge used to store breast milk on the neonatal unit was never checked by staff. Staff were informed of this and from the 14 April 2016, the fridge was checked twice daily.

- Records were completed appropriately and we were able to follow and track patient care and treatment easily. However records, on all wards we visited were kept in unlocked storage units on the ward corridors and were potentially accessible to patients and visitors.
- Staff were not compliant with completing safeguarding level two training, 8% of neonatal staff had completed the training and the compliance rate across other areas was lower than 65%.

Incidents

- All staff followed the policy relating to incident reporting and were familiar with reporting incidents using the electronic reporting system called the Datix.
- Staff were knowledgeable about what types of incident they needed to report and confidently discussed how these would be recorded, reviewed and escalated. They were encouraged to report any incidents and were supported through the process.
- Incidents were reviewed by Band 7 nurses who took appropriate actions, staff received feedback from any incidents they reported and support mechanisms were put in place to help their learning. For example we saw that additional medicine management training was in place to reduce errors, buddying with another member of staff had also been implemented and staff were asked to revisit protocols.
- The children and young people's service reported 276 incidents between 01 September 2015 and 01 February 2016, across the Paediatric ward, Neonatal Unit, paediatric assessment and observation unit and paediatric outpatients. Any incidents that caused harm or resulted in a death were immediately escalated to the ward manager and matron. All level 3 incidents were reviewed at the Women & Children's weekly harm review meetings.
- Trust data showed that 86 incidents reported related to the neonatal unit. A further 115 incidents were related to the paediatric ward, with the majority of incidents categorised as minor or low harm. However we noted that two incidents were recorded as "moderate short term harm need further treatment / procedure". In both these cases the actions taken were appropriate and there was evidence of learning. For example staff incorporated safety huddles to increase effective communication between medical and nursing staff.
- The service recorded a combination of 26 incidents relating to medication, the data we were provided was further segregated into eight categories; administration, equipment, record, delivering, dispensing, preparing, prescribing and storing. This was the highest category of reported incidents, incidents were reviewed and actions were documented and discussed with staff. These included staff being supervised when administrating medication, staff were also asked to read medicines management e reader and attend sessions with the pharmacist.
- Staff across the childrens and young people's service were familiar with the term 'Duty of Candour', this regulation 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

- The environment in which children were being cared for in was safe and clean. The wards, theatres, recovery bay and clinical areas were visibly clean, organised and tidy. Domestic staff used cleaning schedules which were available in all areas and signed on a daily basis to identify the schedule had been adhered to.
- Hand washing facilities, including hand gel and sanitisers were readily available in prominent positions, on entry to each clinical area. We observed staff adhering to, current infection prevention and control guidelines such as the 'bare below the elbow' policy. All areas regularly achieved 100% in hand hygiene audits, between July 2015 and January 2016 both the neonatal and paediatric ward achieved 100% in the trust wide hand washing audit. This was evident in our observations; staff used the appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.
- Curtains between the cubicles on the ward and unit were labelled with the date of the last and the next clean.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- 'I'm clean stickers' were placed on equipment when it had been cleaned, including note trolley, medication trolleys and clinical equipment. However, whilst on inspection we noted that some equipment did not have "I am clean stickers" on them. This meant that staff

could not determine if the equipment was clean or dirty. Staff were informed about the equipment and it was established that the equipment was clean but had not been stickered.

Environment and equipment

- The ward and neonatal unit we visited had controlled access external doors. Patients and visitors were able to enter the ward through the main entrance or the paediatric assessment and observation unit, both entrances were controlled.
- Children story book characters were on walls of the paediatric ward, the environment was child friendly, colourful and welcoming to children of all ages.
- The neonatal unit displayed neonate stories and pictures of baby's they had cared for. Staff told us that the stories were read by parents and was a way of sharing patient and family experiences.
- Facilities for parents and visitors in all areas were clean and tidy and suitable for them to convene in.
- Emergency resuscitation equipment was in place and records indicated that it had been checked daily.
- The ward had a robust system for disposing of waste, waste bins were clearly marked. The handling, storage and disposal of clinical waste including sharps followed protocol. All storage areas were labelled clearly so that staff could find equipment.
- 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 medical equipment had been checked and labels indicated when they were next due to be serviced.
- The High Dependency Unit (HDU) within the ward was close to the main nurse's station, so patients who had more complex needs and needed additional care were visible to the clinical staff.
- There was a shortage of storage facilities on the neonatal ward, we found cleaning products in cupboards that were unlocked which did not meet COSHH regulations and meant that anyone visiting on the unit had access to them.

Medicines

- Medication in cupboards were labelled and systematically stored. Medication that had been opened was dated so that staff were able to discard them if they exceeded the expiry date.
- Medicines, including controlled drugs, were in date, stored securely and access was limited to qualified staff employed by the trust. The keys for the controlled drugs were kept separately for increased security.
- A register was kept to monitor the stock of medication in the controlled cupboard, this was fully completed. All controlled drugs checked during the inspection were in date and accurately recorded.
- Medications stored in fridges were kept at the right temperatures. However we found that fridge temperatures were not always regularly checked.
- Staff who administrated medication received training and competed ward basis competencies.
- The children and young people's service reported 54 incidents relating to medication, all incidents were reviewed by staff involved and action plans were put in place.
- The pharmacist was visible on the ward and the open dialogue between the pharmacist and staff meant that staff were able to ask questions and receive support.

Records

- We reviewed 10 sets of care records on the ward and six care records on the neonatal unit. We found that not all were fully completed. Three care plans did not state the name and grade of the doctor reviewing the patient. However all records had documented evidence of patient observations, diagnosis and management plan. One patient was reviewed by medical staff three times during the night, each review was clearly documented and pain was managed appropriately.
- We found that care plans were not stored in a safe way and were accessible in open trolleys on the corridor. This had not been addressed since the previous inspection in 2014; senior managers were reminded of the data protection act and the importance of storing care plans in a safe and secure area.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect children from abuse. Staff in contact with children, young people and their families were aware of their roles and responsibilities to report safeguarding concerns and to promote the wellbeing of children. Staff in all areas were familiar with the trust's safeguarding policy and the named safeguarding nurse.

- Staff were confident in identifying the potential indicators of abuse and neglect in children and told us they knew how to act on their concerns. The safeguarding lead was based on the ward and worked closely with ward staff and the health visitor
- The children and young people service operated a flagging system that notified staff of children who were subjected to a child protection plan. This was so that staff were made aware of any concerns and alert them to immediately contact the appropriate social care department should a child attend. Additionally a flag was placed on the electronic case note of any child that was discussed at the Multi Agency Child Sexual Exploitation meetings to ensure staff considered any child sexual exploitation issues. If children were identified, staff alerted social care and police.
- Staff reported any sudden and unexpected deaths to the Lancashire Local Safeguarding Children's Board (LSCB) as per Working Together to Safeguard Children 2015, stated in the Sudden Unexpected Death in Childhood (SUDC) protocol. In an event of a death, staff were asked to complete documentation stating the reason for the death and circumstances around the death. Staff were supported by the Named Child Protection nurse and Paediatric Liaison nurse. During 01 April 2014 to 31 March 2015 the trust reported 4 child deaths. All deaths were reviewed and any learning from the deaths were shared with staff.
- Safeguarding training formed part of the trust's mandatory training programme and staff were sked to complete this every three years. Safeguarding level 2 training was low across all areas, 8% of neonatal staff had completed the training and the compliance rate across other areas was lower than 65%. Trust data indicated that 97% of staff across the childrens services had completed safeguarding level three in April 2016. Level three training was required for all clinical staff working with children and young people. Safeguarding was discussed on the Paediatric Study days, this was so that staff were regularly reminded of the importance of safeguarding and any changes to guidance could be addressed.
- Safeguarding issues were discussed at the monthly safeguarding steering group meeting. This was attended by the named safeguarding doctor, named safeguarding nurse, clinical leads, matron, health visitor, midwives and representatives from Sefton and Lancashire Social Care. These meetings were used as a platform to discuss any issues involving children and to identify solutions to care and keep those children safe. The meeting also created an active dialogue between social services and the hospital.

Mandatory training

- All staff received mandatory training which was delivered via various methods such as on-line and face to face sessions. Staff received training in equality and diversity, clinical record keeping, fire safety, consent, hand hygiene, risk management, health and safety, incident reporting and investigation, information governance and confidentiality, slip trips and falls, safeguarding children, violence and aggression, moving and handling, conflict resolution, understanding dementia, medicines management and blood transfusion.
- Staff received a role specific induction when they started work in the children and young people division. Newly qualified nurses received a period of supernumerary status until they had their competencies signed off by the ward manager.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it. However records showed the training completion rate among staff across the childrens and young people's services was poor, data provided by the trust ranged between 5% (clinical recording keeping) and 97% (safeguarding level 3).

Assessing and responding to patient risk

- A paediatric safety thermometer had been devised by the children and young people's service; this was modified to display safeguarding training compliance rates, number of complaints, medication errors, hand hygiene audit results and sickness absence rates. The safety thermometer did not display hospital acquired harms and the proportion of patients that were 'harm free from pressure ulcers, falls, urinary tract infections and Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. Diff). The thermometer was not visible to visitors; it was located on a corridor between the paediatric Accident and Emergency department and the paediatric ward. The information was updated weekly by the ward manager or matron.
- The ward used the Paediatric Early Warning Score (PEWS) system to assess children. Nursing staff described the use of a paediatric early warning score

system, which was used to monitor a patient's condition. The scoring system was used to enable staff to identify concerns before patients became serious and to gain support from medical staff. Care plans documented PEWS scores in them and were regularly used to clinically assess patients, they demonstrated that staff appropriately used the scores to care and treat children.

Nursing staffing

- The expected and actual staffing levels were displayed on the notice board on paediatric ward but not on the neonatal unit. The neonatal unit only displayed the actual staffing levels but staffing numbers in both areas were updated on a daily basis. On inspection the staffing levels were safe and adequate for the number of patients on the ward and the unit met BAPm standards.
- Staff rotated between the ward, assessment and observation unit and paediatric A&E to accommodate any staffing shortfalls. This rotation supported staff competencies and allowed staff to work in different areas of the service. Additionally the children community outreach team was based on site and provided services in the community. When activity was low staff rotated on to the paediatric A&E or on to the ward however this was dependent on service needs.
- Staffing on the paediatric observation and assessment unit was covered by Paediatric A&E nursing staff overnight. However staff told us that it was difficult to manage the activity on the unit during the evenings because activity in Accident and Emergency department was high. This was supported by five incidents that had been reported as "insufficient nurse staffing" between February 2015 – January 2016.
- The paediatric assessment and observation unit had one Advanced Paediatric Nurse Practitioner (Trainee) vacancy; they reported a 62.69% vacancy rate and 24.4% sickness rate in the last 12 months. The ward had three band five nurse vacancies out to advert, they reported a 3.71% vacancy rate and a 3% sickness rate in the past 12 months, The neonatal unit had one 0.6 WTE health care assistant vacancy out to post at the time of inspection, they reported a 2.37% vacancy rate and 7.8% sickness rate in the past 12 months. Staff were asked to do overtime or bank staff were used to fill gaps in staffing.
- The nursing handover was held in the treatment room, it was informative and all staff nurses and the play specialist attended. The play specialist was present so that the needs of children who needed play were captured and subsequently play was then distributed to children according to their age and suitability. We listened to a high level discussion between staff; which included a brief overview of each patient's acuity. However we noted that the hand over sheet did not comply with the Data Protection Act (1998). Identifiable patient details such as the child's name and data of birth appeared on the handover sheet on both the paediatric ward and neonatal unit. Staff were informed and amendments to the handover sheet were made.
- Issues relating to the unit were discussed at safety huddles to increase awareness amongst staff. Both the medical and nursing staff attended the safety huddles. We observed a more detailed patient handover at the bedside, which meant that nurses could be introduced to patients and gain clarification about the patient's clinical needs.
- The ward and neonatal unit had sufficient numbers of trained nursing and support staff with an appropriate skill mix to ensure that patients received the right level of care. Staffing rotas that we reviewed confirmed that staff numbers and staffing skill mix were appropriate to meet the needs of patients. An advanced paediatric life support (APLS) trained staff and a Band 6 nurse worked across the paediatric ward on every shift.
- There was no paediatric nurse in recovery; children were currently being looked after by adult nurses. However recovery staff had recognised the need for paediatric input and were working with the childrens service to assist with caring for children in recovery. An agreement between both services welcomed a 0.3 WTE paediatric nurse to be present in recovery to support existing staff. This meant that both nurses would learn from each other and upskill their knowledge base.
- The paediatric ward had recently successfully recruited new nurses. These nurses were placed on shifts where there was a fair distribution of experienced staff to ensure they received the correct level of support.
- The service was supported by specialist nurses for Diabetes, Respiratory and Epilepsy. These nurses were based at Ormskirk Hospital and were able to provide expertise in caring for children with complex conditions.

Medical staffing

- Medical staffing for consultant cover was lower than the national average at 25%, compared to 35% nationally. However the percentage of middle grade doctors was higher (32%) compared to the nationally (7%) and junior doctors was 18% compared to 7% nationally.
- The paediatric medical staff group reported a 6.10% vacancy rate and 1.2% sickness rate in the past 12 months.
- There were two WTE junior doctor vacancies that were filled by locums at the time of the inspection. We were told that a Business case was being prepared to increase the number of APNP's over the next two years in preparation of the difficulties with number of available junior doctors. Once qualified the APNP would support the SHO rota in Paediatrics.
- We observed medical handover at 09:00am on the paediatric ward, the handover was informative and it was consultant led. The medical staff used a structured proforma to inform the team about the acuity of the patients. The handover was patient focused and clear.

