Southport and Ormskirk NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

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

The trust had two registered locations, Southport and Formby District General Hospital and Ormskirk District General Hospital. They provided the following regulated activities:

- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Family planning services
- Management and supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
From April 2016 to March 2017 the trust had 50,773 inpatient admissions and 389,019 outpatient attendances. The trust had 137,380 A&E attendances, 2,237 deliveries and 935 deaths during the same time period. The trust had approximately 2,500 staff at the time of our inspection.

Please note the A&E attendances shown above include attendances at the trust’s walk-in centre. At the time of this inspection a different provider operated the walk-in centre so figures quoted in the remainder of this appendix exclude the walk-in centre attendances.

**Is this organisation well-led?**

**Leadership**

Since our last inspection the trust’s leadership team had undergone regular changes to executive leaders. This had led to a lack of stability and remained the case at the time of our inspection, with both the chief executive and director of nursing and midwifery both leaving imminently. The substantive medical director was excluded from the trust and the interim medical director, who was on planned absence, was due to leave the trust without returning to work.

Whilst most leaders had the skills and abilities to provide high quality services, key roles were interim, which affected the pace and capability to progress improvements in care provided. The trust had recognised concerns with succession planning and this was entered onto the risk register. However, at the time of our inspection, plans to address this were in their infancy. Since our last inspection in April 2016 the trust has had:

- Five interim chief executives.
- A medical director excluded and four interim medical directors.
- A director of nursing and midwifery appointed in October 2016 (leaving March 2018).
- A new associate director of human resources appointed in June 2017.
- A chief operating officer appointed in October 2016.

At the time of our inspection we were also told that:

- The chief executive would be leaving her post in January 2018.
- The deputy medical director will be standing down from his post in January 2018.
- The deputy director of nursing had gone on unplanned absence.
- The director of finance would be off for six weeks on unplanned absence.
- The interim medical director was scheduled to leave in December 2017.

Members of the trust leadership team told us there was no succession planning in place. There was limited identification of the training needs of managers at all levels, including themselves and opportunities were missed to provide development opportunities for the future of the organisation. At the time of our inspection, job plans were not in place, which would have allowed senior leaders
to identify how many of each type of staff member were needed for a specific service. Whilst leaders understood the challenges to quality and sustainability, plans to identify the actions needed to address them were either not available or in their infancy.

During our inspection staff told us that the chief executive and director of nursing and midwifery were visible. Service leads identified that they saw the chief operating officer. During our core service inspections some staff in clinical areas confirmed they had seen the board members, but this was not consistent with a notable difference at the Ormskirk site where staff told us they were less visible. We observed the director of nursing and midwifery and chief operating officer in clinical areas at Southport during the inspection. The exclusion of the substantive medical director and absence of the interim medical director at the time of the inspection had impacted on medical leadership. Doctors advised us that engagement with them was “haphazard” and there was limited clinical leadership above middle management level. Whilst staff all acknowledged there had been improvements in the working relationship between the nursing clinical lead and business units, medical staff advised us that there was poor engagement with board members.

At the time of our inspection, the chief pharmacist role had been put on hold, but we were informed approval had recently been agreed and the post was to be filled imminently. This will help improve the structure, stability and accountability of the pharmacy leadership team at both the Southport and Ormskirk sites. During the interim period the deputy chief pharmacist had deputised with support from senior staff.

During the inspection, staff were not able to provide evidence of clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There was no leadership strategy, development programme or evidence of succession planning. A risk was added to the trust’s risk register in September 2016, highlighting that if the trust did ‘not develop a recruitment and retention strategy for doctors and nurses, it will be reliant on agency staff, which could potentially compromise patient safety and contribute to the financial deficit.’ At the board meeting in July 2017, it was identified that the review of leadership development had been completed. This review concluded that whilst a significant number of staff have accessed a range of development initiatives, both delivered locally and through the NHS Leadership Academy, the approach had been inconsistent, with limited impact. The benefit of a clear strategy linked to a system of talent management was emphasised. However, at the time of our inspection in December 2017, the strategy had not been completed and senior staff told us there was still significant work to be undertaken.

At the last inspection, we identified concerns in relation to the trust’s assurance processes for complying with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5: fit and proper persons: directors. The concerns related to the correct application of the trust’s own policy and related to the robustness and consistency of the process. At this inspection we identified similar concerns. None of the non-executive directors had any references on file. We reviewed all of the directors’ personnel files. Two of the interim directors did not have complete files of the information required as outlined in the trust’s policy and required by legislation. This meant that the trust could not ensure that people who had director level responsibility for the quality and safety of care, and for meeting the fundamental standards, were fit and proper to carry out these important roles.
Vision and strategy

At the time of our inspection, the trust did not have a vision in place. Senior staff gave different messages regarding the trust’s vision. However, all senior staff outlined that identifying a sustainable future was a key priority for the trust. The values were re-launched during the week of our inspection (originally introduced in 2013). During our core service inspections, we found a lack of consistency in staff members’ awareness of the trust’s values for use in relation to their daily roles. This meant that work in this area was not effectively embedded and was not at the heart of all the work within the organisation.

The trust did not have a current strategy. The trust had identified that the previous strategy (from July 2014 to July 2017) did not produce the intended outcomes. This was recognised in the trust’s data submission to us for this inspection (submitted July 2017). In October 2017, at the board meeting, the importance of a new strategy was emphasised. However, at the time of our inspection, a strategy had not been agreed and approved. Senior staff told us that discussions around creation of a long-term strategy with partner organisations and stakeholders were very much in their infancy. The trust’s own ‘well-led review’ (November 2017) highlighted the need to develop, implement, embed and review the strategic plan. During our core service inspections we did not find evidence of strategic and annual plans for all service pathways.

Senior leaders told us plans to engage with staff and patients were in development. This represented a risk, which was highlighted on the trust’s risk register, that could affect the trust’s capability to deliver high quality, sustainable care, because staff may become disengaged and leave. The trust also needed to develop, implement and embed an operational plan.

The trust’s Medicines Optimisation Strategy 2014 - 2016 had set a number of strategic objectives. However, several of these had not been achieved due to financial and leadership constraints. Areas of limited progress include: implementation of a seven day clinical pharmacy service, improving medicines reconciliation rates, implementation of electronic prescribing and administration and improved medicines fridge facilities. The medicines optimisation strategy also identified that no detailed financial analysis of the trust medicines optimisation and pharmacy service had been carried out.

The trust did not have a communication and engagement strategy. The staff survey (2016) highlighted the trust was performing worse than the England average for the number of staff reporting good communication between senior management and staff (20% compared to the England average of 32%). This indicated there were communication issues, which were highlighted during our core service inspections. At the core services inspections, we found staff were unclear if the trust had a current strategy. There were mixed awareness levels of the trust’s values and variable understanding of them.

Culture

Staff satisfaction was mixed. Improving the culture or staff satisfaction was not seen as a high priority. Staff did not always feel actively engaged or empowered. We found there were teams working in silos and management and clinicians did not always work cohesively. Staff told us that they did not always feel confident to raise concerns or they felt that they were not always taken seriously. Staff told us that responses to concerns were not received in a timely way. Equality and diversity was not consistently promoted and the causes of workforce inequality were not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably. Board members
recognised that they had work to do to improve diversity and equality across the trust and at board level.

**Sickness levels**

The trust’s sickness levels from June 2016 to May 2017 were consistently higher than the England average. Sickness levels followed a similar trend to the England average with lower levels over the summer months and an increase in levels over the winter.

![Sickness level graph](graph.png)

(Source: NHS Digital)

**NHS Staff Survey (2016) Performance on questions relating to bullying, harassment and equal opportunities**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question – Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

The percentage difference between the responses of white and BME for question 17b was significantly significant. It was not significantly different for the other three questions.
Since our last inspection, the trust has had an external cultural review. The content of this was embargoed whilst a further investigation is completed. In August and September 2017, the National Guardian’s Office conducted a review of the speaking up processes, policies and culture at Southport and Ormskirk NHS Trust. This was because it had received information that the trust’s response to its workers speaking up was not in accordance with good practice. The findings are outlined in their report. In summary they found:

- Evidence of a longstanding culture where the trust did not respond appropriately to specific and serious concerns raise by its workers.
- Significant evidence of a bullying culture within the trust where staff were too afraid to speak up, or they alleged detriment at the hands of their colleagues for having done so.
- Failure of the trust to meet its responsibilities regarding equality and diversity, resulting in black and ethnic minority staff not feeling free to speak up,
- No specific training for staff on either how to speak up, or for managers to handle concerns raised according to the policies and procedures of the trust,
- Persistent failure by the trust to feedback to staff regarding any actions it had taken in response to workers’ speaking up, creating a widespread belief among staff that the trust did not take their concerns seriously.
- Since appointing a Freedom to Speak Up Guardian in August 2016, the trust had not provided all the necessary resources to support the role, including adequately promoting it across trust sites.
- The trust did not have a systematic approach to measure the effectiveness of its speaking up policies, procedures and culture.
- Many workers regarded most of the trust’s senior leaders as invisible and inaccessible.
The National Guardian’s Office made twenty-two recommendations to the trust. We will monitor the trust’s performance against these recommendations over the next twelve months. At the time of our inspection, plans for the freedom to speak up guardian role were in their infancy and the action plan to address these recommendations was being developed. Senior staff were developing an equality, diversity and inclusion strategy and an action plan to address progress. At the time of our inspection, the associate director of human resources had board level lead accountability for equality and diversity and a non-executive director also acted as an equality champion. Below board level, the trust did not have an equality and diversity lead, the post having been vacant for two years.

**Governance**

The trust had a governance structure, but the systems for reporting to the board were not fully established. This meant that there was limited oversight of issues facing the service. Whilst there had been improvements in the monitoring of quality and safety across the trust, systems were still relatively new, which meant that improvement was difficult to assess. The board reviewed performance reports that included data about the services, which divisional leads could challenge. During our inspection, we observed two trust board meetings. We were concerned about the effectiveness of the board, as we felt that during our observations there was insufficient challenge and explanation regarding key issues.

Since our last inspection (April 2016), a board assurance escalation policy had been introduced in November 2016. The trust had used the policy to help them develop a ‘floor to board’ governance structure and had introduced committees (Remunerations and Nominations; Audit Committee; Finance Performance and Investment Committee; Quality and Safety Committee; Workforce and Organisational Development Committee; and Mortality Assurance and Clinical Improvement Committee) to support this. The chief operating officer had introduced a ‘triangle’ arrangement for the management of each clinical business unit. This consisted of an associate director of operations, an associate medical director and head of nursing, who were all responsible for quality and safety.

Following introduction of the board assurance escalation policy, the director of nursing and midwifery commissioned an external governance review in March 2017. The review outlined:

- A cumbersome governance framework with multiple formal and informal committees and groups and relationships and accountability structures were not clear.
- Confusion on the roles of the committee’s, particularly the quality and safety committee (Q&SC) and Performance Management and Finance Committee (PMF).
- Senior staff from the clinical business units were unclear who attended the meetings and none of them had attended it.

The review’s report concluded that:

- There appeared to be a disconnect between clinical and corporate services.
- The accountability and reporting framework between clinical business units, sub board committees and trust board was not clear and did not seem to be aligned across the organisation.
- There were inconsistent governance practices across all four clinical business units and corporate teams, leading to a lack of process and information to trust board.
• The system would lead to inconsistency of information and scrutiny on quality and safety of services and missed opportunities for lessons to be learned.

• There were varying practices of governance and levels of understanding on what is required at both corporate and clinical business unit levels.

• There were some gaps in skills and knowledge required to fulfil the clinical governance function within corporate and clinical business unit teams.

The external governance review was presented to the board, after being reviewed by the quality and safety committee, in June 2017. Trust staff told us monthly clinical business unit quality and safety reports were introduced, which reported through the meeting structures, with the aim of providing assurance that quality and safe services were being delivered and maintained.

At our inspection, we found that governance systems were in their infancy. There was inconsistency across divisions. For example, we reviewed the incident reporting policy; the content did not reflect an open policy in line with the Duty of Candour, a regulatory requirement for trusts’ staff to be open and honest. It did not refer to engaging with the patient’s family or sharing investigation findings in accordance with best practice. We reviewed a random sample of 11 incidents resulting in moderate and significant harm. The root cause analysis reports varied in the quality, depth and level of investigations, depending on the business unit that had completed them. We found high quality root cause analysis reports in Specialist Services. We saw no evidence that indicated that these were shared to develop other areas.

In the moderate and serious incident investigations reviewed, not all of the failings in care were identified. There was limited attention to causal factors being a root cause. This meant action to prevent recurrence was not robust. For example, in relation to one incident, we found some of the root causes were identified, but others were missed. The investigation failed to address the patient’s capacity or the care delivery issues. The root cause identified specifically related to the use of a falls bundle. However, it did not encompass any other forms of assessment, such as mental capacity.

With the exception of Specialist Services, the spirit of duty of candour was not fully applied as only apology letters were sent in nine of the 11 incidents we reviewed. There was limited evidence of involvement or engagement with patients and their families. Action plans to ensure learning occurred as a result of the incidents did not always have specific, measurable, agreed upon, realistic and time-based outcomes. For example, in the incident referenced above, the recommendation was ‘ensure falls bundle used effectively’ with an action of ‘discussion at meeting’. This meant there was no evidence of ward level action for nursing staff or follow up to measure achievement of this action. We found that good practice was not widespread or shared. This highlighted the infancy of governance structures and evidenced that opportunities to share learning across the trust were frequently missed.

We reviewed the trust’s policies and procedures. At the time of our inspection we found that 29% (31 out of 106) of the clinical policies were past their review dates by between 12 and 632 days. Policies that were over 12 months out of date included application of the WHO checklist,
management of clinical diagnostics and the purchasing for safety policy. We also found that 30% (26 out of 88) corporate policies were out of date for review, 56% (15 out of 27) of human resources policies were out of date for review and 75% (three out of four) of infection control policies were out of date for review. We discussed this issue with the trust and were informed that staff were aware the policies were past their review dates. We were provided with a ‘trust policy review spreadsheet’. However, this did not include all the policies that were past the review date. The spreadsheet identified that the review dates had been extended for the 35 policies listed on it, which predominantly related to human resources. This gave us limited assurance that the trust board had oversight of this issue and the actions taken to address it, as the review document did not include details of all the policies.

We reviewed the quality and safety committee meeting minutes from July, September and October 2017. The minutes showed that the April, June, July, September and October meetings had gone ahead. In August no meeting was scheduled. The meeting in May had been stood down. We reviewed attendance at all the meetings. We identified varying attendance from board members. We found no evidence of involvement from the clinical business units, even though the governance review highlighted the benefits of this.

Prior to, during and after our inspection, we reviewed information the trust used, including reports the board used for assurance. We found large quantities of information that was not consistent, effectively analysed or provided in a timely way to ensure committees could be truly effective. We found no evidence of an integrated performance report, which resulted in staff being required to read large volumes of information that was not always consistent. Senior leaders were aware of this issue, but effective steps to address this were not in place at the time of our inspection. However, initial steps had been taken to address these issues.