Major incident awareness and training

- The major incident policy was reviewed; it contained a list of personnel who were assigned designated roles and a list of potential key risks to the provisions of care and treatment.
- Staff we spoke to were unsure of their roles and said they would seek advice for senior managers.
- We were shown the major incident box, which was located in the A&E; it contained a number of items such as torches, batteries and folders that contained instructions for individuals with designated roles. However staff members were not aware where the box was located.

Are services for children and young people effective?

Requires improvement

Summary

We rated the effectiveness of services for children and young people as required improvement because:

- During the 2014 inspections we found robust systems were in place to ensure guidelines and policies were in date and referenced appropriately. However during this inspection we found that practice did not clearly reflect current guidelines and best practice as many of the guidelines we reviewed were out of date, unreferenced and some were not available.
- There was a lack of multidisciplinary working with other teams such as theatres although it was good amongst the ward team. Senior managers of the children and young people's services were unaware that children were being seen in adult pre-op clinic.
- Since 2014 inspection the staff appraisal rate had decreased by 3%. In 2014, 93% of staff had received an appraisal compared to 90% in 2016.
- Not all GP's were signed up to the electronic system by which discharge letters were sent so some were sent out via the post. Between April 2015 and November 2015, five incidents were recorded relating to patients leaving without a discharge letter, due to medical staff having heavy workloads and being unable to complete discharge summaries in a timely way.
- The service provided a seven day service across radiology and pharmacy, however childrens mental health services was limited to a five day service.

However;

- It was evident that the children's and young people's service was improving their clinical practice since 2014 inspection and those improvements had led to changing practice. For example in 2014 the neonatal unit was a level one baby friendly unit and in 2016 were continuously working towards full accreditation.
- Children were assessed for pain routinely using the Wong- Barker Faces pain rating scale and the paediatric early warning score system was in place to assess poorly children.
- The nutritional and hydration needs of children were assessed and between July 2015 and January 2016 the ward achieved 100% compliance rate in their monthly audits for completion of fluid charts.
- The service participated in local and national audits. Outcomes to improve care and treatment were reviewed and we saw evidence in changing practice. Actions from audits were documented and timescales were set appropriately. The neonatal unit actively collected data for the UNICEF baby friendly initiative accreditation scheme and the Bliss Charter audit to improve patient care. The unit was awarded the 'Pledge of Improvement' by the National Charity Bliss for working towards accreditation of high quality family centred care.

- Staff were supported and given opportunities to upskill themselves; they felt competent in their roles and worked well as part of a multidisciplinary team. Staff received annual appraisals and were given extra responsibilities.
- There was a clear transition policy to guide 12 – 15 years old children through the transition to adult services, this pathway altered for children with complex needs. Children were assigned a key worker who was responsible for coordinating care and delivering the transition process. Adults and paediatric integrated clinics were offered to children throughout the year, to support them through this change.
- Staff sought appropriate consent from patients and those close to them before delivering care and treatment. Staff used the Gillick competency guidelines to decide whether a child or young person had the mental capacity to understand information about their care and treatment.

Evidence-based care and treatment

- Staff on the neonatal unit were familiar with the current British Association Perinatal Medicine (BAPM) guidelines to ensure they babies were cared and treated appropriately.
- The paediatric ward used National Institute for Health and Care Excellence (NICE) guidelines, to determine care and treatment provided. However whilst on inspection we reviewed guidelines that were out of date or were not available. The pathways and guidelines on the intranet were limited and in some cases the link to the information did not work. Additionally pathways that were in circulation across the department had not been referenced or reviewed.
- The neonatal unit collected data for the Bliss baby charter audit and worked towards achieving the Charters seven core standards which reviewed the care, respect and support babies and their parents received. In February 2015 the unit was awarded the Pledge of Improvement and gained a grant of £7,000 from Bliss in April 2015. This was spent on items that parents had suggested would help improve their stay on the NNU.
- Since being a level 1 baby friendly unit in the 2014 inspection, the neonatal unit were working towards a standalone accreditation for UNICEF baby friendly initiative accreditation. Mothers who chose to breastfeed were supported by a breastfeeding link nurse who saw mothers and their babies on the unit and in the ward.

Pain relief

- Pain was initially assessed at triage in the Paediatric A&E department and reviewed on the ward by nursing staff. The Wong- Barker Faces pain rating scale was used to help children communicate their pain to staff, alongside observations and input from carers or parents.
- We found that pain was managed effectively. Care plans we reviewed showed that pain relief was recorded correctly and given to children appropriately.
- Pain management training was delivered to staff on the annual Paediatric Study day to increase the awareness and confidence of staff.
- Staff on the neonatal unit used non pharmacological techniques to provide pain relief to neonates. These techniques included Kangaroo care, non-nutritive sucking and administration of Sucrose for procedures. Oral sucrose was used as a mild analgesia to reduce short term procedural pain from a single event in neonates.

Nutrition and hydration

- Fluid charts were routinely updated in all areas of the children's service, the weight and age of the child was written clearly for staff to use when calculating fluids.
- Staff told the inspection team that children were offered small snacks such as toast or fresh fruit. However whilst on inspection a child who was admitted after dinner time was not offered any food until breakfast the next day.
- The paediatric ward did not display the weekly breakfast, lunch or dinner choices so that children could choose in advance what they wanted; instead children or parents used the electronic portal on the television screen to order food directly with the catering department.
- Milk in the neonatal unit was stored in a fridge on the corridor across the nurses' station. This was not locked and could be accessed by anyone visiting the unit.
- The milk room on the paediatric ward was not locked and located at the back of the ward. This room contained an array of milk products and baby food, all of which was available to anyone accessing the room.

Issues regarding contamination and access were raised with the matron and a keypad was placed on the door to prevent anyone from entering the room without permission.
- All formulas and baby food were in date and stored correctly. The milk kitchens contained sterilised packaged teats used for formula feeding.

Patient outcomes

- The children and young people's service participated in national and local audits to better outcomes for patients and their families. Actions from audits were documented and clear timescales were applied, such audits identified themes such as incomplete documentation, handover of controlled drug keys, drug errors and errors in administrating infusion rates. Recommendations from audits were actioned to reduce errors and risks to patients. For example medical staff were asked to complete documentation, nurses holding the CD cupboard keys were asked to sign and read protocols around medicine management and nurses worked with the pharmacist to reduce medication errors.
- The neonatal unit participated in the National Neonatal Audit programme to better patient outcomes. In 2013 the unit showed that 76% of babies were eligible for Retinopathy of prematurity (ROP) ROP screening but only 57% were screened on time. ROP is a potentially blinding eye disorder that primarily affects premature infants weighing about 1250 grams or less or babies that are born before 31 weeks of gestation. Since introducing an ophthalmologist to the unit, 90% of babies had been screened for ROP.
- Documentation audits identified that not all care plans recorded a discussion between the senior consultant and the carer/ parents within 25 hours of admissions. In 2013, 90% of parents had a document consultation. After raising the awareness of documentation amongst medical staff, 95% of babies admitted to the NNU had a documented consultation with a senior member of the medical team within 24 hours.
- Staff were given opportunities to develop skills and change practice to better patient outcomes. After nurses had attended the diabetes advanced course, the diabetes team held interactive evening sessions for children to attend called "living well with diabetes". The last sessions focused on exercise and children took blood sugars before and after exercise. By doing this children were educated about the effects of exercise on blood sugars in a fun and interactive way.
- The neonatal unit took part in the National Charity Bliss to enhance patient outcomes; the unit was awarded the 'Pledge of Improvement' by the National Charity Bliss for working towards accreditation of high quality family centred care. The audit identified areas where the unit needed to improve for example staff needed to find further ways of gaining feedback from parents throughout duration of stay, they needed to talk about information in the leaflet with parents rather than just giving the leaflet and introduce Guideline for sucrose.
- The December 2015 Audit of the WHO Safer surgery checklist across all theatres at Ormskirk Hospital showed that there was a 100% compliance rate.
- The neonatal unit were working towards standalone accreditation for baby friendly to increase better outcomes for new-born babies. In 2015, rates of babies of 34 weeks gestation who were discharged home on mum's breast milk improved over the year. Between April and June 14% were discharged home on breast milk, this increased to 71% between October 2015 and December 2015.
- The service reported a higher percentage of patients with a blood sugar measurement of HbA1c less than 7.5 in the 2013/14 Paediatric Diabetes Audit (21.8%) compared to the national average (18.5%). The median blood sugar levels were slightly lower (68%) than the national average (72%). This indicated that more children had diabetes controlled within acceptable limits.
- Trust data showed that there were no emergency readmissions after elective surgery amongst patients under one year old and 1 to17 years old between September 2014 and August 2015.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma between October 2014 and September 2015 was 18.4%; this was poorer than the England average of 16.8%.

Competent staff

- An education practitioner nurse was in post and was situated on the ward. The post holder was responsible for identifying and leading on training within the ward

and unit. There was a strong focus on career progression within children's and young people's service. Staff were given time to attend the Qualified in Speciality (QIS) for neonatal nurses course. This post registration pathway was in collaboration with the local university and provided registered nurses working on the neonatal unit with the knowledge and skills to practice safely and effectively.

- Currently there were two nurses on NNU that were in the process of completing their QIS training, of the 24 nurses on NNU, 22 staff were fully qualified.
- The neonatal unit manager was a New-born Life Support (NLS) S instructor and assisted by the clinical educator delivered NLS training in house. Staff on the NNU were confident in their roles, 75% of staff were NLS trained.
- In 2014 inspection 93% of staff had received an appraisal; however trust data showed that in April 2016, 90% of permanent staff and 66% of staff on zero hour contracts had received an annual appraisal.
- Trainee medical staff stated they were well supported and had received appraisals. Medical staff used the medical grand round as a method of learning; they often presented at the meeting and used it as a valuable teaching and learning session.
- We spoke to three band five and two band six nurses and two health care assistants who all felt supported to learn and develop their skills. Managers encouraged staff to develop in their roles, for example in the neonatal staff room we saw that staff were given specialist areas to champion such as audit, safeguarding, or training. Information about each area was displayed for others to read and become familiar with.
- Newly appointed staff attended corporate training and were given a local induction. Whilst on inspection newly appointed nurses were familiar with where policies were kept and equipment on that ward.

Multidisciplinary working

- There were no weekly multidisciplinary team meetings held on children's ward.
- However there was evidence of multidisciplinary working between the physiotherapist, pharmacist and specialist nurses when assessing, planning and delivering care for any planned transfer or discharge.
- Multidisciplinary working amongst the community outreach team and other professionals was evident; nurses referred clinically unwell babies to the health visiting team. For example if a baby's weight was low the health visitor would be asked to follow this up on a home visit. Any safeguarding concerns were flagged with the safeguarding team and the discussed at meetings. The team was based on the ward and interacted with the ward staff on a daily basis.
- Discharge letters were sent electronically to the patient's GP; however letters were also sent my post to ensure that GP's received them. This was because not all GPs were signed up to the new electronic system.
- There were good links and inter-trust working with neighbouring trusts. Examples of good inter-trust working were given on the neonatal unit; they often worked closely with tertiary centres to transfer babies to a level three unit. A level three unit is for babies needing ventilation, weighing less than 1,000g, born at less than 28 weeks gestation and needing CPAP support (continuous positive airway pressure). There was a heavy reliance on neighbouring trusts to provide guidance and support; staff told us that they rang other trusts if they were unsure of current practice. This was evident in the lack of evidence based guidance.
- The play specialist was available on the ward but was not available in all areas where children were seen.
- Cross departmental working was supported by the matron; staff were rotated across the department to enhance skills and communication. Staff we spoke to felt confident and competent in working and supporting different areas of the service. Clear definitions of what duties staff were expected and able to perform were in place. This meant that staff would only carry out clinical duties that they were trained and competent in.
- Clinics were not supported by paediatric nursing, for example the pre-operative clinics were held across both hospital sites without any paediatric input. These were mixed clinic for adults and children.

Seven-day services

- Daily ward rounds took place on the children's ward and the neonatal unit every day. At the weekends junior doctor completed ward rounds with the support from the on call consultant.
- Staff had access to medicines seven days a week; protocols were in place to support the onsite pharmacy when it was closed.

Services for children and young people

- The CAMHS team did not provide a seven day service, if a child who needed a mental health assessment was admitted to the ward on Friday; this could not be done until Monday unless it was urgent. This was reported on the hospital risk register and the local clinical commissioning group (CCG) were made aware of this risk.

Access to information

- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information. Staff were able to demonstrate that they were confident in using the different systems. We were shown where policies and protocols were kept, however polices were out of date and electronic links did not work.
- Families of baby's on the neonatal unit were encouraged to complete the parent education checklist prior to their babies being discharge. This was so that parents felt comfortable with their abilities to care for their new-born at home. The checklist included resuscitation education, feeding demonstrations and the giving of medication. Families were given written information and DVDs on a variety of topics so that they had a source of information to refer to at home.

Consent

- Systems were in place to obtain consent from patients before carrying out a procedure or providing treatment. Staff spoke to parents and patients about any care and treatment that they were carrying out before they went ahead with the procedure. Both medical and nursing staff explained clinical procedures in a simple way to patients and waited for approval that the child understood what they said before they continued.
- Staff had a good understanding of the Mental Capacity Act, Deprivation of Liberty and Safeguard across the service. They were aware of appropriate procedures in obtaining consent and used Gillick competencies to ascertain if a child could make their own decisions and understood the implications of treatment. For example staff told us that if a child or parent did not have the capacity to make decisions about their care and treatment they would seek advice from social workers or the person who had guardianship.

Are services for children and young people caring?

Good

Summary

We rated caring as good in services for children and young people because:

- Staff continued to develop trusting relationships with children and their families, as they did in 2014 inspection. Families who we spoke to in 2014 and 2016 inspection told us that their child received care in a compassionate way and that staff adapted their style of care to their child's needs so that they felt relaxed and comfortable. This was supported by the latest friends and family test (FFT) data provided by the trust. In March 2016, 89% of parents or carers recommend the ward to their friends and family. However, it is important to note that the ward only received 41% (44) response rate and were working to improve their FFT uptake.
- We observed children being cared for with dignity and respect, curtains were closed when patients were being assessed, treated or spoken to. Patients and their families were involved in their care and treatment and were encouraged to ask questions. Older children were informed about their care and treatment directly and patients were asked if they understood.
- The needs of families were met by the service through operating flexible visiting hours to allow parents and siblings to visit at any time. Whilst on inspection we saw a parent express their gratitude by giving staff a thank you card and chocolates.
- The emotional needs of children were at the forefront of care, staff worked together to make sure children felt comfortable and were distracted. Play specialists were fundamental to understanding the needs of a child, they often picked up what the child liked and disliked through play. The play specialist was actively present at the nurse's handover so that suitable play could be delivered to each patient. The three children we spoke to were comfortable and parents were appreciative of the activities provided.

- Staff understood the religious beliefs of children and their families; a folder was kept on the ward that contained a description of different religions. Staff used this folder as a reference and referred to it to understand and increase their knowledge of certain customs.

However;

- There was a mixed response from parents regarding the levels of communication between them and the staff regarding their child's care and treatment with 22 incidents relating to communication being reported between 1 September 2015 and 1 February 2016.

Compassionate care

- Care was delivered to children in a caring and compassionate way. We observed patients being treated with dignity, respect and kindness in a timely manner.
- We spoke to three patients who all spoke positively about their care and treatment. One patient was a young person who was aware of and was included in the plan of care, the medical team had decided was best. The patient and their parent were happy with the overall care provided by all the staff and felt confident in the professionals they spoke to.
- Staff expressed compassion and positively spoke about their role. Staff interacted with patients and their families. They adapted their style of caring to the needs and the age of the patient. This was evident during ward round; medical staff bent down to speak to young children and reassured them that the medicine will make them better. Older children were asked questions and told about their care and treatment.
- Curtains were closed around patient's bed areas when staff were providing personal care to protect their dignity. We also saw curtains closed around patients whilst they were sleeping, this was to reduce disturbances of light and sound and maintain privacy.
- Patients and parents were shown where facilities were located on the ward or unit. Four parents told us they felt confident in accessing facilities such as the parent room, play room and the milk expressing area.
- Older children had access to their bedside call bell and parents of younger children were aware of its use. A parent told us she was impressed at the response she received after pressing the call bell during the night, when her child was unwell.
- Both the ward and the neonatal unit had private areas, so that staff could speak to families confidentially.
- The Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. The ward participated in the NHS Friends and Family test; the children's ward achieved a 41% response rate March 2016. The test indicated that 89% of participants would recommend the children's ward.

Understanding and involvement of patients and those close to them.

- There were clear and visible information leaflets near the nurses' station; these were all aimed at adults. There was no information provided to children in a child friendly format to help them make decisions about their care and treatment.
- Older children were involved in their plan of care and setting goals, they were spoken to in a way they understood.
- We spoke to four parents who felt that they had been involved in their child's treatment and were kept up to date with developing care plans. However we spoke to another four parents who all felt that communication was poor and that they were not involved in their child's care plan. One couple said they received conflicting information from staff and thought that medical staff were not always available for questions. The ward and unit reported 22 incidents relating to communication between 1 September 2015 and 1 February 2016. Whilst on inspection, nursing staff informed medical staff that a parent was unhappy with the lack of information and communication. During the morning ward round we observed the registrar inform a parent of the next clinical step.
- Interpreter services were available, for example, whilst on inspection a Lithuanian interpreter was called to help translate information to parents about their child's treatment and care.
- Visiting times were set however staff told us they were flexible with visiting to meet the needs of the patient. One patient we spoke to was looking forward to their family visiting as they were bringing in a take away for them all to eat as a family.
- Parents on the neonatal unit were kept informed about their baby's progress. Parents spoke positively about the

information they received. They were given leaflets to support discussions they had with staff. This was so that they could read and digest the information in their own time.
- Parents of neonates felt supported with their emotional needs, staff made them feel empowered to care for their baby independently. For example parents were encouraged to bathe and feed their baby as part of the care and discharge plan.

Emotional support

- Parents felt confident in the care and treatment their child received on the paediatric ward and mothers of neonates spoke positively about leaving their baby with staff when returning home or to the postnatal ward.
- Staff demonstrated that they understood the importance of providing children and their families with emotional support. We observed staff providing reassurance to anxious children and comfort to relatives. For example the community outreach team were alerted to a child who became anxious and emotionally unstable when visiting the hospital for treatment. Along with clinicians and parents, the team agreed to administer antibiotics at home. Subsequently the child became compliant to taking the antibiotics and happier.
- Children and their families were told about the Chaplaincy centre which included a chapel and a multi-faith room which could be accessed 24/7. The chaplaincy team provided spiritual, religious and pastoral support for patients, visitors and staff when required.
- Staff told us they felt confident with supporting families through bereavement. They received training to help them learn strategies and understand the different stages of bereaving.

Are services for children and young people responsive?

Requires improvement

Summary

We rated the responsiveness of services for children and young people as requires improvement because:

- There had been 46 complaints during the period April 2015 to March 2016 across the Paediatric services. Complaints were not addressed in a timely manner and there was no evidence of learning from complaints. We found that staff were not aware of the top three reasons why people complained about the service. Dissemination of actions from complaints required a more robust process to ensure lessons were learnt in a timely manner.
- Leaflets were available to parents in English but were not available in different languages. Patient information was not in a child friendly format, leaflets were aimed at adults and contained long descriptions of conditions such as bronchiolitis or febrile convulsion. Patients had access to a translator if English was not their first language.
- Children and adolescence mental health service was limited, which often meant that children were not assessed during the weekend. There was a lack of CAHMS support from West Lancashire team out of hours for patients who presented with psychosis or severe intent to self-harm. The ward did not have an isolated room available for CAMHS patients if required but if side rooms were available mental health patients were placed in them after a risk assessment was carried out. However senior managers were aware, side rooms were not always available when the ward was busy and patients would be placed with other patients.
- Children, young people and their families were not engaged with or involved in the development of the service. Children who attended the hospital but were older than 16 years old were directed to Southport and Formby District General Hospital and were placed on an adult ward with no option of being admitted to the children's ward. This included children and young people with learning difficulties or mental health concerns.

However

- The service continued to place children and young people at the centre of the care and clinical practice they delivered. During the 2014 inspection, individual's needs of patients were met and no concerns were raised about accessing the service in a timely way. The ward displayed ways of adapting their practice to help children and their families feel comfortable and reassured.

- Referral to treatment times within 18 weeks were 100% across the paediatric service. This was also noted at the 2014 inspection.
- Children's theatres were located near to the ward; the theatre waiting area was colourful and had a small range of toys for children to play with. The theatre recovery bay was also child friendly with a sea life theme, stickers and mobiles were positioned around the bay to make the area fun and colourful.
- The ward had a wide variety of activities for children and young people to do and the facilities were tailored to specific age groups. Children between 8 and 12 years old had a limited choice of things to play with; they were offered colouring activities but other choices of play were limited. The play specialists were visible from 7am and were utilised on a daily basis; they were especially good at helping clinicians with anxious children and ascertaining information from children through play.
- Clinical and nursing staff were attentive to the requirements of children and their parents. To prevent timely waits in the accident and emergency department, staff were able to move across the different paediatric areas to support colleagues during busy times. The paediatric and surgical paediatric referral to treatment times met the trust target of 85%.
- Specialist teams were in place to provide care and support to patients and their families; these included cystic fibrosis, diabetes and the community children outreach team. The diabetes team had formed a parent group, a social media account to communicate with parents and children and groups to teach children how to independently care for themselves.
- Transition was embedded into practice; the policy detailed a three step plan to ensure children were appropriately transitioned into adult services. All staff we spoke to were aware of their roles when transitioning children, staff liaised with link nurses, medical and nursing staff and the family.
- Facilities for parents were accessible throughout the day, parents of neonates were offered rooming in facilities to help them gain confidence when caring for their baby. The parent room held amenities to make beverages and food and breastfeeding mothers were offered meals.
- The neonatal unit had the option to flexible the number of cots from nine cots to 12 cots depending on the needs of patients and appropriate staffing. Staffing through zero hours contracts ensured appropriate staff availability.

Service planning and delivery to meet the needs of local people

- Children, young people and their families were not engaged with or involved in the development of the service. There was no evidence of children being asked for feedback on provisions such as meal choices or toys in the play room.
- The facilities and premises on the childrens wards and neonatal unit were appropriate for the services that were planned and delivered to children and babies.
- The environment on the paediatric ward was appealing and child friendly; the walls were decorated with well-known children characters and each area contained a collection of books for children between 3 – 8 years old.
- There were a variety of toys available for children between 2-8 years old. Children between 12-16 years old were offered games consoles, DVD'S and board games but whilst on inspection a patient expressed that the console games were dated and the choice was limited. Children between 8 – 12 years old had a limited choice of things to play with, they were offered colouring activities but there weren't many things for them to do. There were two play specialists that worked across the service between 7am and 6pm. The play specialists were available to all patients and often helped clinicians with distraction. A play programme was planned for long term patients to avoid boredom and assess developmental needs in accordance to the Early Years Foundation Years Stage (EYFS) Framework.
- Children who were of a similar age and of the same sex were placed together in the ward if the ward was not busy. This was also promoted by staff at the time of the 2014 inspection.
- The 2014 CQC inspection identified there was no isolated area for CAMHS patients on the ward which could be used to secure children with mental health issues safely. This was still a risk and remained on the risk register. However processes were in place to mitigate risks to the CAHMS patient, staff and other patients. CAHMS patients were placed into side rooms, ligatures were removed and a risk assessment was

carried out. However side rooms were not always available and patients were placed with other patients. Senior managers acknowledged that this was not ideal but if the department became busy, patients would be allocated a bed where one was available.

- Theatres were directly above the children's ward. Children were taken up to theatre via lifts and waited in the waiting area. The cubicle was decorated with animal stickers and kept simple toys to entertain children whilst they waited. The recovery area was also nicely decorated with a sea life theme on the walls and ceiling. The theatre was not separate from adult and obstetric theatres but children were taken to theatre through a separate route, which meant they did not see adults.
- The ward introduced a passport system for patients on the ward who frequently visited due to their complex needs. The passport contained information about the patient's siblings, medication, likes, phobias and admissions. This was given to patients and completed on admission so that so parents would not need to keep explaining their child's needs at every admission. The passport also enabled staff to find all important information about the patient in one area.
- Camp beds were available to parents who stayed overnight with their child. Parents had access to the parents room; this room contained a television, kitchen facilities and a seating area. Children were not allowed in this area however whilst on inspection we found that the room was left open and was accessible to children. The matron had introduced safety cups; these could be brought by parents for £3 and allowed them to take their hot drinks to the patient's bedside. Whilst on inspection we saw two parents request a safety cup and both thought it was a great idea.
- The neonatal unit offered parents "roomin in" facilities in preparation of taking their baby home. Clinical staff supported parents who used the rooms during the night, so that parents felt more confident with looking after their baby prior to discharge. The neonatal unit also had a parent's room with a seating area, a television and kitchen. There were a limited number of informative leaflets in the room, we found the friends and family feedback form but we did not find any information leaflets on topics such as financial support, domestic violence or breastfeeding awareness.
- We found that the neonatal unit had a separate room for mum's to express milk; women were able to close curtains around them for privacy. The unit encouraged mums to breastfeed and express milk. They were offered help and support from breastfeeding coordinators if mums who struggled to express. Meals were provided to breastfeeding mums, and a shop in the hospital was available for visitors to use.
- All areas of the children's service displayed information about parking costs. Parents of children in the hospital were provided with a 'parking token', which reduced the cost of parking at the hospital. The play room was bright and was set up with play each morning. Toys were appropriate for children between 2- 8 years old.

Access and flow

- The outpatient clinic received referrals from the General Practitioners (GP's), Asthma Nurse, Diabetes nurse, epilepsy nurse, community outreach team and the hospital. The 18 week referral to treatment time target had been met.
- To help with the flow of patients in the outpatient clinic, clinicians had the scope to directly admit children who were medically unwell to the paediatric observation and assessment unit, so that they could be cared and treated appropriately.
- The outpatients department had a robust "Do not attend" (DNA) policy. If a child did not attend an appointment, a paediatric liaison referral form was completed and sent to the health visitor. The patient's GP was also informed. A copy of the letter was kept attached to the patient's notes and a decision was made by the doctor to either make another appointment for refer back to the GP.
- To improve the access and flow of patients using the children's services, the service offered children who could be treated at home, treatment in the community. The Community Children's Outreach Team (CCNOT) team accepted referrals from the GP, Alder Hey and Manchester Children's hospital for children who had a Sefton address. The team developed a GP triage form that was completed over the phone. This allowed the GP to inform the team of any concerns and a plan of care was agreed. If a patient was deteriorating the Community Children's Outreach Team (CCNOT) referred patients directly on to the ward. This was to prevent children waiting in A&E and to improve the patient flow. Children who resided in West Lancashire did not have access to the CCNOT service which could prolong their length of stay or admission into hospital.

- Children who required observation for less than 24 hours were admitted to the paediatric observation and assessment unit to help the flow in the paediatric accident and emergency. However some patients were nursed in the ward area if a side room was required.
- The children and young people service reduced their cot capacity to 9 cots on the neonatal unit in April 2015. This included; one intensive care cot, one high dependency cot, and nine special care cots with the option to escalate back up to 12 cots provided staffing was safe. From April 2015 -January 2016 the unit reported 91% of cots were occupied based on 9 cots and 68% based on 12 cots. The use of zero hour staffing combined with the permanent staff enabled the unit to increase staffing where required to flex up to 12 cots.
- In March 2016, the paediatric referral to treatment time (RTT) was (100%) and the RTT for paediatric surgery admitted pathways was 100%.