The trust’s response was reactive not proactive. For example, following our last inspection the trust developed a CQC action plan. Senior staff told us that this action plan was used to drive changes. Rather than putting internal systems and processes in place that would help the trust identify and address the issues identified in the last inspection report, focus was placed on the specific issues and how to address them individually. Board members had different understanding of the use of the term ‘complete’ and change in status to green within action plans. We established that the marking of an action as ‘complete’ meant the initial actions to address the issue we had previously identified was complete. We found limited evidence of audits to ensure there was focus on sustained improvement and to ensure that changes became embedded. This was highlighted during our core services’ inspections and at provider level, where recurrent regulatory breaches were identified.

Steps to address the trust’s reactive approach had started to be undertaken, but were in their infancy. For example, at the December 2017 board meeting, the director of nursing and midwifery presented a quality improvement plan and strategy. The plan detailed the measurements the trust would use to drive improvements. The aim of the strategy was to enable small teams to implement continuous improvements in their clinical areas. At the board meeting, one of the non-executive directors identified that a delivery timeline, detailing milestones and deadlines, was missing from the strategy, without which it would not be possible to measure success. It was agreed that further
work would be undertaken on the strategy and plan, including revised control measures and increased differentiation between the strategy and plan.

At the time of our inspection, the trust had six non-executive directors that had been recruited by NHS Improvement. Three of the non-executive directors had commenced their roles in September 2017, the remaining non-executives having started in December 2015, February 2016 and May 2016. We found that the non-executive directors were clear on their roles. As a group, the non-executive directors had a good oversight of the challenges the trust was facing. During the board meetings we observed some challenge to executive directors, but this was not consistent from all non-executive directors.

During our inspection we noted that staff within services were starting to familiarise themselves with the recently introduced governance systems. For example, as a result of the new systems and processes, in November 2017 an incident relating to wrong site surgery that had occurred in July 2017 was identified, reported and investigated. The Drug and Therapeutics Committee oversaw medicines optimisation and safety for the trust. The Medicines Safety Committee had a clearly defined role and directly reported into the Drug and Therapeutics Committee, so any learning from incidents or risks was disseminated to clinical staff and managers. However, doctor and nursing attendance at the Medicines Safety Committee had not been consistent and it was recognised that this should be improved.

The trust had in place a service level agreement with a local mental health provider to ensure there was a psychiatric liaison service. The risk register contained risks relating to mental health provision. At the time of our inspection, plans were in place for the local mental health provider to have a base room at the trust. However, during our core services’ inspections we identified trust-wide concerns in relation to the application of the Deprivation of Liberty Safeguards and Mental Capacity Act assessments. We escalated the concerns during our inspection and the trust took immediate action to address this. At our well-led inspection when we reviewed actions taken, areas of the trust had not fully addressed the issues we identified despite their action plan marking them as completed. These included on ward 14, which provided care for elderly patients, where we had concerns in relation to the use of bed rails. The trust’s policy outlined that patients should be asked whether they consented to the use of bed rails when they had capacity. Where issues with capacity were identified, a capacity assessment should be undertaken. If a patient was deemed not to have capacity, a Deprivation of Liberty safeguard referral should be applied for. During the core service’s inspection concerns were escalated to the trust that the correct procedure was not being followed. Bed rails were found in use for patients without capacity, we found no evidence of capacity assessments or Deprivation of Liberty Safeguards in their records. At the well-led inspection we returned to the ward and found that the only patient on the ward without capacity had not had a timely capacity assessment (nine days before it was undertaken) or application for a Deprivation of Liberty safeguard despite being nursed with bed rails since their admission ten days earlier.

The trust did not have a communication and engagement strategy. Senior staff told us that in the past the culture was insular and that engagement with outside organisations had been limited. The senior leadership team had started work with third-party providers to encourage appropriate interaction and to promote coordinated, person centred care. However, this work was very much in
its infancy at the time of our inspection. We did note significant improvement in the relationships between the clinical commission groups safeguarding team and trust leads. Reviews undertaken by Sefton and Lancashire local authorities identified improvements had been made in relation to safeguarding processes.

Management of risk, issues and performance

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. Discussions with staff identified confusion regarding the completion of actions. We also saw that improvements were reactive and focused on short term issues. This was evidenced by the action plan drawn up following the last CQC inspection and for issues identified during the core services’ inspection. The approach to risk management and incident investigation was applied inconsistently. Clinical and internal audit processes had been implemented inconsistently. The sustainable delivery of quality care was put at risk by the financial challenge facing the trust.

At the time of our inspection, the trust’s risk management system was underpinned by four internal controls systems:

- The board assurance framework.
- The extreme risk register (informed by directorates, clinical business units and teams).
- The audit committee.
- The annual governance statement.

We found comprehensive assurance systems were not in place. The board assurance framework is a high level document that records the key risks that could impact on the trust achieving its strategic objectives. This included the impact and consequences together with the gaps in assurances. Actions were meant to be identified for the gaps. At the time of our inspection, we found there were executive leads identified for each of the risks. There was a clear balance of risks between quality, performance and finance.

Senior staff told us that although there was a board assurance framework, this was a ‘work in progress’. We were told that their aim was to make it more robust. The audit committee meeting minutes from November 2017 highlighted work that had been undertaken on the board assurance framework. Improvements made included the addition of dates on action plans, target scores and assurance received. However, further concerns regarding the content of the board assurance framework were outlined in the Finance, Performance and Investment Committee meeting (November 2017). These related to a risk not reflecting the magnitude of the trust’s financial problems and concerns with the narrative content, gaps and assurances. This information was discussed in the December 2017 board meeting. The audit committee advised the board about the importance of undertaking a deep dive exercise into some of the risks on the board assurance framework.

Senior staff explained that they were confident that the ‘extreme risk register’ reflected key risks, that risks would be added and that risks would be periodically reviewed. At the time of our inspection, we found a risk register that represented most of the extreme organisational risks. At
board level we observed that senior staff members’ reviewed the risk register and noted review dates for risks were changed. However, the assurance and controls were not consistently updated. For example, the bed occupancy risk outlined the lack of winter plan for 2017 to 2018 as a gap, but senior staff told us there was a winter plan. There was a plan in place for the finance risk but both actions were out of date. The action for the risk backlog of diabetic patients waiting for eye screening, the controls stated: “a member of staff from [another NHS trust] will commence in SDGH [Southport District General Hospital] from end of October”. Senior staff told us no one from the other NHS trust had started working for the trust. For the management of the safe staffing risk no action plan actions were outlined. Progress in addressing and mitigating the risks identified in the extreme risk register was limited by an insufficient pace of change linked to the continuing change in leadership personnel and undefined strategic direction.

The trust’s ‘CQC action plan’ had been formulated following our last inspection. The action plan had largely been marked as complete and actions moved to green. Board members had different understanding of what ‘complete’ and the green status meant. Some thought this meant actions were complete and the action to address the issue was embedded. However, others told us they understood it meant initial actions had been implemented. During our inspection we found several repeat breaches of the Health and Social Care Act which were identified in our previous inspection (April 2016). The trust’s own systems and processes for monitoring the progress of actions had not identified this. This meant that the performance issues had not been identified and escalated appropriately through clear structures and processes.

The audit committee met quarterly, with an additional meeting in December 2017, and reported to the board using alert, advise and assure reports known in the trust as triple A reports. The audit committee meeting alert, advise and assure reports also went to the relevant governance committee and also the bi-monthly clinical audit leads meeting. At public board, alert, advise and assure exception reports were provided. These reports provided some assurance regarding current organisational risks. However, they were dependent on effective meeting summaries being created, escalated and reviewed. At the time of our inspection we found no evidence outlining what summaries were expected to contain. Senior staff told us there was variation in quality depending on the clinical business unit providing the report.

The seven day services programme is designed to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. There are ten clinical standards that define what seven day services should achieve, no matter when or where patients are admitted. With the support of the Academy of Medical Royal Colleges, four of these ten clinical standards are identified as mandated priorities on the basis of their potential to positively affect patient outcomes. At the time of our inspection, not all services across the trust were fully meeting the seven day working standards. Trust staff told us it was unlikely that the trust would achieve full compliance against the four mandated standards by March 2018. This meant that the trust would need to be fully compliant with all the standards by March 2020. Of the four standards, the trust was furthest from the target (90% compliant) in standard two, which related to consultant review within 14 hours of admission. The trust’s gap analysis identified that there was no regular board oversight of this issue and that the objectives for delivery were not in an operational plan. Indication was provided that this would be aligned to the performance management framework. However, minutes of the finance, performance and investment
The committee did not indicate how seven day working was being overseen and addressed. The mortality assurance and clinical improvement committee alert, advise and assure report from September 2017 alerted this risk, but subsequent board papers showed no reference to seven day working or discussion as to how it would be addressed.

The use of alert, advise and assure reports without meeting minutes was queried in the Finance, Performance and Investment Committee (November 2017) and was being reviewed at the time of our inspection.

On inspection, we found that the trust’s audit systems were not robust and worked on reassurance rather than assurance. For example, during this inspection we highlighted new concerns in relation to different core services. At our well-led inspection we revisited the areas where we had been advised that issues had been addressed. Half of the areas still had the same issues recurring, despite the trust’s own action plan showing the actions as completed. Medicines missed dose audits had been carried out, but these were not regular and the last one had been completed over a year ago. A number of recommendations for improvement had been made, but the effectiveness of these had not been assessed due to the delay of the latest audit.

Senior staff told us that audits within the organisation were not focused on critical areas of risk. The audit function was described as ‘reactive’. Senior leaders told us that an area would be audited and an action plan would be created, but the subsequent re-audit often did not happen. This meant that it was difficult for senior leaders to assure themselves that change became embedded and affected the pace of improvement. We saw evidence of this on inspection relating to the actions undertaken in relation to the CQC action plan. At the time of our inspection senior leaders told us that they had recently contacted an external organisation (Advancing Quality Alliance) for advice and to arrange training for staff to improve this area.

We reviewed a range of different action plans and found that different colours were used to identify progress against them. For example, in one post-audit action plan, completed actions were marked in blue, whilst in another post-audit action plan the completed actions were marked in green. The lack of consistency in colouring of actions evidenced that a clear consistent process was not in place at the time of our inspection.

During our inspection we reviewed whether there were systems and processes in place to manage current and future performance. Senior staff told us that historically the delegation of authority and accountability for actions had not been well-managed. Staff told us there was a ‘poor performance framework’ with an absence of ‘delegated accountability’, meaning it was hard to hold people to account for their areas of responsibility. At the time of inspection we found that a framework had been developed and was in its infancy. Senior staff were all aware there was further work to undertake, which included development, implementation, embedding and review of a strategic plan and a quality improvement strategy.

The Hospital Pharmacy Transformation Plan outlined how the pharmacy services in the trust needed to develop and integrate into the local Sustainability and Transformation Plans. It was
recognised there were a number of challenges for the pharmacy service that need to be addressed, including extending the pharmacy service to seven days, improving medicines reconciliation rates and implementing electronic prescribing across the trust. Risks and performance were monitored using the pharmacy key performance indicator dashboard and this was linked to the medicines optimisation strategy and the Hospital Pharmacy Transformation Plan.

At our inspection, all senior staff we spoke with described that changes, including cost improvement programmes, that potentially clinically impacted on patients had to be approved by both the medical director or deputy medical director and the director of nursing and midwifery or her deputy. All staff described this as a significant improvement and felt there were now robust discussions between the clinical and finance teams, which resulted in quality-based decisions that considered the impact on patient outcomes, as well as financial implications. Staff told us that historically this had not happened, as the sole focus had been financial.

At our inspection, we found that the absence of a strategic plan, quality improvement strategy, communication and engagement strategy, workforce and organisational development strategy and integrated performance report was impacting on management of current and future performance. Steps to develop these important items were in their infancy and needed prioritising to help the trust progress.

**Information management**

The trust had recently completed a scoping exercise to identify measurable outcomes to demonstrate change and areas for quality improvement. The trust had begun to produce this information, which was currently being piloted to see whether it provided the correct level of assurance. Required data or notifications were inconsistently submitted to external organisations or were not completed in a timely manner. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not always robust.

Prior to our inspection trust staff told us that they were confident in a high level of data quality but acknowledged that there were still improvements to be made in some areas. The trust installed a new patient administration system in 2014, which covered urgent and emergency care, inpatient and outpatient care. In January 2016, the trust installed a new maternity system and in January 2017 a new community patient administration system was installed for the trust’s joint health service. Trust staff told us that with the introduction of new systems they had seen a reduction in data quality which had required investigation, changes to process and re-training of staff. Trust staff told us that the process had proved to be successful and that at the time of our inspection senior staff were confident in the quality of data for the acute services and maternity services. Trust staff told us that through focused data quality reporting for the joint health service, they had identified areas for improvement. At the time of our inspection, the trust board were working closely with their staff and commissioners on improving this.

At the time of our inspection, we found that senior leaders and the informatics team were working to improve the quality of the information that was available. Staff described a history where large
volumes of data were requested from informatics, but the systems and processes had not ensured that what was requested would actually address the need for information/provide the required content that the requestor wanted. This had resulted in large volumes of information being provided that was not always meaningful and led to staff challenging information as incorrect. Senior staff were candid and told us that the information provided had significantly improved, but was not quite providing the full detail required yet, as there was too much information for a holistic understanding of performance which covered and integrated people’s views with information on quality, operations and finance. All senior staff described there had been significant improvements, particularly in relation to communication between informatics and other staff. This was essential to ensure staff were receiving information of use to them and not just data that did not address their needs. Senior staff were confident they could get any data they required for assurance.

Prior to, during and after our inspection we reviewed information the trust used, including reports the board used for assurance. We found large quantities of information that was not consistent, effectively analysed or provided in a timely way to ensure committees could be truly effective. Senior leaders were aware of this issue, but effective steps to address this were not embedded at the time of our inspection. However, initial steps had been taken to address these issues.

Prior to our inspection, trust staff told us that the trust’s data quality strategy set out clear guidelines on the scope, roles and responsibilities for data quality in the organisation. Data quality was also a key branch of the business intelligence strategy, which formed part of the overall information management and technology strategy for the trust. Data quality was monitored internally through data quality dashboards, which reflected performance aligned to NHS Digital Commissioning Data Sets, which cover core areas of data collection, such as urgent and emergency care, admitted patient care and outpatients. Data quality was monitored against four areas:

- Complete (data is present where required).
- Conforming (correct type of data is used).
- Consistent (data is within expected parameters).
- Contradictory (does not contradict any other part of the complete health record).

This dashboard was monitored by the information department and used to assure, advise or alert any issues to the information governance steering group. The information governance steering group was chaired by the associate medical director and attended by representatives of the clinical business units who had responsibility for data quality in their areas. During our core services inspections, staff told us when issues were found, actions could be taken to correct the data. Staff could also be referred to the electronic patient record team for further systems training.