Meeting people's individual needs

- Children who presented at the children's accident and emergency department but were older than 16 years old were directed to Southport and Formby District General Hospital and were placed on an adult ward. These children had no option of being admitted to the children's ward and included children and young people with learning difficulties or mental health concerns.
- We found information leaflets about services and treatments readily available in English in all areas; however these were all aimed at adults and older children. We did not see any leaflets in any other language or for children younger than 14 years old.
- Translation services and interpreters were available to support patients and their families whose first language was not English. Whilst on inspection an interpreter was called to communicate with parents of a child. Staff knew how to access these services.
- The specialist nurses provided support to children with complex needs, specialist teams such as the diabetes and cystic fibrosis team were based on site which made them accessible for advice and support amongst the wider team and patients. For example the diabetes nurse worked alongside clinicians to tailor care that helped children and parents manage their condition at home.
- We reviewed a robust policy for transition, containing structured transition pathways of paediatrics to adult diabetes, cystic fibrosis and epilepsy. Staff acknowledged that the cognitive and physical development of children with long term conditions differed and understood not all children would be ready for adult services when they turn 16 years old. Therefore the emotional maturity and the state of health of a child were discussed on an individual basis amongst medical staff, nursing staff and parents. The service offered children between 16 and 18 years old to attend transition clinics, the purpose of these clinics was to ensure patients were supported throughout the transition and any questions could be answered. Each child was allocated a key worker (either the Consultant Paediatrician or Nurse Specialist) this person was responsible for coordinating care of delivery. This involved monitoring the health, social, psychological, educational and emotional needs of the child. However the transition process could take more time to establish if the young person had more than one health need.
- The CAMHS Service was delivered by two different councils Sefton and West Lancashire. The CAMHS service provided a Monday to Friday service to complete assessments on the ward and follow ups, for all Children and Young People who had been admitted with mental health concerns. Staff recognised there was a lack of CAHMS support from West Lancashire team out of hours for patients who presented with psychosis or severe intent to self-harm.
- The ward lacked an area for adolescents, the play specialists provided support and activities for the adolescents but there was no area for these children to congregate in.
- The children's play room was spacious and welcoming to children, it offered a wide range of toys and play options for children to choose from. The play specialist attended handover to ascertain an oversight to which patients were for theatre or needed distraction. The play room was set up for play on a daily basis, different areas of the play room was set with different toys, for example whilst on inspection we saw an area set up with a wooden play hospital, another with colouring activities and another with construction toys.
- The ward did not have a sensory room; however we did note that sensory toys were taken to children who needed stimulation. Whilst on inspection we saw sensory toys being used to encourage a baby to use certain muscles.
- Children and their families had access to the chaplaincy team for spiritual and/or religious support.

Services for children and young people

- Patients and their families of different faiths were also told about the multi-faith room. The ward held a folder that contained information about different faiths. This was used as a quick reference point by staff.
- Mothers were encouraged to breastfeed their baby on the neonatal unit and were supported by the breastfeeding link nurse. However mothers who did not wish to breastfeed their baby were provided with specialist pre term formula milk.

Learning from complaints and concerns

- During the last inspection, staff considered arranging a focus group to discuss complaints, however this proved to be difficult to arrange. Since the last inspection, nothing had been put in place to reduce the number of complaints or to support the matron in reviewing complaints in a timely manner. This was evident in the number of complaints that had not been addressed.
- There had been 46 complaints during the period April 2015 to March 2016 across the paediatric services. Complaints were not addressed in a timely manner and there was no evidence of learning from complaints. We found that staff were not aware of the top three reasons why people complained about the service. Dissemination of actions from complaints required a more robust process to ensure lessons were learnt in a timely manner.
- Compliant forms were readily available in all areas of the service. However these forms were not child friendly and were aimed at parents or carers. Any formal complaints were investigated by the matron and discussed in the monthly paediatric risk meetings.

Are services for children and young people well-led?

Good

Summary

We rated services for children and young people as good for being well-led because;

- The children and young people service was well led at local and divisional level. The service vision had developed since the last inspection. However staff were not as familiar with the trust wide vision.
- Senior managers actively reviewed the quality and performance of the ward. Data covered topics such as incidents, sickness rates, hand hygiene audits, and readmission rates on both the neonatal unit and paediatric ward. Ward managers undertook risk assessments to evaluate the workload and followed the escalation process to mitigate potential risks. It was evident that risks were appropriately identified, monitored and actions were set out to sustainable timescales
- The governance framework within the service remained robust; we found that senior managers were clear about their roles and responsibilities in this inspection and in the last inspection.
- Staff received trust wide information through emails and achievements were shared via the trust newsletter and team meetings. The culture within the service was positive; teams often engaged with each other and demonstrated joint working amongst staff nurses and senior managers across all areas. There was a cohesive approach to determining ward activity between medical and nursing staff. The matron actively sought involvement and cross working from teams across the service.
- The operational needs of the service were reviewed by senior managers, it had been identified that the workforce needed increasing because the senior managers believed there would be a shortage of junior doctors in the future. Senior managers had already submitted a business case to employ a further two more Advanced Paediatric Nurse Practitioners.

However,

- There was no evidence of efforts on the part of senior managers and leaders to continually improve the service through public engagement. There was no evidence of actively ascertaining feedback from patients and their families. The service did not have an executive or non-executive lead, and therefore was not represented at board level.

Vision and strategy for this service

- Managers and staff were aware of the children and young people's services vision. However staff were not as familiar with the trust wide vision and mission statement.

- Staff recognised they needed to maintain their focus on building and developing the current service and make sure that the hospital experience consisted of excellent care that was safe and well led.

Governance, risk management and quality measurement

- The service did not have an executive or non-executive lead, and therefore was not represented by anyone at board level.
- Senior clinicians and senior ward staff proactively reviewed the performance of their service; during monthly governance meetings. During these meetings senior managers escalated staffing issues to the executive board.
- The previous inspection reported that senior managers conveyed safeguarding concerns at the trust's safeguarding children steering group meeting. This was still the case in 2016; the meeting was still attended by the named safeguarding doctor, named safeguarding nurse, named safeguarding midwife, clinical leads, matron, health visitors and representatives from social services. The group convened on a monthly basis to discuss a list of matters such as changes to guidelines and safeguarding legislation, training, serious safeguarding incidents and safeguarding audits. Monthly risk meetings were attended by the matron, senior clinicians and service leads; the meeting was used to address any clinical issues such as sickness rates, hand hygiene audits, complaints, incidents and safeguarding updates.
- Clinical leads were able to identify the top three risks to the service; a lack of CAHMS input no secure room for CAHMS patient and lack of community input for West Lancashire CAMHS patients.
- Safety huddles across the childrens service took place twice a day which gave both medical and nursing staff the opportunity to discuss any risks they had about patients on the ward.
- The outpatients department reviewed information such as appointment cancellations and DNA (Did Not Attend) rates regularly.

Leadership of service

- The leadership within children's services reflected the vision and values set out by the senior staff.
- The previous inspection reported effective and committed leadership from senior managers. This had not changed, the local leadership of the ward and the neonatal unit was good and staff spoke positively of it. The children's and young people's service was led by Matron, who was still supported by ward managers. Supervision was visible, and leaders were respected and competent in their roles. Senior managers received a minimum of 7.5 hours of protected management time to support staff. Staff spoke positively of their matrons and clinical leads and told us that their managers and senior leaders were approachable. The Matron was named Nursing Times Inspirational Leader 2015.
- There were clearly defined leadership roles across the children's and young people services. These roles also gave rise to development opportunities, for example band seven nurses were undertaking leadership training, and they were supervised and supported by ward managers.
- Safeguarding clinical lead and a named nurse for vulnerable children were visible on the ward. Staff found it helpful that there was a familiar "go to person" on the ward, if they had any safeguarding concerns. Alternatively staff did not hesitate to contact the trust wide safeguarding team if they could not locate the named doctor or nurse.
- There was a clear escalation processes in place when assessing staffing levels and staff were aware of how to do this. The process clearly stated points to consider before escalation, these included reviewing and assessing risks to the unit or the ward. Staff were asked to check the dependency of babies and evaluate their workload.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required. Junior medical staff felt that they had strong leadership and guidance from consultants and the pharmacy department; they were closely monitored and found it easy to discuss concerns with them.

Culture within the service

- The culture on the children's and young people's service was positive, medical and nursing staff were actively engaged with each other. This was evident through our observations. We saw teams communicate effectively when planning a child's care plan.
- Staff we spoke with told us they felt respected and valued. When incidents occurred they felt supported to improve their practice and looked to each other for help and guidance.

- All staff told us they would feel confident raising a concern or issue with their managers. However, there was a disconnect between senior managers and other teams across the trust. For example senior managers were not informed of children attending post-operative clinics alongside adults.

Public engagement

- Staff did not routinely engage with patients and their relatives to gain feedback from them. However the neonatal unit had become part of "neonmates". This was a peer support group for parents & families of neonates, parents used this forum to come together and discuss their neonatal experiences with each other.
- The diabetes service offered parents a face book forum to share experiences with each other and keep up to date with things happening within the service.
- Information on numbers of incidents, complaints and the results of the NHS Friends and Family test were displayed on notice boards in the paediatric A&E department, this was not always visible to patients on the ward. The neonatal unit did not display this information clearly on their unit.
- The children's and young people services participated in the NHS friends and family test, which gave people the opportunity to provide feedback about care and treatment they received whilst using the service. However there was no children friendly way of ascertaining feedback from children about the service.

Staff engagement

- Staff participated in team meetings across the children's and young people services. Staff told us they received support and regular communication from their managers and felt involved in forming the service.
- The service and trust engaged with staff via email and newsletters and those who achieved 100% attendance received "thank you" letters from the Chief Executive. General information and correspondence was displayed on notice boards in staff rooms

Governance, risk management and quality measurement

- There was a robust governance framework within children's and young people services. 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, managers regularly reviewed, updated and escalated the risks on these registers. There were action plans in place to address the identified risks. We reviewed action plans; they were detailed and suitable timescales were set against them. There were systems in place that allowed managers to escalate risks to trust board level but without an executive representative this was at times difficult.
- Audit and monitoring of key processes took place across the ward to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives and they cascaded this to the ward through performance dashboards and meetings.
- There was a regular clinical governance meeting held within children and young people services and we saw minutes from this meeting.

Innovation, improvement and sustainability

- Staff were enthusiastic and willing to develop their service to improve the care they offered children and their families. For example the community outreach team who were based on the ward, contacted General Practitioners (GPs) from North Sefton. By doing this they increased their awareness and understanding of pathways and referral methods. By doing this they worked towards reducing hospital attendance or admissions. The community team was also looking at ways to expand their service for CCNOT for the West Lancashire patients.
- Clinical leads had recognised the need to upskill staff to cannulate patients in their absence. Staff on the neonatal unit were being retrained to cannulate babies to help with the flow and care of patients. This was so that nurses could carry out cannulations when doctors were busy treating patients to prevent delays. The service recognised the need to plan for the future workforce whilst acknowledging that there may be a reduction in junior doctors. Clinical leads had already submitted a business case to employ two more Advanced Paediatric Nurse Practitioners.

Outpatients and diagnostic imaging

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

Information about the service

Ormskirk Hospital is situated in a small university town in West Lancashire and offers outpatient and diagnostic services to approximately 250,000 population from Southport, Sefton, Formby and West Lancashire.

The general outpatients department at Ormskirk hosts approximately 18 different speciality clinics along with other ambulatory care services. These include Ophthalmology, Ear Nose and Throat (ENT), Trauma & Orthopaedic, Dermatology, Maxillofacial, Pre-Operative assessment and Diabetes clinics. Approximately 25,000 patients visit these hospital departments each year.

The radiology department at Ormskirk provides x-ray services for adults and children along with X-ray Computerised Tomography (CT), obstetric and non-obstetric ultrasound and mammography imaging. Combined with Southport Hospital, 18,000 x-rays, 8,000 CT, 14,000 obstetric and 8,800 non-obstetric images and 750 mammograms were performed annually.

Most clinics were open from 8am to 5pm Monday to Friday, though some also offered early evening and weekend appointments. Radiology offered a 24 hour service to the urgent care and Accident and Emergency (A&E) departments and late night and weekend appointments for non-urgent investigations.

Most clinics were on the ground floor of the hospital. They were well sign-posted and had easy access from the car park.

We visited the outpatients and diagnostics departments during the announced inspection between the 12 and 15 April 2016 and the unannounced inspection 29 April 2016. During our visits, we spoke with 31 staff and nine patients and their relatives. We visited general outpatients, dermatology, Eye/ENT, fracture, maxillofacial, dental and pain clinic. We inspected X-ray, CT and ultrasound. We looked at the care and treatment records for five patients. We gathered information at a 'share your experience' event in the main entrance prior to the inspection. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Outpatients and diagnostic imaging

Summary of findings

The hospital was previously inspected by the Care Quality Commission in November 2014 and outpatients and diagnostic imaging received a good rating across the domains. At this inspection, the rating remained the same and the outpatients and diagnostics departments received a rating of 'good' for being safe, caring, responsive and well-led (effective is not rated under the current guidance).

At this inspection, we found the hospital performed well against national targets. Waiting times for appointments were better than average with 50% of patients receiving an appointment within five weeks of referral. Radiology figures were excellent for both receiving appointments and results. In the last 12 months, less than 1% of patients waited six weeks for a radiology appointment. There were a large number of appointment cancellations that had a variety of causes including IT issues, patients received multiple appointments in error. However, managers were gathering evidence and had set improvement targets.

A large number of audits were performed to ensure patients received treatment in line with best practice guidance and there was evidence of collaborative working with neighbourhood trusts.

Staff were positively encouraged to further their education and gave us examples of courses and qualifications gained within their speciality. Some areas of mandatory training showed poor results and managers acknowledged that work was needed.

When something went wrong, the outpatients and diagnostic departments responded well to patients and investigated the causes to make sure errors did not reoccur.

Patients had positive opinions about the hospital and a recent survey of 86 people gave the hospital an overall rating of 4.4 out of 5.

The outpatient improvement project was still progressing from 2014; changes had been made to the environment, clinical coding and staffing ratios. Phase four had been suspended due to staffing issues, which was to address the high cancellation numbers.

Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatient and diagnostic services good in the safe domain because:

- Staff knew how and when to raise concerns and report incidents. The few serious incidents that had occurred had been dealt with well. Information had been shared, analysis completed and any lessons learnt disseminated to staff. Regular safety monitoring was performed.
- All areas were visibly clean, tidy and free from hazards. Staff had excellent hand hygiene records. Facilities staff had regular cleaning schedules to follow, but documentary evidence was not available at the time of the inspection.
- Equipment was regularly serviced and repaired by a third party provider. Regular appropriate safety checks were performed including radiology equipment, ophthalmic lasers and phototherapy booths and their most recent report had been satisfactory.
- Medicines were stored safely and were prescribed and used within current guidance. Resuscitation trolleys stocked and checked according to trust policy and were available if required.
- Staff training was comprehensive and included safeguarding vulnerable adults and children. The target of 90% compliance was met. Annual mandatory training figures showed that 95% of staff were up to date.
- Staffing levels were sufficient to keep people safe because steps had been taken to ensure adequate levels were maintained. A third party company was being used for additional diagnostic reporting, above the capacity of the radiologists in post. There were two full time radiologist vacancies.
- We saw plans readily available on the trust intranet to ensure peoples' safety during a range of possible adverse incidents.

However:

- We found one out of date medicine during the inspection.
- Staff safeguarding children level two training was below target at 61% and basic life support training was only 76%.

- There were shortages of staff in the physiotherapy departments and ultrasound area of radiology. Clinics were maintained with a combination of overtime and agency working. This did not compromise patient safety, but was not ideal.

Incidents

- The hospital provided an electronic system for recording incidents and staff were able to identify what type of incidents they would report and how to access and use the system.
- In March 2015, the dermatology department recorded a serious incident relating to control of infection. The department followed the duty of candour policy and informed patients who potentially had been affected. Analysis of the issue took place and actions were taken. Actions included the introduction of dermatology WHO (World Health Organisation) surgical safety checklist (which aims to decrease errors and increase communication in any theatre setting). In October 2015, an audit of the checklist was undertaken and full assurance given. We sampled some of the checklists from surgeries and found they were appropriate and fully completed. Staff were aware of the incident and the improved processes showed that lessons had been learned.
- Duty of Candour training had only recently been included in regular mandatory staff training; therefore, only recent new starters had received training. The hospital had sent a global informative email and duty of candour was included in planned care's risk governance notice board. Staff we spoke to were able to explain what was meant by duty of candour and give examples when this may be used. 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.
- Since the last inspection in November 2014, the radiology department at both hospital sites had introduced regular staff meetings to encourage sharing of information and improved learning. Discrepancies were escalated to the assistant medical director and actioned as required. There had been some issues regarding the coding of reports for diagnostic tests. Imaging and reporting had taken place in a timely manner however; the findings of the tests had not been highlighted leading to a delay in treatment. This was being addressed with an active follow up process by radiology. The process meant that important safety information now received the analysis required
- During the inspection, the two available computer radiography readers broke down. This meant that no imaging could be performed at the Ormskirk site until repaired. The engineer was called immediately. Patients waiting were informed by the superintendent and receptionists and offered an alternative appointment or the opportunity to be seen at the Southport department. Clinical departments, such as fracture clinic, were informed of potential delays. The engineer told us that he was unaware of another instance when two readers broke simultaneously. The incident caused a one hour delay. All patients were kept informed and the situation was well managed by radiography and clerical staff.

- **Cleanliness, infection control and hygiene**

- All areas we visited in the outpatients and diagnostics areas were visually clean. There were 'I am clean' paper wraps around equipment in store rooms, Patient areas and store rooms were mainly clutter free.
- The trust provided evidence of cleaning schedules, some completed checklists and curtain changes. Facilities staff had regular cleaning schedules to follow, but we saw no evidence of completed work at the time of the inspection. We requested information and received copies of cleaning schedules from the hospital but not signed, dated documentation.
- Radiology rooms had up to date checklists for cleaning and checking equipment on a daily basis when the room was in use.
- Sanitizing hand gels were visible and in suitable locations, we saw both staff and patients using the gel.
- We saw personal protective equipment available for staff, where required, such as gloves and aprons. Examination couches were covered with clean paper hand sanitizer and wash lotion were available where sinks were used.
- The infection prevention and control team produced a monthly report, which reported performance across both hospital sites. The hand hygiene audits submitted from outpatients, X-ray, fracture, dermatology, ENT/Eye and maxillofacial were all 100% from August 2015 to January 2016. This was confirmed on departmental dashboards. The team also performed unannounced

observational audits, checking staff compliance with the trust's uniform policy of 'bare below the elbows.' There were no reports of non-compliance from any outpatient clinics or diagnostics.

- Staff in the orthodontics and maxillofacial and department changed into hospital scrubs on commencing duty to minimise cross infection.
- A member of nursing staff told us when a patient attended with a known infection risk, such as Methicillin-resistant Staphylococcus aureus (MRSA) they were given the last appointment of the day and the examination room used was subsequently deep cleaned following the appointment. The process was the same in diagnostic areas.
- During glaucoma eye clinics, patients may require the use of a gonioscope to assess their condition. A gonioscope makes contact with a patient's eye and must be cleaned and disinfected after each use. We examined the process for cleaning the instruments. There were different versions of the procedure displayed in the sluice room and in the procedure file. Both were out of date for review. The procedure included preparing three solutions in containers with lids and using the solutions throughout the day to clean, sterilize and rinse the instruments. Multiple use of the solutions could lead to a cross infection and using paper tissues for drying the surface could add paper debris to the gonioscope. We highlighted the concerns to a member of staff who immediately raised the concern with the infection control sister. The process was reviewed and an action plan prepared. A new procedure was subsequently written and had a target date to be introduced as soon as the appropriate cleaning products became available. The department implemented the actions and changes quickly.

- **Environment and equipment**

- All visible electrical equipment was checked for evidence of portable appliance testing and any service due dates. Where stickers were not evident, on larger equipment in radiology for instance, staff assured us with up to date service documentation that ensured the equipment safety and we saw bar coded stickers relating to the servicing of equipment. However, we observed one portable suction machine that had no evidence of testing. The superintendent told us the hospital engineering department would be contacted and the equipment placed out of use immediately.
- The radiology department had a long-term contract with a supplier of imaging equipment to service, maintain and replace equipment on a rolling programme. New dental imaging equipment had recently been installed and commissioned at the time of inspection. There was a range of plain film, Computerised Tomography (CT) Ultrasound and mammography imagers in radiology, which were part of the contract.
- An annual report from Christie Medical Physics and Engineering (CMPE) was presented to the trust radiation protection committee in January 2016. This report covered the period January to December 2015 and detailed all equipment calibration and testing performed for the trust. CMPE is recognised by the Health and Safety Executive as a Radiation Protection Adviser Body under Regulation 13 of The Ionising Radiation Regulations. Equipment in dermatology, ophthalmology and radiology was included as well as personal protective equipment, policies, procedures, and assessment of patient exposure safety. There were four recommendations from this report and all the points had been addressed.
- Because of this report, the lead aprons used had been included on the daily safety checklist. Aprons were examined for cleanliness and damage. If the visual inspection identified damage or areas of concern, the apron would be checked using a mobile fluoroscopy machine and actioned as appropriate. The aprons appeared visibly clean and stored appropriately.
- The radiology department were in the process of replacing their gonad protectors, a specially designed shield used to protect the gonadal area of a patient from the primary radiation beam during radiographic procedures, as they were showing signs of age and starting to split. There was a local agreement in place that protectors were used for all pelvic X-rays of male patients under 70 years of age. Usage compliance was regularly audited.
- Clinic rooms had to be shared between Eye and ENT specialists and large and expensive pieces of equipment had to be moved in and out of rooms when the speciality changed. This posed a risk to wheeled equipment becoming damaged; the staff nurse agreed this was an issue, though no incidents had been reported as a result of the procedure, it was also

important that staff used correct moving and handling techniques. One clinical room was being used to store some equipment when not in use and was quite cluttered.

- Resuscitation equipment was available in outpatient areas and staff knew where their nearest one was located. Daily checks were made on equipment and expiry of medicines. A logbook accompanied each trolley and these were found to be up to date. Daily defibrillator tests were done and oxygen cylinders were checked, dated and stored appropriately.
- In the orthodontic treatment rooms, all equipment was clean, sterile wrapped and appropriately expiry dated. All three treatment rooms were in excellent order, there was no unnecessary equipment on worktops and random checks of cupboard contents revealed everything to be in date.
- Sharps bins that were in use in clinical areas were secured to walls and were safe.
- The utility room in orthodontics was used to store waste waiting for collection following surgical procedures. Red bags, theatre 'used' boxes and sharps were stored separately and safely before removal by hospital porters. The room was clean, tidy and in good order.

- **Medicines**

- During our inspection, we looked at the safe and secure handling of medicines in a variety of clinic and outpatient settings. Medicines were kept locked in secure cupboards and the keys were held by a senior member of staff. None of the clinics we inspected used controlled drugs. Radiology contrast media was securely stored in a key coded room.
- Medicine was supplied to clinics by the hospitals on site pharmacy. Most clinics had a member of pharmacy staff that visited the clinic to check stock quantity and expiry dates and to top up medication, as required.
- We saw prescription pads were kept secure in the fracture and orthodontics clinics and supplied to the doctor as required.
- We saw copies of the medicines optimisation policy for the trust in several departments with procedures for prescribing and risk assessments in place.
- Anaphylaxis kits were available in the CT area of radiology. The kits were made up of injections required should a patient have a contrast induced reaction. A roll up pack of emergency drugs was also kept in orthodontics along with a resuscitation trolley.
- Fridges were located in the general outpatient area and used to store a small range of medicine and dermatology test solutions. Fridges were locked and temperatures were monitored daily to ensure the temperature remained within range. In dermatology we found a Glucagon injection that had been short dated by pharmacy, the new expiry information had not been placed over the original and the dermatology staff were unaware that the item had expired. Pharmacy were contacted immediately and a replacement was brought to the outpatients while we were still present.
- There was evidence of monitoring individual patient's medication safety within the health records we reviewed. Patients were given information leaflets and discussions about side effects had been recorded. Evidence of changes to medication was seen and referrals to biologics nurse specialists noted in dermatology patients notes.
- The dermatology department regularly used liquid nitrogen. Staff told us that the liquid was brought into the department by hospital porters from a centralised store. Small flasks were used in each clinical area, which were appropriate for storage and handling of the product. A Control of Substances Hazardous to Health (COSHH) risk assessment had been done and was seen at the inspection. Staff we asked knew what to do if there was a spill from the flasks.

- **Records**

- Patient's health records were stored on site at the hospital. Clinics requested the records days in advance of a patient's appointment and records clerks in the clinic ensured that the notes were available as required. Clerical staff told us there were very few issues when notes did not arrive prior to the appointment.
- Case notes were systematically being scanned onto an electronic system known as Evolve. Since its introduction, the planned care directorate had seen an improvement in the incidents where case notes were not available for the patient's booked appointment. Monthly audits were undertaken until August 2014 and showed 99.84% of case notes were available at the start of the clinic and 100% received by the end. A decision was taken to record any missing notes on the incident reporting system rather than continue to audit. Between January 2015 and December 2015, there were only

seven incidents of late or missing records reported. Of the seven incidents, all patients were still seen with copies of most recent referrals and results printed, though appointments had been delayed.
- We observed a doctor updating clinical information on the electronic case notes, by dictation, immediately after the patient's appointment. This meant the patient's records were immediately up to date.

- **Safeguarding**

- The trust had a policy for safeguarding which informed staff who the named professionals were that could be contacted for advice. The trust wide target for safeguarding training was 90% for level one and 80% for level two in adults and children. A report from October 2015 stated that the trust was compliant in all areas apart from safeguarding children level two, which was 61% of appropriate staff were trained. E-learning for this training was no longer available and staff must attend a face to face session.
- We found staff were aware of the policy and who to contact if they had safeguarding concerns.
- A WHO safe surgery checklist was in place in the dermatology and the ophthalmology department when patients were to have a minor procedure. This ensured the correct patient was receiving appropriate treatment and had consented to the operation.

- **Mandatory training**

- Comprehensive corporate and local inductions were in place at the hospital for all new starters. Staff were expected to undergo mandatory training within three months of commencing work.
- Mandatory training was delivered face to face and via an e-learning package on the hospital intranet. Learning included health and safety, manual handling, basic resuscitation and infection prevention and recently duty of candour. Subjects were repeated either annually or every two or three years, dependent on the subject area.
- The trust target for completion of mandatory training was 90%. The outpatients and diagnostics departments manage staff attendance locally. At the time of the inspection, 95% were up to date with health and safety training. However, in February 2016 only 76% had undertaken recent Basic Life support training, the manager we asked stated this was being addressed and were told that the database was inaccurate and that the figure was higher.