Data, which was reported externally to NHS Digital, was assessed against a series of quality checks and monitored by data quality dashboards. The reporting mechanisms allowed senior staff in the trust to monitor improvement and completeness for a number of fields over the different commissioning data sets, assess the trust’s data to ensure completeness and compliance with data standards and compare their data to national and regional level data.
At the time of the inspection, we found that the informatics team were starting to work more closely with clinical business units. However, in October 2017 the trust had a significant patient safety issue in relation to the referral to treatment times. The informatics team were aware of relevant information but did not realise the clinical risk associated with this information, so they had not highlighted this using the trust’s internal mechanisms.

The Information Governance Toolkit is an online system, which allows organisations to assess themselves or be assessed against information governance policies and standards. It also allows members of the public to view participating organisations’ information governance toolkit assessments. At the time of our inspection, senior staff told us they had limited assurance regarding the trust’s performance. An action plan was in place to address the concerns, which was due for completion in March 2018.

Medicines prescribing and administration systems were not electronic, so monitoring was not in real time, and notably medicines reconciliation audits were only carried out twice a year. The latest figures showed the trust was significantly short of meeting its medicines reconciliation targets.

We reviewed the trust’s arrangements to ensure that data or notifications are submitted to external bodies. We found delays in reporting incidents on the national reporting system (Strategic Executive Information System). Between 1 December 2016 and 30 November 2017, there were 57 serious incidents reported by the trust. We reviewed when these incidents occurred and the date they were reported. We found that 53% (30 out of 57) of the incidents were reported to the Strategic Executive Information System over 14 days after the incidents occurred; 21% (12 out of 57) were reported between 15-30 days after the incident occurred; 16% (nine out of 57) were reported between 31 days and 60 days; 4% (two out of 57) were reported between 61 and 90 days and 12% (seven out of 57) were reported over 90 days after they had occurred. This included serious incidents that would have been immediately identifiable, for example falls with harm.

During our inspection we observed two trust board meetings. We were concerned about the effectiveness of the board, as we felt that during our observations there was insufficient challenge and explanation regarding key issues. The board committees received a variety of information regarding incidents, including serious incidents. However, as the governance structures had recently been introduced, this was not consistently and effectively embedded and there was varying performance between different clinical business units. Senior staff told us that they were giving attention to the effectiveness of procedures for reporting errors, near misses and incidents and using patient/service user feedback. Senior leaders told us that the trust’s staff had scoped out plans to improve all these areas, but steps to address them had not commenced.

At the time of our inspection, the information technology strategy needed to be embedded. Senior staff told us about investment plans to improve clinical systems. Some of this work was being undertaken internally at the time of our inspection. Senior staff told us about information technology plans to improve the quality of care. These were discussed in relevant board sub-committees and we saw evidence of progress against the plans.
Engagement

There was a limited approach to sharing information with and obtaining the views of others. The trust were not consistent in their communication with patients, staff, the public and local organisations. The trust and divisions did not have their own communication and engagement strategies. In some areas, staff were encouraged to get involved with projects affecting patients. The trust were actively involved with the sustainability and transformation programmes and were aware of potential impacts to services provided. Despite this, the staff we spoke with told us they were not aware of and had not been engaged in these discussions. The service was transparent and open with all relevant stakeholders about performance and the challenges to the system to meet the needs of the population.

During our inspection, senior staff told us that the trust did not have a communication and engagement strategy. Since our last inspection, we found improvements in engagement with staff, patients and stakeholders, but significant work still needed to be undertaken to improve gathering and sharing information with these groups. The trust had recognised the risk in relation to staff engagement and had added it to the risk register.

The trust’s staff had recently developed and launched a ‘Developing the Experience of Care Strategy’ 2017 to 2019. This strategy identified eight pledges for implementation to help focus on patients, carers and families being at the centre of everything they did. The strategy had been approved by the board in May 2017 and launched during carers’ week in July 2017. We found the work surrounding this strategy was in its infancy, but was being positively received.

At inspection we found that the trust considered the views of people in some groups of people who experiences discrimination and inequality most often. The trust held provider forums locally, which met quarterly to highlight partnership working with residential homes and hospital and council services. The trust was a member of both local Alzheimer’s societies. The societies’ members participated in the trust’s dementia strategy meetings. In Ormskirk there was an information board in the outpatients department. The trust was a member of both Sefton and West Lancashire Dementia Action Alliance groups. During carers, week the trust invited someone from Dementia Carer Voices to speak to staff. Trust staff also supported charity fundraising event for the Alzheimer’s Society.

Trust staff told us that they held engagement with People First self-advocacy group to support development of, for example, easy read documents. The trust had worked with students from West Lancashire College, who completed work experience placements at the trust. The trust’s staff also attended the local annual learning disabilities transition event and a regional ‘stopping the over medication of people with learning disabilities’ workshop.

Over the last year, the trust was part of an organ and tissue donation awareness event at a local football club. The trust also marked Holocaust Memorial Day in the trust, with an educational stand for staff and the public. Pharmacy management had recently worked with another local trust and adopted their clinical ward services standard to help improve the quality and consistency of the clinical service provided to the wards by pharmacy. In maternity, staff had worked with patients
and a local college to improve the ward environment. We found that the active engagement with patients for service improvement was dependent on the staff working within an area.

Levels of patients’ and their families’ involvement in investigations depended on the clinical business unit undertaking the investigation. Evidence we reviewed highlighted areas of good practice, but also areas where patients and families were not truly engaged in the process.

Senior staff acknowledged that historically the trust’s relationships were not as effective when engaging with external stakeholders, as they would have liked them to be. Senior staff were working to address this and were actively involved with the sustainability and transformation programmes. They were aware of potential impacts to services provided. However, at the time of our inspection we found that this information was not effectively shared with all staff.

Staff engagement

The trust undertook the NHS staff survey to understand staff engagement and experience. In total 3,368 staff were surveyed cross the trust and 1,646 completed questionnaires were returned from the staff sample; this equated to a response rate of 49%. This compared favourably to the overall national response rate for acute trusts in England, which was 43%. The response to the overall indicator of staff engagement was the ‘Staff Friends and Family test question’, this question looked at staff members’ willingness to recommend the trust as a place to work or receive treatment. The trust scored below (worse than) average compared with all combined acute and community trusts across England. Another area looked at in this survey was staff motivation at work (the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs). This score showed a score of average (no change on 2015).

Senior staff told us that the 2016 staff survey and subsequent board reports and plans had highlighted the areas they needed to focus on to improve the experience of the staff who work in the trust. Senior leaders acknowledged that the trust required significant development input into the weaker areas of staff engagement, communications between staff and senior management and effective team working, along with attention to the effectiveness of procedures for reporting errors, near misses and incidents and using patient/service user feedback. Senior leaders told us that the trust’s staff had scoped out plans to improve all these areas, but steps to address them had not commenced. During our inspection, senior staff told us that not all staff did have email addresses. Plans were in place to address this.

An overview of the 2016 survey went to board in March 2017. Following this, the interim chair asked for an in-depth analysis of the results to ascertain if the 2016 Survey was a consequence of recent events around changes at the trust board or was indicative of previous year’s results. A further report, which included a five year past results overview, went to the board meeting in May 2017. This had amongst its recommendations the formation of an engagement plan for the trust. The plan was scoped, presented to the June 2017 board meeting and was approved.

The question in the survey around staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have
frequent opportunities to show initiative in their role, and are able to make improvements at work) showed a below (worse than) average score compared with all combined acute and community trusts. This was reflected in the findings from the national guardian’s office (outlined above).

During our core service inspections, most staff commented positively about the chief executive’s commitment to improving staff engagement since her arrival at the trust. Senior leaders told us that work had recently been completed on improving the appraisal process.

**NHS Staff Survey Performance**

In the NHS Staff Survey 2016, the trust performed better than other trusts on five questions, about the same as other trusts in five questions and worse than other trusts in 22 questions.

The questions for which the trust performed better than other trusts were:

- KF28 – Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (27% compared to the England average of 29%)
- KF17 – Percentage of staff feeling unwell due to work related stress in last 12 months (32% compared to the England average of 36%)
- KF16 – Percentage of staff working extra hours (66% compared to the England average of 71%)
- KF2 – Staff satisfaction with the quality of work and care they are able to deliver (3.99 compared to the England average of 3.92)
- KF27 – Percentage of staff reporting most recent experience of harassment, bullying or abuse (48% compared to the England average of 45%)

The questions for which the trust performed worse than other trusts were:

- KF12 – Quality of appraisals (2.82 compared to the England average of 3.11)
- KF13 – Quality of non-mandatory training, learning or development (3.99 compared to the England average of 4.07)
- KF20 – Percentage of staff experiencing discrimination at work in last 12 months (12% compared to the England average of 10%)
- KF21 – Percentage of staff believing the organisation provides equal opportunities for career progression or promotion (79% compared to the England average of 87%)
- KF29 – Percentage of staff reporting errors, near misses or incidents witnessed in last month (87% compared to the England average of 91%)
- KF30 – Fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.48 compared to the England average of 3.73)
- KF31 – Staff confidence and security in reporting unsafe clinical practice (3.49 compared to the England average of 3.68)
- KF18 – Percentage of staff attending work in last 3 months despite feeling unwell because they felt pressure (66% compared to the England average of 55%)
- KF15 – Percentage of staff satisfied with the opportunities for flexible working patterns (48% compared to the England average of 51%)
• KF1 – Staff recommendation of the organisation as a place to work or receive treatment (3.49 compared to the England average of 3.71)

• KF7 – Percentage of staff able to contribute towards improvements at work (65% compared to the England average of 71%)

• KF8 – Staff satisfaction with level of responsibility and involvement (3.86 compared to the England average of 3.92)

• KF9 – Effective team working (3.62 compared to the England average of 3.78)

• KF5 – Recognition and value of staff by managers and the organisation (3.28 compared to the England average of 3.47)

• KF6 – Percentage of staff reporting good communication between senior management and staff (20% compared to the England average of 32%)

• KF10 – Support from immediate managers (3.60 compared to the England average of 3.74)

• KF3 – Percentage of staff agreeing that their role makes a difference to patients/service users (90% compared to the England average of 91%)

• KF32 – Effective use of patient/service user feedback (3.41 compared to the England average of 3.68)

• KF22 – Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (15% compared to the England average of 13%)

• KF23 – Percentage of staff experiencing physical violence from staff in last 12 months (3% compared to the England average of 2%)

• KF25 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (31% compared to the England average of 26%)

• KF26 – Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (25% compared to the England average of 23%)

The engagement score for this trust was 3.66, which is worse than the England average of 3.80.

(Source: NHS Staff Survey 2016)

Learning, continuous improvement and innovation

There was no strategic approach to service development improvements. There was limited knowledge and appreciation of improvement methodologies. Improvements were localised and best practice was not being shared across the organisation. The organisation had not identified all the risks, including patient safety risks we identified during our core service inspections. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance or always monitored.

At the time of our inspection, senior staff were prioritising putting essential and consistent systems and processes in place. They acknowledged that there was limited identification of the training needs of managers at all levels, including themselves and that opportunities were missed to provide development opportunities for the future of the organisation. As highlighted above (see
leadership section), there was no leadership strategy, development programme or evidence of succession planning. Whilst the trust recognised this as a risk in September 2016, at the time of our inspection a strategy and plan to address this was not in place. Senior staff told us there was still significant work to be undertaken.

Prior to our inspection the trust’s staff told us they were in the final stages of planning a leadership and management development programme (including board development) that would commence in September 2017. At the time of the inspection, we did not find evidence that this was in place. We found no workforce and organisational development strategy. Staff told us that this required development before it could be implemented.

At the time of our inspection, senior staff acknowledged that there was a ‘gap in terms of service improvement and how to finish things off and check [they were in place] as at [the time or our inspection] the trust weren’t effectively doing this’. Staff within departments were undertaking small initiatives to improve care. The trust team were working using ‘Safe at all times,’ a trust improvement plan that included ward movements, to improve and make services safer.

The trust was developing a frailty hub, in order to stream patients away from the emergency department setting. This was planned to be a multidisciplinary service, including geriatricians, therapists and primary care to consider alternatives to admission to hospital with wraparound access to community and social support. The plan was that, where possible, patients would be discharged back to their original place of residence. The service will also consider how outreach service could be encompassed enhancing quality of the patient journey.

The trust staff told us they had realised in their work across the trust that they responded to requests from departments to help with improvement reactively to address lapses in performance. Although this approach worked in the short term, the trust staff had realised that they needed to identify what their priorities were in relation to improvement, innovation, research and development. The trust was producing a performance development framework that will identify their priorities so that they could put the right resources in place to support the areas of our work that will contribute to real improvement for the trust and its patients. The framework was in development at the time of our inspection.

The trust had plans in place to improve information technology systems to help them have integrated patient care records. The trust had established in September 2017 a mortality assurance committee that reviewed mortality and morbidity. In December 2016, NHS Improvement awarded the trust the most improved trust regarding four hour accident and emergency department performance. The trust had been awarded the Named Lecture Award at the Diabetes UK professional Conference in 2018. This award will be focused on the trust’s ongoing work integrating technology and diabetes within their unit.

The trust had introduced a patient safety associate medical director to oversee and review different patient safety initiatives. At the time of our inspection, innovation was limited, as the trust was focusing on putting essential and consistent systems and processes in place.
The pharmacy service had eight independent pharmacy prescribers that supported medicines optimisation and prescribing at the trust. A recent pilot utilised a pharmacist in accident and emergency to support medical staff in taking drug histories and complete medicines reconciliation. Although this pilot was recognised as valuable, funding was no longer available. A valuable drug library of medicines information had been developed that supported safe medicines administration.
Southport District Hospital

Spinal injuries unit

Facts and data about this service

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

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

The ground floor of the unit houses the reception, offices, meeting rooms, therapy rooms, the gym, swimming pool and a flat, which was used by patients’ families and also to assess the ability of patients to live independently before leaving the facility. The first floor of the building houses the outpatient department (with four consulting rooms), a dayroom for patients and the wards. There are 43 patient beds in total. Nine of these beds are able to be allocated to ventilator dependent patients at any one time though there are ten ventilator-enabled beds in total. Four of the beds are managed by the intermediate community outreach team.

There are nine additional static community beds in three community healthcare settings (two in Southport and one in Preston). In 2016, 62 patients utilised the outreach beds. A further 33 patients utilised the four beds managed by the outreach team in the Spinal Injuries Centre.

From April 2017 to October 2017 there were 80 patients admitted to the unit from the three major trauma units and other referring hospitals and a further 30 patients were admitted through elective or non-elective admissions. From April to October 2017 there were 1095 outpatients seen in the unit, an average of 156 per month. From April to October 2017, a total of 104 patients were discharged from the unit with 32 of these discharges being delayed.