- **Assessing and responding to patient risk**

- At the last inspection in November 2014, the breast screening service had been suspended following a risk assessment, to ensure patient safety. The issue had been a lack of substantive medical cover. Since then the service was able to perform mammograms for five-year follow up patients and two sessions of up to nine patients were being seen per week with reporting and clinical decisions made by staff at another trust. Results were typically received within 24 to 48 hours.
- Controlled area illuminated warning signs were evident next to all X-ray facilities. Doors had yellow warning signs. Fire exits were clearly marked, break glass alarms and within service date fire extinguishers were examined in the X- ray department
- There were designated staff in each area who were trained to advise on safety. Radiation protection supervisors (RPS) were present in radiology and trained laser protection supervisors (LPS) were employed in the Eye clinic. The radiation protection advisor was external to the trust and staff could access information from them via telephone, email or during the annual inspection.
- In the CT department, the noticeboard provided information regarding the location of the nearest emergency equipment. Flow charts were evident for staff to follow to assess the risk of use of contrast media and how to manage diabetic patients on metformin. Staff were trained to administer anaphylaxis medicine, which is a possible risk to patients following administration of contrast media and trained to intermediate level in life support.
- We asked staff how they would manage a patient whose condition deteriorated during their appointment. Staff were confident in their response and knew how to act appropriately. Staff in both general outpatients and x-ray were able to give us examples of actual events.
- In radiology, we observed a patient being asked if they could be pregnant prior to their procedure. Staff later explained the trust policy and showed us the form signed by the patient. Signs were evident in the waiting room and camera rooms informing patients to let staff know if they may be pregnant.
- In the phototherapy area, a patient's erythema (redness) was assessed throughout their course of treatment. A redness score was recorded and the area assessed prior to subsequent treatments.

Outpatients and diagnostic imaging

- **Nursing staffing**

- The outpatients department was managed by a part time matron and a full time deputy matron. There was a number of nursing sisters responsible for managing areas of speciality, such as ophthalmology or dermatology. A number of outpatient staff had been able to rotate through the department and learn new skills, increasing flexibility in staffing.
- A review of the staffing was being undertaken as part of an outpatient project. At the last inspection, we were told that additional staffing grades were being introduced, this work was still ongoing and the outpatients project plan provided showed target dates were exceeded and many objectives not yet achieved.
- Sickness levels in the general outpatients department was reported as 1.5% for the period February 2015 to January 2016. The sickness/absence rate for radiology staff in the same period was 3%, which was low compared to the trust target of 4.75%
- The expenditure on agency staff during the period February 2015 to January 16 was £312. This low figure was managed by staff covering other roles across both hospital sites and the goodwill of staff working additional shifts.
- There was a challenge recruiting substantive ultra-sonographers. The unit at Ormskirk was staffed with agency workers during the inspection. The department had highlighted a cost improvement potential of £48,000 that had been used for agency staffing.
- There was a shortfall in establishment of physiotherapists reported to us. Across the specialities, over a four-month period, there was an average of 23% vacancies/absences on the established staffing numbers. From 38 whole-time equivalent (WTE) staff, in February 2016 there was a 13.5 WTE shortfall. The largest was from the MCAS where instead of 10.8 staff there were only three in post. Locum staffing and extra hours ensured the service was maintained.
- **Medical staffing**

- Medical staff were present in speciality clinics as necessary. Some clinics were run by consultants from other trusts, or patients were referred to attend other hospitals when a speciality was not offered such as initial breast screening referrals.
- There were 27 medical vacancies throughout the trust including consultants in a number of specialities, namely urology, dermatology and ophthalmology at the time of the inspection. The urology clinic was experiencing appointment delays as they were funded for three additional lower grade urology doctors who were also not in post. A consultant ophthalmologist, urologist and trauma and orthopaedic specialist had been appointed but not yet commenced.
- The radiology department across the trust was challenged with a shortage of two substantive consultant radiologists. This issue had been highlighted on the risk register in 2014 and was still not adequately resolved. Additional reporting radiographers were utilised to report extremity plain film images however, for abdomen and chest x rays and CT reports the department were relying on external third party reporters to make up the shortfall in staff. We were assured that all images had been reported in time for the patients' next appointment even if there were instances where the five-day target was breached.

- **Major incident awareness and training**

- We asked staff what they knew about the hospital's major incident policy. We were assured that staff knew how to access the policy and what role they took in the plans. The general continuity plan was that staff would be utilised at the acute site.
- The superintendent was able to show us the major incident procedure on the intranet along with the Failure of Major Utilities procedure. We asked three staff knew how to access the policies and what to do in the event of an incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effective element of this report is not rated, however; this service demonstrated excellent results in the care and treatment of patients.

- There was a multitude of clinical audits performed in line with best practice and results frequently shared at a regional and national level. Results were monitored to ensure consistency and improvement. Good patient outcomes were evident as a result of assessments and evidence based treatments

Outpatients and diagnostic imaging

- The pain management team demonstrated coordinated care from a range of specialists and had good outcomes
- Education of staff was important to the service and competencies in specialist fields were seen as a priority. Staff were supported to develop their professional skills.
- Many clinics offered a late, evening or Saturday service.
- Care records were in a process of transition to electronic records, some minor incidents had been recorded, but this had not affected appointments or clinical decisions.
- There was evidence in health care records that consent had been sought when required to carry out procedures. Patients had agreed to treatments.

Evidence-based care and treatment

- A large number of audits were in place across the planned care directorate to ensure the care and treatment provided was relevant and current. There was a comprehensive internal audit programme where standards were measured against national guidelines. The trust participated in regional group audits including melanoma, biologics pre-screening and fumaric acid esters audits, and national audits including the National Prostate Cancer Audit and participation in the National Joint Registry (NJR).
- Radiology ensured continued quality and best practice with a number of audits including assessment of CT pulmonary angiograms, reporting accuracy of lung cancers, audit of voice recognition reporting, quality of imaging for neonatal chest x-rays for example. Peer assessment was undertaken among the reporting radiographers.
- Ophthalmology used a version of the World Health Organisation (WHO) surgical checklist to improve patient safety in the perioperative environment. The use and completion of the checklist was sample audited in November 2015 and compared with the previous year's audit. The results gave a significant assurance level.
- We saw a number of standard protocols on display in clinical areas to remind staff of national guidelines and best practice.
- The diagnostic reference levels were monitored and assessed during the annual radiation protection advisor inspection. Discrepancies between sites and equipment were highlighted and discussed.
- **Pain relief**
- We discussed pain relief during our visit to the fracture clinic. The clinic had access to Entonox, a medical gas combining nitrous oxide and oxygen, which was stored in the urgent care centre, should a patient require it during a procedure.
- If oral pain relief were to be given to a patient in the clinic, we were shown the process that the medicine, for example paracetamol or ibuprofen, would be prescribed on an inpatient prescription sheet which would then be attached to the health records prior to administration. The outpatient's nursing sister told us this did not happen often and it was more likely the patient would be given a prescription to take away.
- A team of eleven staff operated a pain management clinic that had approximately 80 outpatient referrals per month. The clinic followed the Faculty of Pain Medicine's Core Standards for Pain Management (2015), by having more than two consultants and a pain specialist nursing sister in the team and holding multi-disciplinary team meetings to discuss individual patient treatments.
- **Patient outcomes**

- The physiotherapy department undertook multiple sclerosis and ear, nose and throat patient audits in order to monitor patient outcomes.
- A service review to evaluate patient satisfaction with the spinal Musculoskeletal Clinical Assessment (MCAS) was in progress, the results would be used to monitor and improve patient outcomes.
- The audiology department was in the development stage, leading towards accreditation with the Improving Quality In Physiological Services (IQIPS) programme. The IQIPS programme is professionally led with the aim of improving service quality, care and safety for patients undergoing physiological diagnostics and treatment. The department at Ormskirk had undertaken a number of self-assessment audits, the most recent being October 2015, where they scored between B and E for the 26 standards with a view to becoming accredited.
- The pain clinic team used an evidence based pain management programme to treat patients, which included therapeutic support groups. A local patient focussed assessment tool was developed to measure outcomes that resulted in an innovation award for the team in 2013.

Outpatients and diagnostic imaging

- The pain team gave an example where therapeutic network support could improve patient outcomes. The development of a choir by, and for, patients demonstrated both qualitative and quantitative benefits for patients.
- The ECG department did not participate in IQIPS, however, the four x Band seven Clinical Physiologist's were all British Society of Echocardiography Accredited and registered with the Royal College of Clinical Physiologists which ensured competency.
- The dermatology department assessed all patients prescribed phototherapy before and after treatment using a quality life audit tool. Patient answers were scored and the figures compared demonstrating that the treatment had a positive benefit to a patient's life. This audit was a recent addition and was yet to be collated but results were good. Psoriasis patients also completed a Psoriasis Epidemiology Screening Tool annually. Scores could determine the onset on psoriatic arthritis and referral to a rheumatologist indicated.
- We saw evidence in team meeting minutes that patient quality issues including waiting times were discussed and actions included where possible.
- **Competent staff**

- All trust staff were expected to have a regular annual personal development review in line with trust policy. The trust target was 90% and data for January 2016 ranged between 87.5% and 100% across the divisions. Dermatology was 87.5% but showed an improving picture over the previous 12 months.
- Four dermatology nursing staff had minor operations theatre training and attended a phototherapy training course in Glasgow, which was a three day examinable course.
- The trust supported radiographers to complete the reporting radiographer qualifications. This allowed radiographers to interpret plain film x ray images and report conclusions. Three staff currently worked as reporting radiographers. The staff were supported to attend national study days and remain competent using e-learning packages
- Radiographers were supported with continued professional development . We saw a file that contained a comprehensive, varied number of certificates including radiation protection updates, information governance and dementia workshops.
- We spoke with the radiology clinical tutor who was responsible for staff education on both hospital sites. She was responsible for student radiographers and as such attended a 'Preparing to Teach course' herself. Staff in radiology were encouraged to learn and attend the UK Radiological Congress, an annual three day conference.
- Radiography students told us they wished to continue their career at Southport and Ormskirk hospitals as they had opportunities to develop in technical areas such as CT or Magnetic resonance imaging (MRI).
- Nursing and dental staff in maxillofacial and orthodontics departments regularly rotated between sections so that all staff had up to date practice experience.
- **Multidisciplinary working**

- There were many examples of multidisciplinary team working within outpatients and diagnostic services for example the cancer pathway group and the pain management team meetings. Staff told us there were good working relationships across teams at Ormskirk. Staff rotated within outpatient teams and felt part of the hospital, not just their area. Training was facilitated to allow staff to work across specialities.
- The hospital employed specialist nurses to provide nurse led clinics in a number of areas.
- The phototherapy team met every two months. There was a review of the quality folder and individual patients were discussed. Waiting times and future planning were also regular agenda items. Meetings included doctors and nurses involved in the patient's treatment.
- The pain management team had weekly educational and case conference sessions, monthly performance and operational meetings, and half-yearly service strategy afternoons. These included psychologists, physiotherapists, physician, occupational therapist, nurse, pharmacist, therapy assistants and clerical support.
- **Seven-day services**

- Many specialities incorporated waiting time initiative clinics into their schedule. Late night and Saturday morning appointments were available to reduce waiting lists and provide access to appointments. A specialist nurse told us they had been employed for eight years and there had always been additional clinics that were staffed on a voluntary basis as overtime.

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- The physiotherapy department regularly operated clinics until 8pm to allow greater flexibility for patients who worked.
- Diagnostic services were available seven days per week. Outpatient appointments were available for non-urgent plain film imaging six days per week.
- **Access to information**

- All staff had access to the most current policies and procedures via the trust intranet, which could be accessed at any computer terminal.
- We saw evidence in health care records of information being shared between specialities caring for an individual. Referrals to other professionals had taken place and responses received.
- All diagnostic images were reported in time for the patient's next appointment, which meant there were no delays in treatment decisions. This was achieved by using external reporting providers and radiologists working additional hours.
- The radiology department were in regular contact with referring general practitioners (GP's) to ensure current practices and information was known. The service did not have an electronic communication service with referring GP's and patients had to access appointments either by phone or in person. Imaging and reporting details were shared including current patient attendance numbers and number of patients who did not attend their appointment. GP's were also informed of any future known delays in service, for example during holiday periods.
- **Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

- All staff we spoke with had a good understanding of when consent would be sought, and were able to explain guidance from the Mental Capacity Act. We were shown a copy of the Best Interest Decision Record and given an example when this might be used.
- At the time of inspection, approximately 60% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, as they had been a recent addition to mandatory training. Staff knew who to contact to seek advice.
- There was evidence in patients' health care records that consent to treatment had been gained prior to commencing phototherapy treatment in the dermatology department. Consent prior to minor operations had also been received.

Are outpatient and diagnostic imaging services caring?

Good

We rated the outpatients and diagnostic services as Good for caring because:

- During the inspection, we saw staff interacting with patients in a caring and compassion manner. The service had a relaxed but efficient atmosphere and staff made time for patients. We heard staff offering patients' drinks during their wait and saw a patient bring a thank you card to the department.
- The dermatology department monitored the emotional effects of a patients' condition rather than just the clinical improvements. We inspected health care records and saw evidence of staff counselling patients repeatedly over a series of appointments when the patient required emotional support for their condition.
- Eighty-six patients were recently surveyed and rated the outpatients department 4.6 out of five for care and compassion. However, we did speak to two some patients who were unhappy with their care.
- **Compassionate care**

- The environment in the outpatient department ensured that patient's privacy and dignity was maintained. The large reception ensured that conversations with receptionist were not overheard. Patients were directed to the appropriate seating area nearest to the clinician's room.
- We witnessed a patient attending for a X-ray computed tomography (CT) study. The patient was uncomfortable and the staff performing the test were sensitive to this. The staff were considerate but efficient and treated the patient with compassion.
- Despite being busy, we observed the reception staff in radiology interacting with patients in a kind and caring manner. Patients' identity and demographics were checked and clear directions and waiting times were given. Staff made an effort to make eye contact with patients and not just their carers and the clerk left her chair to speak directly to a patient in a wheelchair.
- We saw a patient in fracture clinic being offered a drink while waiting for hospital transport to return home following an appointment.

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- We saw a patient bring a thank you card to the phototherapy staff. The patient had completed a 24 treatment course and the card said "thank you for taking such good care of me, I will miss you."
- We received feedback via our Share Your Experience event where two patients reported that two different doctors had been abrupt and lacked compassion. One patient told us this had prompted a complaint.
- **Understanding and involvement of patients and those close to them**

- We saw an instance in a set of health records where a patient had been counselled in their condition and treatments available over a number of appointments. The notes stated the patient was confused and unsure of treatments and side effects. Several specialists had been involved in the patient's care and provision of information leaflets and other advice was documented.
- We saw information regarding a change in medical staffing displayed on a whiteboard outside an outpatient clinic.
- Two patients we spoke to said they had been given sufficient information about their treatment options and given contact information for the clinic if they had further concerns.
- The patient experience survey undertaken by Healthwatch Lancashire stated that of 86 people surveyed, the helpful information received scored 4.4 out of five.
- Whilst visiting the outpatients department we spoke to a patient waiting for a urology appointment. The patient had waited over half an hour, and had not been informed there was only one doctor in clinic and the waiting time was approximately one hour. A trolley with cold drinks was available but none of the patients had not been offered anything. There were also long delays for dermatology but the patients had been informed.
- **Emotional support**

- Dermatology staff regularly monitored a patient's well-being using a Life Quality questionnaire. The survey included ten practical and emotional questions about how the skin problem had affected their life. Staff explained that the survey produced a score and the patient would repeat the test throughout their course of treatment.
- We saw a number of quiet rooms available for patients receiving bad news or were anxious about their appointment. Staff said they utilised the rooms for patients with special needs and sought privacy.
- A survey by Healthwatch Lancashire had taken place in October 2015. A number of patients visiting outpatient services and x-ray had been questioned. From 86 patients the hospital scored 4.6 out of five for staff care and compassion.
- NHS Friends and family feedback forms were visible in clinic waiting areas; however, no information was supplied regarding outpatients comments, however we spoke to a number of patients who were happy with the care they received.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the service as good for being responsive to patient's needs because:

- Services were planned with thought for the needs of local people. Many outpatient clinics were available on both hospital sites for the convenience of patients and had good access once in the hospital.
- The time it took from referral to appointment at Ormskirk hospital was better than the national average. The 18-week target was exceeded and 50% of patients received an appointment within five weeks. Patients have a legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.
- All national cancer targets were also met by the hospital.
- In radiology, 99% of patients received their appointments within 6 weeks of referral. This was better than the national target.
- Outpatient and radiology facilities were good. Areas were clean and bright. Patients were informed of waiting times for appointments and refreshments often available if patients had a long wait. The needs of different people were considered and accessibility was good. Hearing loops and interpreters were available, if needed. Patient information was available in large print, other languages and on-line.

- Staff explained that usually patients who were unhappy with the service would discuss their issues informally at the time. If the problem could not be resolved and the person wished to make a formal complaint the staff provided details of how to do this. We saw information regarding the Patient Advisory Liaison Service in many clinical areas. The number of complaints received was low and we found that they all had been appropriately managed.

However:

- There was no transport service between sites, which patients told us could lead to difficulties with multiple appointments.
- There were a high number of cancelled appointments recorded by the trust. This was something the management were aware of and a piece of work was planned to look at causes and make improvements

Service planning and delivery to meet the needs of local people

- Many outpatient clinics were available in both Ormskirk and Southport hospital sites, which offered patients a degree of flexibility in terms of where they preferred to attend.
- There were 18 speciality clinics available at Ormskirk. Services were assessed and planned to meet local population demands. However, the dermatology department only operated from the Ormskirk site. This was considered an advantage in terms of the team being in one location but meant the space was restricted and patients had to wait in the main outpatients for their appointment. There was no transport link between the two hospital sites. This was a disadvantage for patients who had multiple appointments. Three staff who had cross-site roles mentioned this issue.
- At Ormskirk hospital, the outpatient areas were all well sign posted and easily accessed on the ground floor, apart from the pain clinic and maxillofacial clinic on the first floor with stair and lift access. The entrance led directly from the ground level car park and an attendant was available to assist patients with mobility problems. Wheelchairs were available in the entrance if required. Areas were uncluttered and free from trip hazards.
- The radiology department waiting area was spacious and visibly clean. There were separate areas for each imaging speciality and a separate children's area. A water fountain was available for patients and relatives.
- The fracture clinic was a small area with a small number seats provided for the number of patients seen, during the inspection, we saw people standing in the waiting area. Space was restricted for patients in wheelchairs and we were told that patients in beds had to be taken into a clinical room straight away, as the space was so restrictive.
- The Eye/ ENT clinics had a separate area to the general outpatients with a large waiting room and central reception desk. The waiting area was clean and uncluttered, but older and more dated décor than the main outpatient area.
- The outpatient waiting area had undergone a redesign in recent years. There were specific coloured seats outside each clinic door within the open plan room and a centralised reception with good distance for privacy. Some of the chairs were fitted with arms and single separate seats were available for patients with mobility difficulties. Some of the rows of chairs were positioned so that the patients had their back to the examination room door; we observed some confusion with patients who were unsure where to sit.
- Waiting areas were bright and airy but most had no windows or natural light. Some treatment areas had windows that were not clean and a patient garden was available but, during the inspection, we saw no signs to access the garden or anyone doing so.
- Seven large television screens had been installed in the main outpatient waiting area. The matron explained that these should enable specific information to be displayed along with the current clinic wait time. This is an enhancement on using hand written whiteboards; however, since their installation there had been a problem with the IT in that all screens displayed the same waiting time, which was inappropriate when there were up to seven different clinics running simultaneously. During the inspection the screens displayed 30 minute wait time even when there were no delays and on our return the screens were all switched off and patients were informed by staff how long they could expect to wait.
- In the orthodontics and maxillofacial clinic there was a white board displaying times for each speciality, the

maximum wait displayed was 30 minutes. The department had a kitchen so that staff could make hot drinks for themselves and any patients or relatives who had a long wait.

- The audiology area was brightly decorated for paediatric patients attending for hearing tests. The plain film x-ray rooms had a Starlight distraction box containing toys to entertain a child during a procedure. We were told these were cleaned regularly and the cleaning schedule supplied to us, stated 'when necessary'.
- The dermatology clinic was accessed from the main outpatients area and patients used the large waiting room until called through. The clinic was busy at every visit during the inspection and waiting patients were not visible from within the clinic area. The reception desk in dermatology was poorly lit with no natural light and was not used as a reception for patients.
- The UV phototherapy room had a planned date for refurbishment of July 2016. The two fifteen year old machines were being replaced and the area refurbished to accommodate two new UVA full body cabinets within separate rooms so that both lamps could be used at the same time. This will reduce the waiting list for the PUVA treatment, which was 12 weeks. At the time of inspection, the two cabinets were side by side and a room previously used for bath PUVA was utilised as a changing room allowing only one patient to be treated at any time. Considerations had been made for patients currently on a course of treatment and alternative plans for patients while the facility was under construction
- The radiology department was also well signposted, with cartoon skeletons at low height for children to follow and on the ground floor. The waiting areas were segregated dependent on speciality required and a separate carpeted children's area was available with an activity board, television with DVD, a games console and a selection of children's books. Staff told us that the radiology domestic regularly cleaned the toys and children's area, the schedule stated cleaned when necessary. Toys were visibly clean
- We were told that patients who were unusually delayed would have their car park charges waived. We saw this in radiology when the CR reader failed and appointments had to be rearranged.
- An audit had taken place over a two-month period, November and December 2014, examining the factors affecting efficiency of the CT department during the day. Three particular issues were found to cause delays and a plan was developed to reduce the issues.
- **Access and flow**

- Almost 200,000 appointments were made at Ormskirk Hospital between September 2014 and August 2015 according to Hospital Episode Statistics. The number of patients who did not attend was similar to the national average. In several departments, we were told of methods used to improve the numbers of patients not attending.
- Waiting times for suspected and diagnosed cancer patients at Southport and Ormskirk were better than the national average. The urgent two- week referral target, the 31 and 62 day targets were all exceeded.
- The incomplete referral to treatment targets for England is that 92% of patients have an appointment within 18 weeks. At Ormskirk, 50% of patients were seen within five weeks and 92% were seen within 15 weeks at the end of April 2016. The trust performed better than the England average for 2015 for incomplete patient pathways. Targets were met by waiting time initiative clinics, in addition to planned clinics run by staff over their normal working hours.
- Diagnostic waiting times for the hospital were excellent. For all tests, across both hospitals for the last 12 months, less than 1% of patients waited six weeks for an appointment. This is much better than the national average of 2%. In X-ray, CT, MRI, ultrasound, Electrocardiogram (ECG), Audiology, Dexa scans and gastroscopy, no patients waited more than six weeks for an appointment. The only tests that required any wait was Urodynamics and Cytoscopy due to staffing issues. However, all patients were given an appointment within 10 weeks.
- According to the Hospital Episode Statistics supplied, ten per cent of outpatient appointments at Ormskirk were cancelled by the hospital. . We asked for clarification regarding numbers and reasons for cancelled appointments, and were told that between July 15 and April 16, twenty-two clinics had been either cancelled or reduced due to doctors required to cover wards. This was due to vacancies, either locums not turning up or no success in filling shifts and gaps in trainee rota. Fifteen of these were in March 2016.

Outpatients and diagnostic imaging

- Work had been undertaken to identify the causes of the cancellations as part of the outpatient project. It was found that a large number were due to IT errors, for example a patient had received duplicated appointments and therefore one cancelled. Some were due to lack of medical cover as annual leave and study leave had not been coordinated. The deputy matron explained that project work was ongoing to improve the efficiency and targets had been set.
- The radiology receptionists were proactive regarding cancellations. The staff explained that they call patients on the diagnostic waiting lists, for example bone density tests, to fill appointment spaces made by cancellations. Efforts were made to see patients who attended the department with a referral but no appointment.
- Staff in X-ray mentioned that patients were often anxious to be seen quickly so that they do not incur car park charges, which were free for first 20 minutes. The radiographer said this was often achieved.
- The length of time a patient waited once they had arrived in clinic was not regularly recorded, however during our visit we saw a range of waiting times, with some patients being seen immediately and some waiting up to one hour.
- The dermatology team had managed a 20% increase in patient numbers over the previous 12 months and had continued to meet national 18-week targets. We saw evidence of continuous learning and improved practices despite the pressure on the department to manage the workload. Improvements to the phototherapy facilities were due to begin and staff had planned this well, so that there was little disruption to treatment.
- **Meeting people's individual needs**
- Patients attending outpatients for the first time were always given a longer appointment time in order to make assessments and to allow the patient to ask questions.
- We saw patient information leaflets readily available throughout the areas we visited. Information regarding specific conditions was available along with additional contacts and assistance information such as Macmillan advice. Trust leaflets gave details of how to access the information in other languages.
- Services had been planned to allow access to clinics for patients with individualised needs. Hearing loops were available to assist people with hearing difficulties. Wheelchair access was good and there were additional load bearing beds that could accommodate larger patients.
- We were told of a patient initiative in the CT department. Patients who required a head CT as part of a diagnosis of dementia were offered an appointment on a Saturday morning. This allowed the patient to attend a less busy hospital and was more convenient for relatives to accompany the visit.
- Staff had arranged for a light installation to be installed in the ceiling in the CT room. This was a good distraction aide for patients who needed to remain still for long durations during their study.
- Changing rooms and toilets in radiology were clean and spacious. Facilities for children, for example nappy changing and potties were available. There were several double width changing facilities that allowed access for wheelchairs and were fitted with alarms if the patient got into difficulty. A patient did tell us that the toilet facilities in the main dining area did not accommodate wheelchairs. The nearest toilet available was a considerable distance away near the main entrance. This was confirmed with a permanent notice in the dining room.
- The receptionist told us that the outpatients department utilised an interpreter service for patients attending clinics. Telephone interpretation services were also available but only used in situations that could not be pre-planned. Location specific information was not provided
- The CT department had a service level agreement with another trust to provide head CT studies for patients with memory loss. The patients were seen on a Saturday morning so that the department was less busy, patients with the same condition were seen at the same time and relatives could accompany the patient more easily out of normal working hours. This decreased any anxieties the patients may have.
- There was a four- month wait for phototherapy at the time of the inspection due to the planned down time for refurbishment. However, we noted a three-month wait in patients' health records prior to the improvements. The service was only providing morning appointments. During the inspection, 24 patients received treatment in a four hour clinic session. There were plans to expand the service to try to meet demand.

Outpatients and diagnostic imaging

- Prescriptions were dispensed by an onsite-outsourced supplier. The average turnaround time for prescriptions between April 2015 and March 2016 was 7.78 minutes.
- Pain management patients who required no further input from the service were offered an open appointment, which enabled self-referral for flair management rather than discharge.
- In the radiology waiting area there was a range of information leaflets that explained procedures and help patients know what to expect. Further information could be sought via a phone number or web address on the leaflets.
- The trust had a website that provided patients with practical information about appointments at the hospital and also additional information about their condition. For example, the Musculoskeletal Clinical Assessment Service (MCAS) provided links to websites that provided self-help information for specific conditions such as whiplash or ligament strains.
- **Learning from complaints and concerns**
- We saw information leaflets in several locations that offered guidance on how to make a complaint and who to contact if unhappy with the service.
- We saw evidence in team meetings that incidents and complaints were discussed with staff in order to learn from experiences and improve service delivery.
- Numbers of complaints were visible on outpatient dashboards and were regularly monitored and assessed by management teams. There were 25 complaints recorded between February 2015 and January 2016. Seven of these related to staff attitude/behaviour and six were related to clinical treatment. Issues and themes were identified and the number of complaints over the 12 month period had decreased.
- A radiographer gave us an example where she had received a complaint from a parent after having refused to X-ray their child's arm. The procedure was not justified with regard to radiation exposure as the child demonstrated full movement and was pain free. Having discussed the issue with the parent they were in agreement with the staff involved.
- The hospital had a PALS team who were the main contact for the patient or relative who wished to complain.