The unit employs specialised and experienced staff, including consultants, specialist doctors, physiotherapists, occupational therapists and psychologists. Case managers oversee each patient’s care and facilitate an appropriate discharge with all relevant equipment and adaptations in place to meet the patient’s rehabilitation needs. The unit aimed to maximise patient independence, regardless of their level of injury.
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. However, statistics provided by the trust showed that the trust’s target of 90% or more staff to have undertaken training modules was not being met by trained staff on the unit in eight out of 11 required modules. However, we saw there had been improvement in completion of mandatory training since the time of the last inspection.

Compliance rates for mandatory training are detailed below for the period 1 July 2016 to 30 June 2017.

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Resolution</td>
<td>97</td>
<td>73</td>
<td>75%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>101</td>
<td>60</td>
<td>59%</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>101</td>
<td>40</td>
<td>40%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>101</td>
<td>70</td>
<td>69%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>101</td>
<td>89</td>
<td>88%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>13</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>90</td>
<td>69</td>
<td>77%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>101</td>
<td>90</td>
<td>89%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>11</td>
<td>10</td>
<td>91%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>90</td>
<td>77</td>
<td>86%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>14</td>
<td>14</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The data provided by the trust in relation to the number of safeguarding referrals made were reported at trust wide level only, so cannot be broken down by core service. The safeguarding training compliance rate was 92.7% for all staff groups across level one safeguarding and 95% across level two safeguarding. Training was undertaken on a three yearly basis. During our inspection we found that the unit had appropriate processes in place to safeguard patients from abuse. There was an escalation process and staff knew where to find policies for safeguarding vulnerable adults and children.

We were shown an example of a safeguarding referral that had been made when a vulnerable
patient who lived in a nursing home was seen as an outpatient in clinic and pressure sores were identified. It had been followed up by a referral to the spinal injuries outreach team who liaised with the nursing home and advised on treatment for the pressure sores.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Cleanliness, infection control and hygiene

The service controlled infection risk though we did observe some lapses in controls on the unit and the service was failing to minimise the risk of the spread of infection.

The unit had one isolation room. If this was occupied, any other patient developing an infection would have to be moved from the unit. At the time of our last inspection staff told us about a proposal to increase the number of isolation rooms on the unit. At this inspection staff told us they were frustrated that this had not been progressed since our last inspection of the unit.

During our inspection we observed that the door to the isolation room was kept open despite it having a patient inside who had an infection. There was no signage to remind people that it was an isolated area and the precautions that should be taken on entering and leaving the room. We observed that dirty laundry was being moved in open trolleys. Staff did not wear disposable aprons when moving dirty laundry.

Clinical areas, offices, corridors and store rooms were visibly clean. At the time of our inspection there was some clutter in ward areas. Floors were covered in a wipeable material (except in the patient dining area), as were chairs and couches. The trust had infection prevention and control policies in place and these were accessible to staff.

Staff on the unit were ‘arms bare below the elbows’ in clinical areas and washed their hands after touching patients. We observed staff were using personal protective equipment (PPE), such as gloves and aprons and changed this equipment between patient contacts, in line with trust policy.
There was adequate access to hand washing sinks and hand gels. Hand gels were available outside the doors. We observed staff using hand gel whilst working on the ward, although we saw staff were not all wearing hand gel toggles with uniforms. Curtains were disposable and clean although there were not dates on all of the curtains to indicate when they had last been changed.

Cleaning schedules were displayed on the ward. However, we saw that the records were not always fully completed. There was a daily and weekly cleaning regime to ensure that wheelchairs, commodes and shower chairs were cleaned after patient use. However, we observed commodes and shower chairs in ward areas not displaying “I am clean” stickers.

**Environment and equipment**

The service did not have suitable premises to ensure that people were kept safe and personal property and equipment was kept protected at all times.

The entire unit was unsecure except out of hours when the doors to the unit from outside were locked. However, the unit could still be accessed from the main hospital. There were no internal security doors and the unit could be accessed by people who had no business there.

Rooms were left unsecured with the doors opened. The high dependency ward was fully accessible to anyone and there were vulnerable patients in there who would have been unable to call out in the event of an intruder. At times, the nurses on the ward were required to attend to patients behind curtains and there was no one to watch the ward or the other patients. This represented an immediate patient safety issue. We escalated this to the trust at the time of our inspection and the trust took immediate action. The gym area was open to the public and was unsupervised for most of the time. Gym users could gain access to the rest of the unit when most administration or therapy staff had gone home.

There was no security door, buzzed entry system or the need for visitors to sign in and declare who they were there to access the ward areas.

We saw that lockable strong boxes for patient property were not being used and patients’ possessions were susceptible.

**Assessing and responding to patient risk**

The service planned for emergencies and staff understood their roles if one should happen.

Assessing the risks to the health and safety of service users receiving the care and treatment was not always carry out fully and appropriately. Patients were assessed by a consultant very shortly after entering the unit and their care and treatment was planned by a multidisciplinary team. However, Malnutrition Universal Screening Tool (MUST) scores were not being routinely completed, meaning that the risk of malnutrition was not being monitored appropriately. Risk assessments for moving and handling were not undertaken or reviewed in all cases and there was a risk to patients being moved inappropriately.
However, patient records showed that staff carried out other risk assessments on admission and on an ongoing basis to identify patients at risk of specific harm, such as pressure ulcers, risk of falls or nutritional risks. If staff identified patients susceptible to these risks, patients were placed on a relevant care pathway to reduce the risks, such as pressure care using suitable equipment.

The service used a national early warning scores (NEWS) system. This was a scoring system with the aim of identifying deteriorating patients early and quickly. The early warning scores used an aggregated weighting system with physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation. We saw evidence of the use of national early warning scores in the unit in patient records.

Staff carried out “Safety Huddle” meetings once a day where specific patient needs were discussed.

There was a monthly mortality and morbidity multidisciplinary meeting led by the consultants where any patients experiencing a complication were discussed and actions planned to avoid further complications. Any patient deaths were also discussed and looked at holistically during this meeting so that lessons could be learned as to whether the patient had been in the right place and whether decisions had been made at the right time.

**Nurse staffing**

**Sickness**

From July 2016 to June 2017, the trust reported a sickness rate of 4% for spinal unit. *(Source: Routine Provider Information Request (RPIR) P19 Sickness)*

**Vacancy rates**

From July 2016 to June 2017, the trust reported vacancy rate for the year of 13.8%

*(Source: Routine Provider Information Request (RPIR) P17 Vacancies)*

During inspection, managers confirmed the current nurse staffing for the unit. There were two band 7 nurses (whole time equivalents (wte)) in post.

Band 6 allocation was for 13.76 wte nurses, with 12.41 actual in post.

Band 5 allocation was for 34.29 wte with 23.71 wte actual in post.

Band 4 allocation was 3.08 wte with 3.08 wte in post.

Band 3 allocation was 25 wte with 25 wte in post.

Band 2 allocation was 10 wte with seven in post and a further three that had been recruited.

At our inspection managers said nurse recruitment was ongoing but was a challenge. The service used bank and agency staff to cover shifts when needed. The nursing vacancy rate at the time of our inspection was 7.94% and there were five trained and two untrained nurses due to start work on the unit within the following two months from our inspection.

There was ongoing local recruitment to attract registered nursing staff, especially to fill vacancies at band five nursing level. This was done with the support of human resources. The service had attended RCN job fairs; Southport Flower Show and internal recruitment events, to attract staff to the unit. A media package was planned to advertise vacancies. Students were proactively offered posts during their placements. Clear pathways of access were being planned in discussions with local health and education providers.

We saw that in high dependency areas on the unit, that a 1:2 nurse to patient ratio was
maintained in accordance with best practice. However, there was a high untrained to trained ratio per shift for the remaining beds with an average of 1:8 ratio (trained to untrained). An NHS England Clinical Reference Group had indicated that safer care multipliers on the unit required further review to improve this ratio.

An acuity tool was used to help plan nurse staffing. Staff within the unit followed an escalation process, which included a matron’s meeting three times a day to review safe staffing across the hospital. At these meetings the number of patients, their acuity and staffing levels were reviewed. Staff were redeployed across the hospital and additional staff sought where necessary. If the required number of qualified staff were not available, the number of unqualified members of staff would be increased and ward managers and matrons would support patients’ care.

**Turnover**

From July 2016 to June 2017, the trust reported a turnover rate for staff within spinal of 9.4%:

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

<table>
<thead>
<tr>
<th>Bank and Agency staff</th>
<th>Filled by bank</th>
<th>Filled by agency</th>
<th>Unfilled</th>
<th>Total Shifts</th>
<th>Filled by bank</th>
<th>Filled by agency</th>
<th>Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Nurse Shifts</td>
<td>283</td>
<td>632</td>
<td>212</td>
<td>7808</td>
<td>4%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>641</td>
<td>1</td>
<td>229</td>
<td>6345</td>
<td>10%</td>
<td>0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

The service used bank and agency staff sourced from NHS professionals. There were monthly operational meetings with NHS professionals attended by key leads from clinical business units to ensure that business unit staffing requirements were actioned. Block booking of regular agency or bank staff was encouraged to ensure continuity. Since January 2017, the service had enabled three to four named agency critical care qualified nurses to block book shifts to support the high dependency beds within the unit. This facilitated the movement of staff from those rooms onto the general spinal area.

Student nurses across the trust were able to join NHS Professionals within 72 hours to support non-registered shift fills.

**Shift fill rates and shift patterns**

The overall nursing fill rate was consistently greater than 90%, indicating safe staffing. However, from August to November 2017 there was a decrease in the percentage registered fill rate and an increase in the percentage unregistered fill rate. This was due to a vacancy level of 11 trained staff posts and an increase in nursing sickness. The service increased the use of agency staff and reduced the number of ventilated patients admitted to mitigate the risks during this period. During this period, 11 incidents were reported where the nurse in charge felt there was a potential for unsafe staffing on a shift. However, no harm was reported to any patients as a result of potential unsafe staffing.

In October 2017 a discussion took place at spinal management regarding the inability to admit all ventilated patient referred. It was acknowledged by the team this decision was reviewed weekly in
relation to staffing levels. Options were discussed as to alternate solutions to address the staffing situation. However, the decision was taken to continue to support the approach used by the team in declining admissions when assurance could not be provided that staffing levels were deemed 'safe.'

<table>
<thead>
<tr>
<th></th>
<th>Nursing Fill Rates - Overall</th>
<th>Nursing Fill Rates - Day – Registered</th>
<th>Nursing Fill Rates - Day - Unregistered</th>
<th>Nursing Fill Rates - Night - Registered</th>
<th>Nursing Fill Rates - Night - Unregistered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec-16</td>
<td>92.86%</td>
<td>91.40%</td>
<td>90.32%</td>
<td>96.77%</td>
<td>99.19%</td>
</tr>
<tr>
<td>Jan-17</td>
<td>93.53%</td>
<td>91.04%</td>
<td>93.73%</td>
<td>97.18%</td>
<td>94.35%</td>
</tr>
<tr>
<td>Feb-17</td>
<td>93.41%</td>
<td>91.27%</td>
<td>94.25%</td>
<td>96.88%</td>
<td>91.07%</td>
</tr>
<tr>
<td>Mar-17</td>
<td>92.78%</td>
<td>90.50%</td>
<td>93.73%</td>
<td>94.76%</td>
<td>93.55%</td>
</tr>
<tr>
<td>Apr-17</td>
<td>92.50%</td>
<td>90.00%</td>
<td>92.41%</td>
<td>96.67%</td>
<td>93.33%</td>
</tr>
<tr>
<td>May-17</td>
<td>93.17%</td>
<td>92.29%</td>
<td>93.73%</td>
<td>93.55%</td>
<td>93.55%</td>
</tr>
<tr>
<td>Jun-17</td>
<td>92.65%</td>
<td>91.48%</td>
<td>93.70%</td>
<td>94.58%</td>
<td>89.17%</td>
</tr>
<tr>
<td>Jul-17</td>
<td>93.79%</td>
<td>90.14%</td>
<td>96.95%</td>
<td>95.16%</td>
<td>92.74%</td>
</tr>
<tr>
<td>Aug-17</td>
<td>92.96%</td>
<td>85.84%</td>
<td>98.21%</td>
<td>94.35%</td>
<td>96.77%</td>
</tr>
<tr>
<td>Sep-17</td>
<td>91.28%</td>
<td>81.11%</td>
<td>99.26%</td>
<td>92.50%</td>
<td>96.67%</td>
</tr>
<tr>
<td>Oct-17</td>
<td>93.12%</td>
<td>84.27%</td>
<td>102.58%</td>
<td>91.13%</td>
<td>96.84%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>91.22%</td>
<td>86.34%</td>
<td>98.07%</td>
<td>91.76%</td>
<td>86.36%</td>
</tr>
</tbody>
</table>

(Source: Additional data supplied by the trust on request)

The service had a number of different shift patterns to staff the unit. These included long days (07:30 – 20:00); early (07:30 – 15:00); late (12:30 – 20:00); night (19:30 – 08:00) and twilight (21:00 – 04:00). There were also flexible shifts by the healthcare support workers to accommodate patient needs, starting at 06:00.

Medical staffing

The site had a dedicated spinal medical team with on-site medical cover between the hours of 9am and 9pm Monday to Friday
The unit had three medical consultants who were supported by three associate specialist doctors and three other doctors who were on-call. Medical cover on the unit was provided from 9am to 9pm each day.

From 9pm to 9am medical cover was provided by the hospital at night team on site and consultant provision came from the medical or surgery division.

On-call duties were divided by the doctors so they covered one day per week and one doctor who was on-call at the weekend. There was also an on-call consultant who could provide face to face or telephone advice to ward patients. They were also contactable through the first on-call doctor should this be deemed necessary. The consultants worked on-call for one week in three.

This meant there was a 24 hour, seven day a week on call consultant available, should this be deemed necessary. Consultants told us they were satisfied that they had enough medical staff for the number of patients in the unit.

**Records**

Staff kept records of patients’ care and treatment. Records were clear and up to date.

We reviewed 10 sets of patient notes across the various departments and found them to be clearly documented and legible. Patient records were paper-based.

However, records were not always stored securely. We observed unattended open trolleys in the ward area, the ward office was cluttered and notes trolley were unlocked. On one occasion we saw patient’s details left open on an unattended computer in the ward area.

Patients’ case notes were separated by department (medical, nursing, therapy, case management and psychology). Due to the length of patient stay and volume of notes, each set of notes were stored in a different location around the unit. This meant there was a risk that decisions about care and treatment were being made without access to full information about the patient.

During our inspection we found that Malnutrition Universal Screening Tool (MUST) scores had not been completed at all or correctly in five out of five case notes checked. Moving and handling assessments had not been completed in two out of four patient records and had not been reviewed in another record.

**Medicines**

Staff prescribed, gave, recorded and stored medicines well. We saw evidence that patients received the right medication at the right dose at the right time.

There were appropriate storage and disposal facilities for medicines. Controlled and other drugs were stored in line with legal requirements.

Controlled drug stock balances were correct and registers were signed by two staff members when drugs were dispensed.

Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in fridges and there were daily maximum and minimum fridge temperatures recorded daily. Staff were aware of what they needed to do in the event of fridge temperatures being out of range and there were appropriate arrangements in place for the destruction of unwanted and expired medicines.
A pharmacist visited the unit on a daily basis to review medications and to ensure that patients had enough medicine available during planned leave from the unit.

The pharmacist had electronic access to GP records so was aware of existing medications that each patient had been prescribed and needed to continue.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Between 01 July 2016 and 30 June 2017, the trust reported no incidents classified as never events for The Regional Spinal Injuries Unit.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

From 1 July 16 to 30 June 17 no serious patient safety incidents were reported relating to Spinal Injuries Unit.

(Source: Strategic Executive Information System (STEIS))

Since June 2017, the unit had reported one serious incident that involved a patient who had a pressure ulcer under a body brace. The pressure ulcer had been acquired before they entered the unit but a root cause analysis investigation was undertaken and the referring trust were involved in the investigation.

Incidents were reported on an electronic incident reporting system. Staff were aware of how to report incidents and gave a comprehensive account of what had happened on the system. Actions taken following the incident were also fully recorded.

Learning from incidents was discussed at the daily safety huddles, where appropriate, and in ward meetings. Incidents were also discussed at the monthly medical management meeting that was attended by medical, nursing and therapy staff managers from the unit. There was the opportunity to escalate and share lessons learned to a directorate clinical governance meeting.

In the six months from May to October 2017, the unit reported 34 incidents involving patients. All incidents were patient falls and all were given severity ratings as causing no harm or low harm to the patient. The falls were classed as “on the same level”, “from a height”, “collision with an object or person” or an “assisted fall”. Four of the falls were classed as assisted falls where the patient fell from their wheelchair or bed with the assistance of a staff member. Patients are taught to fall safely and lower themselves to the floor as part of their therapy.

In the 12 months from November 2016 to October 2017 there were a total of 72 incidents reported. All incidents were given a severity rating of low or no harm.
Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. The measurements included unit acquired pressure ulcers, falls with harm, urinary tract infections (UTIs) and new blood clots (venous thromboembolism, VTEs). Data collection takes place one day each month.

Data from the patient safety thermometer showed that the trust reported no unit-acquired pressure ulcers, falls with harm, new catheter urinary tract infections or venous thromboembolisms in the year before our inspection. Safety thermometer results were prominently displayed on the unit.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Care and treatment was evidence-based and was broadly based on the National Institute for Health and Care Excellence (NICE) Guidelines. Guidelines on spinal injuries and bladder management were in use on the unit.

The unit was a leader in best practice in the field of spinal injuries. One Consultant on the unit had assisted in writing NICE Guideline NG41 on assessment and initial management of spinal injuries as an expert in the field.

The unit followed an admission criteria for assessing patients who were being referred.

Care pathways and standard operating procedures were followed on the unit and were in line with national guidance.

Clinical guidelines were available on the trust intranet and staff were aware of where to find them. Compliance with national guidelines and other evidence-based practice was monitored through audit.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

Dieticians were available to assess and provide advice for patients who required support for their nutritional needs. All new patients were seen by a dietician and those patients who required feeding by nasogastric tube were regularly reviewed. Patients who continued to feed normally were monitored for any weight loss, with follow up as needed.

Patients had a choice of food with sandwiches and plenty of fresh fruit available. Patients could access kitchen facilities to make their own breakfast and drinks. However, during inspection we
saw some records for patients’ nutrition and hydration needs were incomplete. We reviewed five nutrition and hydration records: all of these were either absent or incomplete. In one of the two nursing charts we reviewed, details of the patient’s weight were not recorded.

**Pain relief**

Staff monitored patients at regular intervals for any symptoms of pain. Patient records showed that patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.

Patients told us staff responded to requests for pain relief promptly

There was a specialist pain team available when required, However, staff reported this service had only been needed by patients twice in the past 12 months.

**Patient outcomes**

The trust routinely collected and monitored information about the outcomes of people’s care and treatment. They compared local results with those of other similar services to learn from them.

Data was submitted to the national spinal injuries database, which published a dashboard of outcomes on a quarterly basis. Managers reviewed this data to benchmark in comparison to other regional spinal injuries units.

The trust provided details of two audits which had been undertaken and were specific to the spinal injuries unit from 01 July 16 to 30 June 17. The outcomes are detailed in the table below.

<table>
<thead>
<tr>
<th>Name of Audit</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-audit of Spinal Code of Conduct</td>
<td>Code of conduct has been agreed and introduced in the Spinal Unit. Patients sign the agreement on admission.</td>
</tr>
<tr>
<td>Incomplete cases of Urinary surveillance (KUB)</td>
<td>Project provided very limited assurance</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) Audits)

The trust also monitored information about pressure ulcers, rates of infection and falls resulting in harm. Data showed there were no reports of unit-acquired pressure ulcers, falls with harm, new catheter urinary tract infections or venous thromboembolisms in the year before our inspection.

**Competent staff**

The service made sure staff were competent for their roles. Generally, managers appraised staff members’ work performance. However, some staff said they did not receive appraisals.

Nursing staff were supervised by the ward manager. They completed their competencies for different nursing procedures, such as changing tracheostomies and managing ventilator settings.

We reviewed records of staff competencies and saw these were up to date. A database for electronic recording of competencies was being planned.

Physiotherapy staff provided training to staff for specialised equipment, including drop in sessions for staff on night shifts. Staff completed their own competency records for this training. Additional training was also provided by company representatives for any equipment updates and new products.
Physiotherapy staff kept records of their continuing professional development.

New staff nurses were supported by a nurse mentor to ensure orientation to their job role and were provided with a new starter pack.

One of the case managers was due to begin the role as practice educator on the unit from January 2018. Plans were in development to formalise clinical supervision and introduce a spinal injuries course following this.

**Appraisals**

Current year to date figures show the trusts appraisal completion rate for staff in spinal at 86.9%.
(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Staff we spoke with confirmed they had their learning needs identified and assessed during their annual appraisal.

**Multidisciplinary working**

Staff worked together as a team to benefit patients.

We found a positive and comprehensive multi-disciplinary approach to working. Patients had access to support from a number of specialist professionals, from both medical and non-medical backgrounds.

Staff described working between consultants, nurses, allied health professionals, psychologists, counsellors and other members of the team as good.

We observed a meeting to discuss patients who were due to be admitted, which incorporated staff from a variety of disciplines. The care needs of patients were discussed in detail and plans identified for their treatment.

Each patient was allocated a case manager and a psychologist. Case managers co-ordinated patients’ overall care plans, with the various different services involved. This included referral to the local authority, for further support with social care and support needs in preparation for discharge. Three case managers were available on the unit to ensure cover and continuity of patients’ care plans.

A peer support officer from the North West Spinal Injuries Association was available on the unit.

**Seven-day services**

The unit was operational for inpatients 24 hours a day seven days a week. However, patients were not admitted to the unit on a weekend, unless it was an emergency admission. These were generally the readmission of a patient who had been unable to fully cope with their rehabilitation outside the unit. Similarly, patients were not discharged from the unit at weekends or overnight.

There was 24 hour access to specialist care from a ventilator trained consultant on site. Consultants described access to other services, such as for Computerised Tomography (CT) scan, was good at weekends.

**Health promotion**
Patients were supported to be self-managing in their own care, with a focus on wellbeing and maintaining function. During goal planning meetings, patients were educated in skin care and prevention of pressure sores.

Goal planning involved families, who were also informed about how to support patients in their self-care activities.

Information leaflets and a care pack were provided for patients and their families. Follow up guidelines for patients were also available on the trust’s website.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff did not always understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

We found evidence that processes to identify and support patients with reduced mental capacity were not clear. There was inconsistent identification and recording of best interests decisions for patients who lacked capacity. Also staff were unaware of local procedures which had recently come into place in October 2017.

We reviewed records for two patients who had a learning disability. Only one record had a completed capacity assessment. This record was incomplete and had not been reviewed appropriately.

We were concerned about one patient record which included a do not attempt cardio pulmonary resuscitation document from a previous trust which was based on a best interests decision. The patient had subsequently regained capacity and their condition had improved. There was no record of the decision having been reviewed or communicated with the patient’s family, despite it being against the patient’s wishes.

We raised these issues with managers during our inspection, who took immediate action to address this and acknowledged this area needed further development.

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. All staff introduced themselves and communicated well to ensure patients fully understood.

We observed staff interacting positively with patients and those close to them throughout the unit. Staff spoke to patients sensitively and appropriately dependent on individual needs.

Staff treated patients, and those close to them, with respect and dignity. They were aware of patients care needs and communicated in an appropriate and professional manner. Staff were observed to ask patients’ permission before undertaking their personal care.

Patients were encouraged to ask questions and were given time to ensure they understood what was being said to them.
Patients described excellent care from all staff. This included nurses, doctors, allied health professionals and administrative staff. Patients often said that staff went above and beyond or went the extra mile. One patient commented the unit was “An excellent facility giving people in dire circumstances the opportunity to rebuild their lives and integrate back to society”

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

**Emotional support**

Staff provided emotional support to patients to minimise their distress.

There were specialist staff available such as counsellors, nurse specialists, and spiritual leaders to provide for patients’ emotional support needs. A patient described how they were upset and having a good cry. A nurse and psychologist came very quickly to sit and talk with them.

A number of staff had themselves previously been patients with a spinal injury. This meant they were able to relate more directly to and empathise with patients’ experiences of having a spinal injury.

**Understanding and involvement of patients and those close to them**

Staff involved patients and those close to them in decisions about their care and treatment. Patients and their families were invited to visit the unit prior to patients being admitted. During visits, staff outlined the facilities and rehabilitation activities of the unit, indicating an anticipated length of stay. Families were invited to attend goal planning meetings every four to six weeks, where they could be involved in supporting patients to identify and progress their individual goals.

The service planned for patients who needed to remain as inpatients at Christmas, involving families in Christmas celebrations on the unit.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.

The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care. Specialist professionals from a wide range of disciplines were involved throughout the patient’s journey, from pre-admission to discharge and community follow up. The service identified where improvements needed to be made and was working with other organisations to deliver these improvements. The facilities and environment were generally accessible for wheelchair users, with wide doors, corridors suitable equipment for patients’ care and rehabilitation needs.

However, we saw the facilities in the kitchen and dining room did not always provide for the needs of wheelchair users, despite having recently been refurbished. This was because cupboards had not been adapted in terms of height and to promote easy access. Tables were not at different heights.
Meeting people’s individual needs

The service took account of patients’ individual needs.

The spinal injuries unit team was strongly person centred in its approach to patient care. Patients’ individual needs were considered as a priority and assessed on a case by case basis. Appropriate support was available from specialist professionals to meet patients’ needs. Each patient was provided with a patient passport, indicating their personal preferences, rehabilitation goals and progress towards achieving these. Staff and patients reviewed these together, adapting plans and referring to other professionals if this was required.

Interpreters were available to support patients where this was identified. During inspection, we observed Polish interpreters attending ward rounds to assist in communication with Polish patients who were on the ward. As part of a trust-wide development, plans were in place for dementia friendly improvements to the unit environment.

A self-contained area with adapted kitchen, bathroom and aids to daily living was available on the unit. This was used for patient assessment and rehabilitation, in particular when preparing for discharge.

Access and flow

People could mainly access the unit when they needed it.

However, the unit lacked sufficient facilities for patients who required isolation due to infection. There was one room available for isolation, which meant some patients with existing infections were unable to access the unit when they needed.

Patients were admitted to the unit following their referral, either for rehabilitation following spinal injury, or for surgery, or as an emergency via A&E.

Data provided by the trust showed a total of 195 acute referrals for patients were made to the unit between April and October 2017. The average time from referral to admission ranged between 24 and 37 days during this period.

The unit followed an admission criteria, based on patients’ diagnosis, medical condition, rehabilitation goals and anticipated discharge options. Consultants approved all patient referrals prior to their admission. Patients were admitted before 1pm to allow for full assessment of their needs. 100% of referred patients were visited by outreach team within five working days and assessed for suitability to be admitted to the unit.

Discharge planning began from the date of patients’ admission, Patients’ care needs were assessed, reviewed and prioritised throughout their inpatient stay.

Beds were full during the week, with a weekly discharge planning meeting to review patients who were preparing for discharge. Patients were not admitted or discharged at weekends, unless this was an emergency.

The unit held a regular meeting to review delayed discharges. Staff identified that delays in patients’ discharge were often due to waiting for housing and adaptations to be in place.

Data from the trust showed between April to September 2017 there had been a total of 32 patients with a delayed discharge, including ventilated and non-ventilated patients. Waiting time for delayed discharge ranged between 39 days and 200 days during this period.
The service had identified these issues and managers were engaging with NHS England, service commissioners and other organisations to support improvements in delayed discharge.

An outreach team of specialist nurses and therapy staff supported patients through and following discharge. When patients felt confident and had reached a stage of their rehabilitation, they went on weekend trials at home prior to discharge. Following discharge, patients were seen by for review in clinic after three months. Patients could request to be seen more urgently if this was needed.

On occasions the ward was asked to accept patients from other wards. Staff told us this was usually at weekends and there had been 10 occasions over the past twelve months when this had happened. Data provided by the trust indicated there had been 12 occasions when other patients had been on the spinal injuries unit. However, staff told us there had been no adverse effect on spinal patients when other patients needed to be accepted to the ward.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

The service had received a total of four complaints over 12 months between 01 July 2016 and 30 June 2017. One was partially upheld which involved communicating with relatives following a medication error and one was a verbal complaint.

Staff worked with patients to resolve any issues that were raised. Complaints were reviewed in unit management meetings and quality and safety meetings.

73 compliments were received across the service between 01 July 2016 and 30 June 2017.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Information about how to make a complaint was available for patients in the unit. During our inspection patients we spoke with said they had been informed about the complaints process.

We only heard isolated negative remarks from all the patients we spoke with during our visit, These were mostly limited to issues such as broken equipment, the cost of car parking or regarding food.

Is the service well-led?

Leadership

The trust did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

The trust leadership was relatively new and leadership was not embedded.

However, staff we spoke with were positive about the leadership of the spinal injuries unit. Staff said that they were well supported and managers were very receptive to new ideas to improve services.
Staff at all levels were complimentary about the chief executive of the trust who they described as visible, supportive and committed. They told us that they had seen more of her than any other chief executive at the trust and she had engaged with the Spinal Unit Action Group (SUAG) who were a local charity for the unit. We were told that the Deputy Director of Nursing had attended a patient forum in the unit. However, staff did tell us that the current executive leadership team was not yet settled, as there was a vacancy for the director of nursing and it was uncertain whether the chief executive would attain a permanent position in the trust.

It was not considered that changes in the trust leadership team had impacted on improving the service but had made an impact on proposed capital investment into the unit. However, senior staff expressed concern that they had not been supported by the trust’s executive team in their plan to create further isolation beds on the unit.