Are outpatient and diagnostic imaging services well-led?

Good

We rated outpatient and diagnostic imaging services as good for well-led because:

- A lengthy programme of improvement was underway at the time of the inspection. Results were evident with better facilities and good referral rates, further phases of improvement were planned. There were well-defined objectives and plans in place for improving quality.
- Local level leaders had a good understanding of factors affecting the performance of the directorate and quality was assured with regular monitoring.
- Staff were complimentary about their managers and had good relationships and communication with the heads of department. Safety huddles within teams ensured good communication.
- Staff engagement was good, with regular surveys and involvement in projects along with awards for recognition of service. Continuous learning was promoted and staff felt supported to continue their education.

However:

- The outpatient improvement project was behind schedule, staffing restructures and appointment cancellations had not been addressed.
- **Vision and strategy for this service**
- The general outpatient's team had a project for improvement that had been ongoing since April 2014. The project had seen some improvements to access and flow but still had not reached stage four of the plans due to staffing issues. The matrons were passionate about the project and were striving to make improvements. The environment, clinical coding and staff skill mix was continuing. Stage four of the plan was to reduce cancelled appointments.
- At local level, the staff were conscientious and were proud of the care they provided. However, there was little knowledge of the strategy and future vision of the hospital. The lack of information regarding the future trust board was evident. Managers were focussed on the team and the service they provided.

Outpatients and diagnostic imaging

- Strategies were seen with analysis of services and potential direction of the planned care directorate. These had been developed by the management team to provide a sustainable service.
- There was a poster on the reception wall in the eye clinic that displayed the 'Outpatient Department Philosophy'. We asked staff if they were involved in creating the philosophy and were told it had been there a very long time. There was no name, date or trust information on the poster proving its ownership.
- **Governance, risk management and quality measurement**

- Since the last inspection in November 2014, the radiology department at both hospital sites had introduced regular staff meetings to encourage sharing of information and improve learning. Subsequently discrepancies were fed back to the assistant Medical Director and actioned as required.
- Risk assessments were recorded on the trust risk register. Equipment that was unique or old was identified and assessed for its impact on patient care should the equipment fail. The impact of reduced staffing numbers and effects on patient care was also assessed and recorded on the register.
- There was an effective governance framework in place at directorate level and there was a clear definition of roles and accountability.
- Service performance was measured using dashboards and actions were taken to improve performance.
- There were working arrangements in place with third party providers in radiology regarding service and maintenance of equipment and reporting radiologists. Providers were used that assured quality and met service level agreements.
- Quality was assured with many regular clinical and internal audits performed. Audits compared against national standards and followed best practice guidance. Safety standards were monitored and policies and procedures in place to ensure continuity.
- Some hard copies of procedures that were seen were noted to be out of date. The infection prevention department produced monthly audit data, which highlighted any issues across the hospital.
- We saw the documentation required for ensuring safety and quality whilst providing phototherapy. Quality control, servicing, external quality assurance and risk assessments had all been undertaken. The annual CMPE report from January 2016 stated, "No action required", assuring good practice.
- **Leadership of service**

- Staff told us that the managers were visible and approachable. They felt supported and able to speak to line managers easily. Senior staff were always available for advice and guidance including the Directorate Manager.
- We saw an example of adaptations being made to accommodate staff to continue employment with a disability. The department had been assessed for accessibility and job roles adapted. Options for flexible working, and working from home had been discussed
- We examined the nurse staffing structure with regard to roles and responsibilities and found that there was some disparity. Staff confirmed that there was line management of staff with higher grades than the manager. We asked for confirmation and job descriptions but were given information to the contrary. Job descriptions were requested but not supplied. This issue may have been addressed if the improvement project had been completed.
- Staff were complimentary about the leadership in radiology. They felt that positive changes had been made to the service in the last 12 months.
- **Culture within the service**

- All staff told us they felt supported and valued as team members. Receptionists told us they did not feel isolated in clinics and were supported by their administration manager, who was easy to contact.
- Cross-site culture was good and all staff reported there was good collaborative working, staff were happy to move between hospital teams, though regular cross site workers complained of commuting and parking issues.
- In the 2015 NHS Staff survey the trust performed poorly with nine positive findings and 14 negative findings. However, the planned care management team met and created an action plan to address the issues within their directorate.
- **Public engagement**

Outpatients and diagnostic imaging

- The outpatient department took part in the Healthwatch Lancashire survey in October 2015. Eighty-six patients from various locations within the hospital gave comments on what they thought of the care provided.
- The radiology department had the 'You said we did' initiatives in place that were established in the treatment centre and were something the outpatient department were considering.
- The friends and family comment cards and post box were in evidence in the outpatient waiting area. We were told that comments were regularly collected and the information passed to management: however, we discussed with the deputy matron who told us the comment cards had only recently been reinstated and no data had been collected.
- **Staff engagement**
- We saw evidence of safety huddles being completed within departments in the outpatients. This is a gathering of staff at the beginning of a shift to discuss concerns and actions for the day. A template was completed so that the details were recorded for later staff shifts. The huddle included relevant safety information about patients, families and the work environment. The huddle form completed in fracture clinic included the X-ray down time due to equipment failure.
- A project called Scope for Change had begun in July 2015. One thousand staff had participated in workshops to understand what staff wanted to change. Five topics were chosen and teams engaged to work on the changes. Regular electronic updates were sent to staff demonstrating the improvements. The first five projects chosen were; value and respect, time to recruit, car parking, career development and mandatory training.
- Trust staff participated in the NHS Staff survey annually.
- The trust held staff awards for recognising teams and individuals who had done exceptional work. We were told of several nominations of staff from outpatients and diagnostics since the awards began.
- **Innovation, improvement and sustainability**
- The dermatology phototherapy service was in high demand and the need had been recognised. Staff had been trained and the facility improved to ensure greater patient throughput and a sustained service.
- Directorate managers were aware of where services could be improved and extended to meet the needs of the population. Analysis of risks and opportunities had been performed and management teams had a good understanding of strategic issues.
- Southport and Ormskirk hospital teams were involved in the Mersey Cancer Network and regularly participated in regional meetings to ensure the local population were receiving the most up to date treatments possible.
- The pain management team recognised the lack of a patient focused outcome measurement tool, so developed their own. This was modified to be used therapeutically and became known as iGro. The team won a national innovation award in 2013 and are currently developing an electronic application.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Surgery

- The service must ensure that there are sufficient staff in theatre area.
- The service must ensure that that there is a schedule for the replacement of old theatre equipment.
- The service must ensure that the WHO checklist is completed in full on every occasion.
- The service must take action to develop an action plan to reduce the high readmission rate in elective surgery.
- The service must take action to ensure that mortality and morbidity events in surgical services are reported to the trust board.

Outstanding practice and areas for improvement

Medicine

- The service must take action to ensure that all staff have the up to date training they require to be able to safety care and treat patients in line with trust policy.
- The service must ensure that all records relating to patients are kept securely.
- The service must ensure that there are always sufficient numbers of qualified, competent staff on the ward and ensure there is adequate medical cover to provide the RMO with sufficient time off.
- The service must take action to ensure that any patient who is deemed not to have capacity to consent to remain in hospital and does not wish to do so has a relevant and up to date deprivation of liberty safeguard in place. All actions taken in the patients best interests must be recorded.

Outstanding practice and areas for improvement

Maternity and Gynaecology

- The service must take action to ensure that controlled drugs on the labour ward are correctly stored and staff do not have to leave the operating theatre to obtain controlled drugs.
- The second obstetric theatre must be suitable for the purpose for which it is being used.
- The administration area for the community midwives must be fit for the purpose for which it is being used, including provision for **Regulation 10 (1) (a)** ensuring the privacy of a service user when speaking on the telephone and between professionals.

Childrens

- The service must ensure that all clinical pathways are up to date and reflect current standards and guidance.
- The service must ensure complaints are dealt with robustly and in a timely manner.

Action the hospital SHOULD take to improve

Urgent and Emergency Services

- Ensure action plans following CEM audits target areas of poor performance and improve practice.
- Ensure the PED contributes to ensuring monthly mortality meetings take place when instigated by the main ED.
- Ensure the PED contributes to the main ED task of ensuring action plans following CEM audits target areas of poor performance and improve practice.
- Ensure steps are taken to provide continued support for WLHC staff going through the tender process.
- Work to ensure staffing levels are safe in the WLHC.
- Improve training where there are pockets of low compliance in both medical and nursing staff, to ensure levels meet the trust target.
- Surgical services should use service user complaints to drive service improvements.

Outstanding practice and areas for improvement

Surgery

- The service should review the necessity of lengthy suspensions of clinical staff during disciplinary investigations.

Medicine

- The service should consider is the use of a regular formal process of monitoring the performance of each ward by senior staff to ensure ward quality standards and that staff are compliant with all necessary policies and procedures. For example, a daily/weekly matron checklist.
- The service should consider more appropriate areas for storage of equipment on the ward and review the equipment needs of the service.
- The service should consider improvements in seven day services to provide an equitable service throughout the week.
- The service should provide staff with a clear vision and strategy of the direction of the trust, and all senior managers should be visible and approachable to all staff.
- The service should consider making leaflets and literature available to all patients on the ward.

Outstanding practice and areas for improvement

Outpatients and Diagnostic services

- The trust should ensure that staffing levels are sufficient and recruit medical consultants, radiologists and ultra-sonographers in line with substantive numbers.
- Procedure documentation should be accurate and reviewed in a timely manner, and ensure all appropriate staff are aware of procedural changes.
- Liaise with pharmacy to develop a robust system for highlighting short dated drugs and replacement when expired.
- Ensure that outpatient and diagnostic staff numbers reach trust target figures for Basic Life support, Mental Capacity Act, Derivation of Liberty Safeguards and Duty of Candour training.
- Consider investment in an electronic communication system between GP services and radiology in line with the rest of Merseyside and Cheshire, to improve referrals, appointments and report accuracy and timeliness.
- Ensure continuation of the outpatient improvement project and:
  - Review roles and job descriptions so that senior staff are performing appropriate roles and clinical staff are graded to match the role performed.
  - The cancellation of appointments project continues and reaches the targets of improvement defined.
  - Consider improving the IT system to enable the waiting time screens to work effectively.
- Consider introducing visible cleaning checklists so that all staff and visitors have assurance that cleaning has been completed.

Maternity

- The service should ensure all emergency equipment is checked in line with the trusts' policy.
- The service should ensure all identified actions to mitigate the risks to patients of delays in obtaining blood products are in place.
- The service should ensure community midwives have timely access to patient information including safeguarding information.
- The service should ensure all midwives should be up to date with their annual appraisals.
- The service should ensure specialist midwives are available to provide support to patients with specific needs.
- The service should consider improving the environment for bereaved patients.
- The service should consider improving the facilities for partners to remain with the patient.
- The service should consider recording the review dates and version control of all policies and procedures.
- The service should consider recording a benchmark against their own targets and national data for all patient outcomes on the maternity dashboard.
- The service should consider recording the waiting times for patients in the maternity admissions suite and auditing this information.
- The service should consider the suitability of the hand held documentation for pregnant patients.

Outstanding practice and areas for improvement

Childrens

- The service should consider improving their CAHMS pathway.
- The service should consider cross departmental working to support clinics where children attend.
- The service should consider appointing an executive to represent them at board level.
- The service should consider children friendly methods of ascertain feedback about their service.
- The service should consider involving children and their families to improve the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18 (1): There was not always sufficient numbers of suitably qualified, competent, skilled and experienced persons on the medical ward deployed to meet the needs of the patients 18 (2a):Not all staff on the medical ward had received appropriate training to enable them to safely care and treat patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2c): Records on the medical ward were not always secure. This was because the record trolley was left unlocked on the ward and nursing assessments were not kept secure. 17 (1)(2)(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; We found that surgical services did not use service user complaints received to drive continuous service improvements. 17(2)(b) HSCA (RA) Regulations 2014 - Good Governance Systems and processes must enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In children's services not all clinical pathways were up to date or reflected current standards and guidance.

This section is primarily information for the provider

Requirement notices

The children's service did not respond to all complaints robustly or in a timely manner.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15(1) All premises and equipment used by the service provider must be- (c) suitable for the purpose for which they are being used. (e) properly maintained In surgical services we found that the plan for replacement theatre equipment had not been implemented. Regulation 15 (1) (c) The second obstetric theatre must be suitable for the purpose for which it is being used. The administration area for the community midwives must be fit for the purpose for which it is being used, including provision for **Regulation 10 (1) (a)** ensuring the privacy of a service user when speaking on the telephone and between professionals.

Regulated activity	Regulation
Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1)(2)(a) assessing the risks to the health and safety of service users of receiving the care or treatment; We found that on two occasions during the inspection the WHO safer surgery checklist was not performed in the recommended way for each point of the pathway. These omissions supported the findings of the service WHO audits, which found that the WHO was completed in full on only 75% of occasions.

This section is primarily information for the provider

Requirement notices

12 (1)

The maternity service must take action to ensure that controlled drugs on the labour ward are correctly stored and staff do not have to leave the operating theatre to obtain controlled drugs.

12 (1)(2)(b) doing all is reasonably practicable to mitigate against any such risks;

In surgical services we found that the risk of re-admission for elective orthopaedic procedures was significantly worse than the national average.

12 (1)(2)(c) ensuring that persons providing care or treatment to services users have the qualifications, competence, skills and experience to do so safely;

In surgical services we found that the high level of vacancies in theatres meant that the service was relying on high numbers agency and bank staff to provide a service in theatres.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (5)** The maternity service must take action to ensure that any patient who is deemed not to have capacity to consent to remain in hospital and does not wish to do so has a relevant and up to date deprivation of liberty safeguard in place. All actions taken in the patients best interests must be recorded.