Managers did not know whether there was a non-executive director at the trust who had responsibility for an oversight of the spinal injuries unit.

**Vision and strategy**

The trust did not have a vision for what it wanted to achieve and did not have workable plans to turn this into action, developed with involvement from staff, patients and key groups.

However, in 2017 the unit developed a set of values and a vision alongside their own five year strategy for delivery of the service. At the time of our inspection this was in its infancy. Previous to this, the latest strategic plans for the unit had expired in 2015. Since this time, the unit had implemented yearly development plans to align with CQC and peer review requirements. Staff said the vision and values felt relatively new.

The current service strategy identified five strategic objectives. These were to: deliver effective service pathways; deliver patient-centred services; deliver an effective, high calibre workforce; provide cost-effective, sustainable services and, invest in audit, research and innovation to drive quality services.

An annual work plan was developed each year to ensure that the service was working towards its strategic objectives. The current work plan was in draft form. The work plans were monitored at the spinal management and governance meetings and at staff forums.

The vision for the service was developed in partnership with the workforce. The vision was “An integrated specialist team offering patient centred care to international standards. Supporting people to live well with spinal cord injury.”

The service also had a mission. This being: “To provide every opportunity for individuals to achieve their maximum potential in order to adopt the lifestyle of their choice within the extent of their ability. Restoring individual’s prerogative based on remaining abilities inclusive of quality of life.”

The service followed the trust-wide set of values, these being that staff should be supportive; caring; open and honest; professional and efficient.

**Culture**

Managers across the unit promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
The culture of the service was aligned with the trust values. There was an open and transparent culture that encouraged the reporting of incidents in order to learn from them and improve care quality for people in the local population.

There was a positive attitude within the spinal unit where staff valued each other. Staff from all specialities reported good team working and a sense of pride in the work of the service. Staff said that the chief executive was proud of the unit. Staff told us a lot of things had changed since the last inspection and there was now a more transparent culture, which they enjoyed. Staff generally reported that working with other trust services was good. However, we also heard that staff felt somewhat separate from the trust as a regional spinal injuries centre. Managers felt they needed to spend a lot of time raising awareness and trying to educate the trust about their different needs as a regional unit.

**Governance**

The service did not always use a systemic approach to continually improving the quality of its services and safeguarding high standards of care in which clinical care would flourish.

Although governance arrangements were in place, the trust leadership was new and these arrangements were not well embedded. Staff felt there was a sense of separation between the spinal injuries unit and the trust as a whole. However, the service held weekly management meetings, incident reporting and performance meetings. Also, managers attended meetings across the trust which included input from medical staff, clinical staff and senior managers. The unit reported to the quality and safety meetings for planned care and staff worked together on governance issues.

Staff we spoke with felt that services were safe and that arrangements were clear. Staff at all levels were clear about their roles and responsibilities and felt supported by their managers. There had also been a peer review of the service requested by the NHS England Specialist Commissioning Team and undertaken by a team of specialist from other spinal injuries units.

The report highlighted many areas of good practice such as the dedicated respiratory team and reported regular use of patient passports. A number of areas of concern were also identified in the report. These included concerns about clinical governance processes and approvals for business cases. No areas of serious concern were identified. Amongst recommendations were development of networking with major trauma centres; development of clinical governance and for the trust to approve business cases which had impact on patients’ privacy and dignity. We did not see any action plan specifically relating to the recommendations made in the report. However, the unit had identified an annual work plan.

**Management of risk, issues and performance**

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, or cope with both the expected and the unexpected.

Although risk registers were maintained on the unit, during our inspection we observed several key risks which had not been identified or actions implemented, for example the overall risks to patients due to lack of security in the unit had not been identified.

At the time of inspection, managers told us risks which were identified including the lack of hydrotherapy facilities due to breakdown, the lack of sufficient isolation rooms and the lack of a ceiling track hoist. Managers said all these identified risks had associated business plans, which had been submitted to the trust board. However, risk registers we reviewed at the time of
inspection identified different risks from those we were informed of. These risks included a lack of space in the unit; uneven pavement limiting wheelchair access; lack of isolation facilities; staffing levels and deteriorating profiling beds.

The spinal management meeting was continuing on a monthly basis and any new issues were raised to the trust board when these arose.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The unit collated a wide range of data for submission to the National Spinal Injuries Centre and staff were proud of this work.

However, managers identified the Electronic Patient Record (EPR) used by the trust was unsuitable for the type of patients on the spinal unit. This was because their care needs were more complex and length of care longer than other types of patients seen in the trust.

In addition, the quality of information was variable due to the volume of data collected by the trust.

**Engagement**

The unit engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Staff told us they attended meetings on the unit and received information in daily safety huddles. The trust issued updates and briefings for all staff via email and staff had access to trust news via the trust intranet. Not all staff had email accounts but in general, staff felt there was good engagement with the trust. However, a number of staff we spoke with were not aware of the trust’s Freedom to Speak Up Guardian. The unit participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed.

The unit engaged with the Spinal Unit Action Group and a number of different charities. These organisations provided activities for patients and families, such as sports activities, barbecues and quiz nights. There was a monthly patient forum for patients. Travel expenses and overnight accommodation were available for patients’ relatives. Volunteers provided support on the unit, assisting with feeding and talking with patients. Disclosure and Barring Service (DBS) checks were completed for volunteers and held securely on the unit. Volunteers signed in and out when attending the ward.

**Learning, continuous improvement and innovation**

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. As a regional spinal injuries unit, staff were at the centre of research and development in the specialism and participated in a number of different research activities and national specialist networks. The clinical director attended a national meeting twice yearly to share developments with other regional spinal injuries centres. This learning was shared with staff.
The case management team shared news of best practice in a flyer. Some of the items included in this were “involvement in development of a pathway for long term ventilated patients, development of a NWRSIC discharge pathway and news of a team member who had completed a degree module in Case Managing Long Term Conditions “.

Staff said managers were supportive to new ideas and they had access to development opportunities. A member of the team had recently attended a course on mindfulness at a local university and was introducing this for patients. Students from local universities had placements on the unit. Three recent students were due to join the team as permanent staff.

Staff from the unit provided training in spinal injuries care to external organisations. The unit had recently hosted a national meeting of the spinal injuries network. Unit managers said the future of spinal injuries care was in technology, which was a focus for development. The respiratory team provided telephone support for patients and monitored patients remotely in a “virtual clinic “.

Physiotherapy staff liaised with a national specialist centre for patients undergoing upper limb surgery. Video assessment of patients were made prior to and following surgery, to monitor patients’ progress.
Southport and Ormskirk NHS Trust

Evidence appendix

Town Lane
Kew
Southport
Merseyside
PR8 6PN

Date of inspection visit:
20 to 23 November, 27 to 28
November and 5 to 7 December
2017

Date of publication:
xxxx> 2017

Tel: 01704 547471
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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Acute services

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services
Southport and Formby District General Hospital

- Observation Ward

The department has a minors’ area with chairs and trolleys to see patients with minor injuries, a majors area with 11 cubicles to accommodate patients with more serious conditions; three of which are side rooms used to isolate patients with infections. There is also a resuscitation room with four trolley spaces used to accommodate patients presenting with life threatening conditions. Adjoined to the emergency department there is an observation ward which is designed to accommodate patients who need short term additional observation prior to discharge from the department. There are two designated triage areas within the department; one for patients who self-present to the department and one for patients who present by ambulance.

Ormskirk and District General Hospital

- Accident and Emergency Observation Ward
Activity and patient throughput

Total number of urgent and emergency care attendances at Southport and Ormskirk Hospital NHS Trust compared to all acute trusts in England

There were 134,973 attendances from April 2016 to March 2017 at Southport and Ormskirk Hospital NHS Trust as indicated in the chart above.

(Source: NHS England)

There were 107,428 attendances for the same period at Southport General Hospital emergency department and Skelmersdale walk-in centre. This had increased since the last inspection. At the time of our inspection another provider was responsible for care provided at Skelmersdale walk-in centre.
Urgent and Emergency Care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission fell from 2015/16 and 2016/17. In both years, rates were lower than the England averages.

(Source: NHS England)

Urgent and Emergency Care attendances by disposal method

(Source: Hospital Episode Statistics)

We visited all areas of the emergency department including the triage area, majors’ area, resuscitation room, minor injuries unit and the observation ward.

We spoke to staff of different grades, including nurses, doctors and the management team from both the department and the medicine division. We also spoke to six staff from other areas of the hospital that had regular contact with the emergency department.

We reviewed 36 sets of patient records, including emergency department record cards,
prescription charts, assessments and observation charts. We reviewed information that was provided by the trust before and after the inspection. We also spoke to 18 patients and relatives about the care they received and we also observed direct care and treatment being delivered.

Is the service safe?

Mandatory training

Mandatory training uptake levels had improved since the last inspection. However, there remained areas for improvement. Staff told us that they could not always be released to attend training.

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has not provided any targets for the completion of mandatory training. However, during the inspection senior staff within the emergency department told us that the target for all subjects was 90%.

Southport and Formby District General Hospital

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Urgent and Emergency Care at Southport and Formby District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>20</td>
<td>25</td>
<td>80.0%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>19</td>
<td>25</td>
<td>76.0%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 &amp; 5 (Prevent Awareness) - 3 Years</td>
<td>17</td>
<td>25</td>
<td>68.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>16</td>
<td>25</td>
<td>64.0%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>15</td>
<td>25</td>
<td>60.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>13</td>
<td>23</td>
<td>56.5%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>14</td>
<td>25</td>
<td>56.0%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>13</td>
<td>25</td>
<td>52.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>10</td>
<td>25</td>
<td>40.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>8</td>
<td>25</td>
<td>32.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>2</td>
<td>7</td>
<td>28.6%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1</td>
<td>43</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

For medical and dental staff in urgent and emergency care services at Southport and Formby District General Hospital, the overall completion rate was 53.5% from July 2016 to June 2017. Only the corporate induction and the equality and diversity modules had completion rates of over 80% while the infection prevention level one and two modules had completion rates of 28.6% and 40.0%, respectively. One of the 43 eligible staff completed the resuscitation module over this time period.

Analysis of the trust's data found that no medical staff at Southport and Formby District General Hospital had completed resuscitation training in 2015/16 or 2016/17. However, after the inspection the trust assured us that six out of seven consultants had advanced life support training and six out of seven consultants had advanced paediatric life support training. No middle
grade staff had advanced paediatric life support training but both middle grade staff had advanced life support training. The infection prevention level one module had been completed by 12.5% of medical staff in 2016/17 while no data was provided by the trust for 2015/16. Infection prevention level two training was completed by 27.3% and 28.0% of medical staff in 2015/16 and 2016/17, respectively.

A breakdown of completion rates for nursing staff in Urgent and Emergency care at Southport and Formby District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine management training</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Medical Devices - No Renewal</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Corporate Induction</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Record Keeping - No Renewal</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>90</td>
<td>92</td>
<td>97.8%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>88</td>
<td>92</td>
<td>95.7%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>36</td>
<td>38</td>
<td>94.7%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>84</td>
<td>92</td>
<td>91.3%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>79</td>
<td>90</td>
<td>87.8%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>80</td>
<td>92</td>
<td>87.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>78</td>
<td>92</td>
<td>84.8%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 &amp; 5 - 3 Years</td>
<td>65</td>
<td>92</td>
<td>70.7%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>59</td>
<td>92</td>
<td>64.1%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>56</td>
<td>91</td>
<td>61.5%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>53</td>
<td>91</td>
<td>58.2%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>53</td>
<td>91</td>
<td>58.2%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>18</td>
<td>123</td>
<td>14.6%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 1 &amp; 2 - 3 Years</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

For nursing staff at Southport and Formby District General Hospital, from July 2016 to June 2017 the overall mandatory training completion rate was 71.9%, with completion rates for the majority of the training modules above 84%. Only 18 of the 123 eligible staff (14.6%) completed the resuscitation module while the one staff member eligible for the level one and two preventing radicalisation module had not completed this module.

Analysis of data for 2015/16 and 2016/17 found that 22.8% and 13.2% of nursing staff, respectively, had completed the resuscitation module while no data was provided for the level one and two preventing radicalisation module.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Staff working in the department told us that they are generally unable to attend training unless it was deemed urgent due to pressures within the department and short staffing. We discussed the mandatory training compliance with the senior managers for the emergency department and the
medical division. They told us that staff were encouraged to undertake mandatory training. However, seasonal pressures meant that on some occasions training was postponed to meet the needs of the service.

We reviewed training records and found that all staff had completed a basic level of resuscitation training. However, the service was unable to provide evidence of more advanced resuscitation training uptake levels during our inspection. After our inspection the trust confirmed that all nursing staff and health care assistants had completed immediate life support training and two senior nurses had completed advanced life support training.

There was no mandatory training programme for sepsis management. However, staff told us that they had received training locally and also learned about sepsis during resuscitation training. There was no plan in place to address the very low rates of compliance with some subjects.
Safeguarding

Prior to our inspection, the trust did not provide a target for the completion of safeguarding training.

The trust only provided data for adult safeguarding level one training at both hospital sites in 2015/16 and not for the most recent time period, July 2016 to June 2017. The trust’s data indicated it did not allocate children’s safeguarding level one to any nursing or medical staff in the urgent and emergency care department from April 2015 to June 2017.

The service did not provide information specifically relating to the uptake levels for safeguarding children level three training. However, at trust wide level information provided showed an upward trend of compliance throughout 2017 and the compliance level was given as 93%. This had improved significantly since the last inspection and was above the trust’s target of 90%.

Southport and Formby District General Hospital

Staff were able to tell us how they would report a safeguarding issue and showed a good general level of knowledge in relation to the reporting and recognition of abuse in safeguarding adults and children. However, staff we spoke with were not aware of specific trust wide policies and pathways designed to meet national guidance on key safeguarding issues such as female genital mutilation and child sexual exploitation.

Trust-wide safeguarding assurance meetings were held bi-monthly. We observed that prompts and flow charts explaining how to refer safeguarding issues were displayed around the department in easy to read posters. Staff also told us that there was a corporate safeguarding policy and they told us that they could access this electronically.

There was a safeguarding trigger to identify any patients who may have been experiencing domestic abuse. However, in 10 out of 10 records we reviewed this section of the record was not completed by staff.

The trust had a local policy to guide the care and treatment and reporting of any incident of female genital mutilation (FGM). The policy contained the national pathway to be followed when seeing a patient who disclosed FGM or plans to undergo FGM.

The trust’s policy indicated that staff should complete an incident report via the trust’s incident reporting system should a women reporting FGM be seen. This would also trigger the national dataset to be completed and to be returned quarterly in line with national policy. Where appropriate a safeguarding referral would be made.

The trust told us that all clinical staff had received some level of FGM awareness from mandatory safeguarding training. However, the department did not have the flowchart and staff were not aware of the process to follow in suspected or actual cases of FGM.

The trust had developed a pathway for those concerned around child sexual exploitation (CSE). However, staff we spoke with in the emergency department were not aware of this. This was also reflected in an exercise undertaken by the trust where they reviewed staff’s awareness and enquiry relating to CSE. The conclusion of this exercise was that there was not sufficient awareness or professional curiosity in relation to identifying potential signs of CSE. The trust had introduced bespoke training for sexual health staff around CSE; However, this had not been extended to the emergency department, where victims of CSE may present.

Patients presenting with mental health conditions were referred to a mental health liaison team from a neighbouring trust. This team had safe facilities in the department to undertake assessments and ensured that all referrals were followed up. Staff were aware of the Mental Health Act (section 5) which outlines nurse and doctors holding powers. However, we observed that these were exercised in one case but there use was not appropriately documented in line with the trust’s policy. This issue was escalated to the trust for immediate action.

There were pathways and referrals specific to suicide attempts and self-harm. These included specific processes to follow in the case of children presenting.
The trust used the adult accident and emergency department as the designated place of safety for patients on a section 136 (a specific section under the Mental Health Act). There was a ‘high risk room’ mental health assessment room, suitable for conducting assessments based in the emergency department. We saw three assessments being conducted in this room. No patients were left on their own in this room at any time before or after these assessments.

The trust did not collect section 5(2) data centrally and told us that all forms were part of the patient’s clinical records. However, they had recently developed a process in their clinical incident reporting system to record all patients on section 136 and section 5(2) which will centralise the data and allow reporting going forward.

The mental health liaison team actively followed up referrals to ensure they have been received by other services and also in cases of service user non-attendance. This was key in ensuring vulnerable service users were safeguarded.

Southport and Formby District General Hospital had an overall safeguarding training completion rate for medical/dental and nursing/midwifery staff of 86.3% from July 2016 to June 2017.

Safeguarding uptake levels for level three safeguarding children were low at 57% and 77% for medical and nursing staff respectively. This was below the trust’s target of 90%.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental and nursing staff in Urgent and Emergency Care at Southport and Formby District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Safeguarding training completion by module</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southport and Formby District General Hospital</td>
</tr>
<tr>
<td>(Medical and Dental Staff)</td>
</tr>
</tbody>
</table>

- Safeguarding Children (Level 2): 100.0%
- Safeguarding Adults (Level 2): 96.0%
- Safeguarding Children (Level 3): 57.1%
Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one 93.9%
- Safeguarding adults level two 92.8%
- Safeguarding adults level three 94.2%
- Safeguarding children level one 94.7%
- Safeguarding children level two 90.9%
- Safeguarding children level three 92.7%

However, this information was not broken down into the core services we inspected.

**Cleanliness, infection control and hygiene**

The department did not always effectively manage cleanliness, infection control and prevention risks.

Mandatory training levels for infection control and prevention were low at 58.2%. We observed that staff cleaned trolleys between patient uses and washed their hands between patient contacts. However, we observed debris on the floor throughout the department on all days of the inspection. This included dressings, electrodes and soiled tissues.

We observed, in two cubicle areas, that there was soiling to the floor and walls. We inspected two toilets for patient use in the department and in both toilets there was soiling visible on the floors and toilets.
We reviewed six patients’ records in relation to the completion of the documentation of the insertion of intravenous cannulas. This section was designed to document when a cannula was inserted and whether aseptic technique had been used to minimise the risk of infection. In all six cases this section was either blank or partially completed.

Staff in the department were aware of the infection control and prevention policy and appropriately identified patients requiring screening for influenza and infections such as methicillin-resistant staphylococcus aureus. We observed that staff demonstrating their awareness of how to isolate patients with transmittable infections.

Cleaning schedules were in place and we saw that these were followed by staff members. These schedules included commodes, toilets and curtains.

Senior staff told us that the department had not reported any incidents of patients developing methicillin-resistant staphylococcus aureus, methicillin-sensitive staphylococcus aureus or colostrum difficile in the 12 months prior to our inspection. Antimicrobial stewardship was monitored on a monthly basis and data produced to chart progress against good prescribing practice. This information was fed through to the monthly governance meetings. The trust also promoted a smartphone app to all clinical staff to increase access to the trust’s antimicrobial prescribing guidelines. Blood culture collection packs were available across the trust to promote proper collection of samples and reduce contamination and were also included in sepsis.

Environment and equipment

Patients were not always treated in the most appropriate area, which increased risks to their safety.

We found that patients were not always treated in an appropriate area for clinical care to be delivered. For example, we observed that staff had made a temporary four bedded area in a corridor outside the emergency department majors’ area. This was referred to as the escalation area. This corridor was located directly outside the x-ray department and a public toilet. It was also a very busy through corridor.

On the first day of inspection we observed that this area was very cramped and there was insufficient space between the bed spaces (there was less than 12 inches space between beds) for staff to deliver care safely. This also meant that conversations could be overheard and one patient told us they could hear bodily functions. We also found that oxygen cylinders were not secured and there was no piped oxygen in the escalation area. One the first day we found all oxygen cylinders were empty. Patients did not have call bells and there was no suction available. There was no equipment for staff to call for help. There was no standard operating procedure to cover this area in order to mitigate the risks associated with this area. Staff told us they did not feel the area was appropriate and that it was unsafe. We raised concerns about this area immediately and the trust advised that they would implement measures to make the area safe. These measures included having a phone in the area; call bells, emergency equipment and reducing the
bed numbers to three to allow more space. We returned on day two and three and found that although some measures were in place, the phone was not in the area on either day. We also found that the oxygen cylinders remained freestanding by the beds.

Equipment in all other areas of the department was visibly clean and well maintained. Staff told us they had easy access to the equipment they needed to care for patients.

Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated it had been checked daily, with a more detailed check carried out weekly as per the hospital policy. This was with the exception of the escalation area where we found medication which was out of date and that equipment checks were carried out but did not identify equipment which was out of date.

There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.

Bariatric equipment used for patients living with obesity was readily available when required.

Although the department saw a small number of children as they were treated at a neighbouring site, all appropriate equipment was available for paediatric patients including resuscitation equipment.

Resuscitation trolleys were secured with a tamper evident tag system.

Portable appliance testing (routine testing of electronic devices) was up to date for all electrical equipment we reviewed. Records of these checks were held centrally.

Staff told us that they made the best use of space in the department but they felt that it was too small for the number of patients presenting. We observed that patients in the waiting room did not always find a seat to sit down. The department saw a small number of children and they were expected to wait in the main waiting room. Staff told us that children were routinely redirected or transferred to the paediatric emergency department at a neighbouring site.

**Assessing and responding to patient risk**

The service did not manage all areas of assessing and responding to patient risk effectively. In some cases, due to lack of compliance with local policies and guidelines, patients were placed at significant risk of harm.

Staff were required to carry out risk assessments for different risks such as pressure damage and falls. We found that staff did not always carry out these risk assessments. One example of this was the completion of pressure damage risk assessments. We reviewed 20 patients records in
relation to this assessment and found that 14 out of 20 patients’ records did not have the pressure
damage risk assessment completed. These records included patients who may have been at risk
of developing pressure damage such as elderly patients and patients with a pre-existing medical
condition.

We also found that patients who presented with sepsis were not always placed on the trust’s
sepsis pathway. This pathway was designed to assess the risk and potential severity of sepsis.
We reviewed four patients who had been diagnosed with sepsis. In three cases the patient did not
have a sepsis pathway in place. All four patients received antibiotics within 1 hour 30 minutes.
However, in three cases a review by a doctor was not documented until much later (up to four
hours) and the antibiotics were prescribed by a doctor who appeared not to have seen the
patients. All four patients did not receive all steps set out in the pathway. This included observation
every 30 minutes. In some cases the observations were undertaken at four hourly intervals. This
presented a significant risk of harm to patients and breached the trust’s policy.

Staff were required to undertake regular observations on patients who presented with relevant
conditions. Senior staff told us that they would expect patients in the ‘majors’ category to have
observations undertaken at least one hourly. We reviewed 19 patients’ records in this category
and found that in 19 out of 19 patients this frequency was not met.

An early warning score (EWS) system was in use in the department. The EWS system was used
to monitor a patient’s vital signs and identify patients at risk of deterioration and to prompt staff to
take appropriate action in response to any deterioration. Staff carried out monitoring in response
to patients’ individual needs to identify any changes in their condition quickly. We found that staff
were using this system and had a good awareness of how to escalate any deterioration in a
patient’s condition.

In the emergency department a system of screening patients for sepsis at arrival had been
introduced using national early warning score (NEWS) scoring. A NEWS score of 5, or 3 in one
area, (in line with national guidance) prompted a review by a middle grade doctor or above to
decide if infection was present. If a patient was suspected to have sepsis, the antibiotics and first
fluid bolus were prescribed, intravenous access was established and lactate measurement was
performed. A sticker denoting ‘Sepsis screening’ should also be placed on the patient’s record. We
observed this set working well for patients presenting by ambulance. However, observations were
not always taken for patients self-presenting to triage. This meant that there was no NEWS score
to trigger the review. We also found that, although in most cases this initial review was occurring, it
could a number of hours before further review was undertaken. During this time patients’
observations were not monitored in line with the trust’s policy, which meant deterioration was not
always picked up and acted on.

The trust had a sepsis management policy and protocol in place. This met national guidance and
came with an associated sepsis care pathway.
Sepsis data was collected at trust level looking at the application of the sepsis screening tool and antibiotic stewardship in sepsis. For quarter four of 2016-17, 70% of patients presenting to the emergency department (adult and paediatric) were screened appropriately for sepsis and 70% of those with red flag signs of sepsis or septic shock were treated with antibiotics within the required time with an antibiotic review at maximum 3 days.

We found that patients who would ordinarily require a heightened level of observation were accommodated in the waiting room. These patients included patients with severe abdominal pain, new onset stroke, confusion, skull fracture and abdominal pain in pregnancy. We found these patients did not receive an adequate level of observation. This included not receiving clinical observations, analgesia and clinical reviews of their condition. We raised this with the trust immediately and they advised us that patients would receive appropriate levels of observation. When we returned the next day we found that patients were still not receiving sufficient observation.

The trust scored “about the same” as other trusts for all five of the Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust met the standard for 11 out of 12 months over the period from September 2016 to August 2017.

Performance against this standard showed a trend of decline from May 2017 onwards, peaking in July 2017 when the median time to treatment was 67.0 minutes compared to the England average of 60.0 minutes. In the most recent month, August 2017, the median time to treatment was 59.0 minutes compared to the England average of 53.0 minutes.

However, during the inspection we found that patients were being categorised as receiving treatment when a nurse or doctor would attend to them and take blood tests, x rays or checklists. We found that in some cases patients were then left for a number of hours before receiving a full assessment from a doctor or nurse practitioner. In three cases we found that this time exceeded four hours.
Ambulance – Time to treatment from September 2016 to August 2017 at Southport and Ormskirk Hospital NHS Trust

![Graph showing time to initial assessment](image)

1 95% of patients should be seen within these times

(Source: NHS Digital: A&E quality indicators)

The median time from arrival to initial assessment was zero minutes in all months from September 2016 to August 2017. This was lower than the overall England median. Over this time period, 95% of patients each month were seen for initial assessment in between eight and 12 minutes.

We found that patients brought into the department by ambulance were seen by a nurse quickly. This nurse would take the patient’s baseline observations and then return the care of the patient to the ambulance crew unless their condition was deemed to be life threatening. The patients would then queue in the department corridor until a trolley became available and the ambulance crews would stay with them. When the department became very busy with multiple crews in the corridor patients would be ‘cohorted’. This meant that one ambulance staff member would observe between one and four patients in the corridor to free up ambulances to attend emergency calls.

We found that on all three days of the inspection patients were held in the corridor area. The time they were resident in the corridor area ranged from 10 minutes up to four hours. During this time it was not clear who retained overall responsibility for the patients’ ongoing monitoring. Some ambulance crews told us that they would take routine observations but others told us they would not as the hospital staff would do this.

There was a designated ambulance triage nurse. However, we observed that this nurse was frequently pulled into other areas of the department to cover. This left the ambulance triage area without a registered nurse presence. We found that patients who presented with high risk medical conditions were held in this corridor for lengthy periods of time. We reviewed five patients in the corridor area and found that four out of five had high risk medical presentations including suspected stroke, head injury and chest pain. The time these patients were resident in the corridor was between 10 minutes and four hours. This was also highlighted as an issue during the 2014 inspection and we found that this had not improved since the last inspection.

Ambulance – Median time to initial assessment from September 2016 to August 2017 at Southport and Ormskirk Hospital NHS Trust

![Graph showing median time to initial assessment](image)
Southport & Formby District General Hospital

From October 2016 to September 2017 there was a slight upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Southport & Formby District General Hospital, peaking in the most recent month, September 2017, when 77% of ambulance journeys had turnaround times over 30 minutes.

Ambulance: Number of journeys with turnaround times over 30 minutes - Southport & Formby District General Hospital

Ambulance: Percentage of journeys with turnaround times over 30 minutes - Southport & Formby District General Hospital

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From July 2016 to June 2017 the trust reported 1,153 “black breaches”, with an upward trend from December 2016 to March 2017. Performance improved in the three most recent months, April to June 2017.
Nurse staffing

The staffing levels expected on a day time shift for the department were 11 Registered nurses and three health care assistants, one of whom was based within the triage room. At night time this was reduced by one staff nurse and one health care assistant. At the time of our inspection we found that night time staffing was not altered in order to the service manage winter pressures.

The staffing in the department was sufficient during the inspection, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. Managers had regular staffing meetings and filled gaps in shift rotas with bank and agency staff. Managers attempted to reduce the risks associated with using bank and agency staff by ensuring these staff were mixed with permanent staff members.

Managers in the department were unable to tell us how staffing levels had been decided and whether a recognised workforce and acuity planning tool had been used. However, there was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty. This included ensuring staff trained in triage were available on each shift.

We observed one nursing staff handover which was comprehensive and well structured. Safety information was handed over as part of this so that staff were aware of any issues, which could affect patient safety.

Managers for the medical division told us that they had an ongoing recruitment campaign and new staff were being recruited all the time.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for nursing and midwifery staff working in Urgent and Emergency Care for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>Planned WTE Staff</th>
<th>WTE in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>107.9</td>
<td>85.6</td>
</tr>
</tbody>
</table>
From July 2016 to June 2017, the trust reported an overall vacancy rate for nursing staff of 22.0% in Urgent and Emergency Care. As at June 2017, the vacancy rate was 20.7%.

Southport and Formby District General Hospital

Southport and Formby District General Hospital reported an overall vacancy rate of 24.4%, with rates consistently over 20% from October 2016 onwards.

As at June 2017, the vacancy rate at the hospital was 23.5%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

From July 2016 to June 2017, Southport and Formby District General Hospital reported a turnover rate of 18.7% for nursing staff in Urgent and Emergency Care:

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From July 2016 to June 2017, Southport and Formby District General Hospital reported a sickness rate of 6% for nursing staff in Urgent and Emergency Care:

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. We are aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported overall bank usage for registered nurses of 1,085 shifts in Urgent and Emergency Care and agency usage of 1,704 shifts. The trust reported that 488 shifts were unfilled by bank and agency staff over this time period.

The trust indicated that high bank and agency staff in Urgent and Emergency Care could mainly be attributed to long term sickness. In addition, the department had recently undertaken a workforce review and the establishment within the department had been increased. Subsequently, this had increased the vacancies within the department.

Southport and Formby District General Hospital

Southport and Formby District General Hospital had bank usage for registered nurses of 939 shifts in Urgent and Emergency Care from April 2016 to March 2017, while 1,703 shifts were covered by...
agency staff. Over this time period, 473 shifts were unfilled by bank or agency staff.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Consultants worked on a rota basis to provide cover seven days a week. Their shifts ran from either 8pm until 12 noon or 12 noon to 8am. The most senior doctor on duty would be a registrar grade doctor (very experienced senior doctor). Consultant cover after 12am was available on an on call basis. However, there were two senior middle grade doctors present in the department between 12am and 8am.

Junior and registrar grade doctors told us they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.

Nursing staff told us that they were able to access medical assistance and advice easily.

We saw evidence that patients were seen promptly by medical staff if flagged up by the nurse following triage and also when additional reviews were requested by nursing staff.

The trust has reported the following planned and actual whole time equivalent (WTE) staffing figures for medical and dental staff working in Urgent and Emergency care for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>Planned WTE Staff</th>
<th>WTE in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>36.0</td>
<td>33.0</td>
</tr>
<tr>
<td>May 2017</td>
<td>36.0</td>
<td>35.0</td>
</tr>
<tr>
<td>April 2017</td>
<td>36.0</td>
<td>33.0</td>
</tr>
<tr>
<td>March 2017</td>
<td>36.7</td>
<td>33.0</td>
</tr>
<tr>
<td>February 2017</td>
<td>36.7</td>
<td>32.5</td>
</tr>
<tr>
<td>January 2017</td>
<td>36.7</td>
<td>33.5</td>
</tr>
<tr>
<td>December 2016</td>
<td>36.7</td>
<td>35.5</td>
</tr>
<tr>
<td>November 2016</td>
<td>35.7</td>
<td>35.0</td>
</tr>
<tr>
<td>October 2016</td>
<td>35.7</td>
<td>37.0</td>
</tr>
<tr>
<td>September 2016</td>
<td>35.7</td>
<td>36.0</td>
</tr>
<tr>
<td>August 2016</td>
<td>35.7</td>
<td>37.0</td>
</tr>
<tr>
<td>July 2016</td>
<td>35.7</td>
<td>31.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

From July 2016 to June 2017, the trust reported an overall vacancy rate for medical and dental staff of 8.3% in Urgent and Emergency Care. As at June 2017, the overall vacancy rate was 8.4%.

Southport and Formby District General Hospital

Southport and Formby District General Hospital had an overall vacancy rate of 4.3% from July 2016 to June 2017. As of June 2017, the rate was 3.0%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)
From July 2016 to June 2017, Southport and Formby District General Hospital reported a turnover rate for nursing staff of 41.1% in Urgent and Emergency Care:
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From July 2016 to June 2017, Southport and Formby District General Hospital reported a sickness rate of 3.1% for medical and dental staff in Urgent and Emergency Care:
(Source: Routine Provider Information Request (RPIR) P19 Sickness)

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the 23 whole time equivalent staff working in Urgent and Emergency Care at Southport and Ormskirk Hospital NHS Trust**

![Staffing skill mix chart]

(Source: NHS Digital Workforce Statistics)

**Records**

The department used paper based patient records and some electronic records.

We reviewed 36 patients’ records in total during our visit and found that records relating to patient treatment were legible and easy to follow in most cases.

We found that records were not secure and were placed in clear plastic holders on the wall of the main department where members of the public could see and access them. The inspection team attempted to read the records through the clear holder and all were successful in being able to ascertain personal details and clinical condition without removing the records.

In 23 out of 23 full records we reviewed we found that at least one section of the nursing record was not completed and key information was missing such as dates, times and interventions. We found that patients’ mental health needs were not always detailed accurately and with sufficient detail to inform staff of their needs. An example of this was a patient who presented with a long standing history of mental health conditions. Their usual medication regime which was an injection was not documented in their records clearly. During our inspection we identified that the
on the triage form was not large enough to transcribe detailed information in. Senior staff in the department told us this issue was being addressed.

The department did not audit records routinely; however, senior nurses told us that they would review records on an ad hoc basis and feedback to staff. There was a monthly ‘cas card audit’ which was undertaken on a monthly basis and looked at the entire patient record. The trust told us that this had improved documentation; however, we did not see any data to support this assertion.

**Medicines**

Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. There were appropriate arrangements in place for the destruction of unwanted and expired medicines. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy.

Emergency medicines and equipment were readily available and there was a procedure in place to ensure they were fit for use. However, we found that in three grab bags of emergency medications there were medications that were out of date and had their seals broken. In one of these bags the fluid in one medication had become cloudy, which meant the medication was no longer effective. We also found some analgesia tablets which were past their expiry date by two years. In the same medication storage area we found that 11 bottles of medication suspensions were all opened with no open date. One of these was issued to the department over two years ago.

Medicines fridges were secured and maximum and minimum temperatures had been recorded in accordance with national guidance. Ambient temperatures were not recorded and the department was noted to be warm.

A number of initiatives had been undertaken by the trust to remind staff that oxygen is a drug that must be prescribed, such as screen saver messages, signs at all oxygen points and medicines management training at staff induction. We found that oxygen was still not prescribed in all cases.

Patient Group Directions (PGDs) were not in use to support patient access to medicines in a timely way, and there was no procedure in place to manage and review them. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We observed that this meant patients did not always receive timely medication. An example of this was a patient with severe abdominal pain who was not provided analgesia at the point of triage.

Most controlled drugs were stored appropriately in locked cupboards in line with legislation on the management of controlled drugs. Records showed these medications were checked on a daily basis. Controlled drugs require additional checks and special storage arrangements because of
their potential for abuse or addiction and also require clear and precise documentation of any wastage.

Across most of the urgent and emergency care service, there were appropriate processes in place for ordering medications and stock reconciliation. A designated pharmacist assisted the department with this. However, during our inspection we found paracetamol tablets that were out of date in 2015. We reviewed medication suspensions and found 11 bottles which were all opened but had no open date. One of these medications was issued in 2015. Hydrogen peroxide was inappropriately stored in the oral suspension cupboard. We found minijets of medications including calcium, atropine and adrenaline that had their seals broken. Staff also had 24 hour access to pharmacy support, if required.

We observed nurses administering medications to patients. They undertook appropriate checks including checking the patient’s name, date of birth and allergy status.

Discharge medications and prescriptions were managed well. Prescriptions for these medications were completed legibly and records for take home medications were amended accordingly. Discharge notifications were provided to patients and to their GPs, where appropriate.

Guidelines on the use and preparation of medication were readily available including specific guidelines for children.

**Incidents**

All staff had access to the trust wide electronic incident reporting system. Staff were able to tell us and demonstrate how they would report an incident using this system. Staff had a good understanding of what would constitute a reportable incident and gave examples of when they had completed an incident report.

Managers reviewed all low level incidents and we saw evidence that appropriate responsive actions were taken as a result of incidents. Managers were able to give examples of incidents they had reviewed and actioned. For example, after a review of incidents by the department and a governance meeting a need to refurbish the mental health room was identified. This was then undertaken in collaboration with a neighbouring trust to ensure it still met the standards required for holding patients subject to a section under the Mental Health Act.

Staff were aware of duty of candour which is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. The urgent care service had exercised duty of candour eight times in the twelve months prior to the inspection. We found that the trust sent a letter explaining and apologising for any harm caused. However, they did not offer face to face meetings and did not involve patient’s relatives in investigations.
We reviewed the timelines of the serious incidents reported for the department, specifically to understand whether they were reported in a timely manner. We found that in all seven cases there was a delay in reporting the incident from the initial date of the incident. The time delay ranged between six days and seven months. We also found that the investigations into serious incidents were not always timely. In some cases the investigation took up to eight months to complete. We reviewed three serious incidents investigation reports and found that in two cases the investigation was thorough and appropriate actions had been identified. However, in one case we found that key causal factors had not been examined and potential areas of learning were missed.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2016 to August 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

(Source: NHS Improvement - STEIS)

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in Urgent and Emergency Care from September 2016 to August 2017 which met the reporting criteria set by NHS England.

The types of incident reported were:

- Slips/trips/falls meeting SI criteria with two (25.0% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (25.0% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (12.5% of total incidents)
- Treatment delay meeting SI criteria with one (12.5% of total incidents)
- Abuse/alleged abuse of adult patient by third party with one (12.5% of total incidents)
- Pressure ulcer meeting SI criteria with one (12.5% of total incidents)
Site specific information can be found below:

- Southport and Formby District General Hospital: six incidents

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017)

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported zero new pressure ulcers, one fall with harm and one new catheter urinary tract infection within urgent and emergency care from September 2016 to September 2017.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Southport and Ormskirk Hospital NHS Trust

(Source: Safety thermometer - Safety Thermometer)
Is the service effective?

Evidence-based care and treatment

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

The emergency department used both National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM) guidelines to guide the care and treatment they provided to patients. Staff were able to show us how they would access guidelines and pathways.

At trust wide level every NICE guidance that is published was reviewed using a gap analysis. This was co-ordinated by the trust’s NICE officer who identified the responsible clinician in conjunction with the trust consultant leads, which included emergency clinicians. Compliance with NICE guidance was documented on an electronic database. The trust wide quality dashboard also included NICE metrics.

A range of evidence based clinical care pathways were available and staff were required to put these in place for patients with relevant conditions. These included fractured neck of femur, sepsis, and stroke and chest pain. These pathways included prompts and treatment steps for staff to follow. We found that in some cases patients were placed on appropriate pathways as soon as their condition was diagnosed, which ensured that they received timely and appropriate interventions. Examples included patients presenting with symptoms of stroke and fractured hip. However, we found that in some cases patients were not placed on the appropriate pathways. Examples included patients presenting with chest pain and sepsis.

The pathways reflected current guidance from the National Institute for Health and Care Excellence (NICE) and RCEM. Policies and procedures reflected current national guidelines and were easily accessible electronically. Staff were able to tell us how they accessed these.

The sepsis pathway was designed using national guidelines for the management of sepsis and included red flag triggers and specific, clear actions to take. The trust audited compliance with the pathway. However, the audit was limited to patients who were placed on the pathway. It did not sample or take account of patients who may have presented with symptoms of sepsis and not been placed on the pathway.

Nutrition and hydration

Patient’s nutrition and hydration needs were well managed.

There were facilities within the department to make drinks and food was available as needed including sandwiches and meals for patients who had spent extended periods in the department.
Patients we spoke with did not raise any concerns about the provision of food and drink within the department. We asked four patients who had been in the departments longer than four hours whether they had been offered food and drink and they all confirmed that they had.

Staff identified patients who were not able to eat and drink and assistance was provided as they required. We also observed staff arranging for patients to receive intravenous fluids if they were unable to eat or drink to ensure they received hydration.

In the CQC Emergency Department Survey, the trust scored 6.5 for the question “Were you able to get suitable food or drinks when you were in the A&E Department?” This was about the same as other trusts.

<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q35. Were you able to get suitable food or drinks when you were in the emergency department?</td>
<td>6.5</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 01/09/2016 - 30/09/2016)

**Pain relief**

Patients did not always receive pain relief when they required it and pain was not always assessed effectively.

We reviewed 26 records specifically in relation to the completion of pain scoring. We found that 26 out of 26 patients did not have pain scores recorded. In 15 of these cases the patient had a primary presentation of pain. We also found that zero out of 26 patients received analgesia on triage.

One patient told us that they had been in pain for a number of hours and despite asking for analgesia they had not received any.

We found that there was no alternative pain scoring tool for patients with a cognitive impairment. In one case we found that a patient who was living with dementia had presented with a fractured hip. This condition can cause significant pain. We found that there was no assessment of pain for this patient and they had not received any analgesia since presentation, over four hours earlier. This was escalated during the inspection and we reviewed this at the well led inspection on 6 December. We found that in three out of three cases pain scores were recorded.

In the CQC Emergency Department Survey, the trust scored 4.3 for the question “How many minutes after you requested pain relief medication did it take before you got it? This was worse than other trusts.

The trust scored 7.6 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.
<table>
<thead>
<tr>
<th>Question – Effective</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q31. How many minutes after you requested pain relief medication did it take before you got it?</td>
<td>4.3</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q32. Do you think the hospital staff did everything they could to help control your pain?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (30/09/2016))

Patient outcomes

Southport and Formby District General Hospital

Southport and Formby District General Hospital did not participate in the RCEM Audit: Moderate and acute severe asthma 2016/17 audit.

(Source: Royal College of Emergency Medicine)

Southport and Formby District General Hospital

In the 2016/17 RCEM audit for severe sepsis and septic shock, Southport and Formby District General Hospital was in the upper quartile compared to other hospitals for all eight agreed metrics:

- Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival
- Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED
- Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to): Within one hour of arrival
- Standard 4: Serum lactate measured: Within one hour of arrival
- Standard 5: Blood cultures obtained: Within one hour of arrival
- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival
- Standard 7: Antibiotics administered: Within one hour of arrival
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival

Senior medical staff told us that although the department was in the upper quartiles, they were still striving to improve against the metrics in this audit and an action plan was in place.

(Source: Royal College of Emergency Medicine)

The 2016/17 Consultant Sign Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

Southport and Formby District General Hospital

Of all 304 patients aged over 30 admitted to Southport and Formby District General Hospital for chronic chest pain in the 2016/17 audit, 20.2% were seen by a consultant, which was in the upper quartile when compared to other hospitals, and 38.5% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%. We found that there was no action plan in pace to address this issue.
Of all patients making an unscheduled return to the ED in 2016/17 with the same condition within 72 hours of discharge, 18.2% were seen by a consultant, which was between the upper and lower quartiles when compared to other hospitals, and 45.5% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%. We found that there was no action plan in place to address this issue.

Of all audited patients over 70 years of age who were admitted with abdominal pain, 10.0% were seen by a consultant, which was between the upper and lower quartiles when compared to other hospitals, and 36.0% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.

(Source: Royal College of Emergency Medicine)

From September 2016 to August 2017, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%.

Whilst the trust’s rate was consistently worse than the England average from September 2016 to April 2017, there was a decrease in the rate from May to August 2017.

In the latest month, August 2017, trust performance was 7.0%, which was better when compared to an England average of 7.8%.

Unplanned re-attendance rate within 7 days - Southport and Ormskirk Hospital NHS Trust

(Source: NHS Digital - A&E quality)


**Competent staff**

From June 2016 to June 2017, 68.9% of staff within Urgent and Emergency Care at the trust had received an appraisal compared to a trust’s target of 90%.

Managers within the department showed us records which showed that over 90% of staff had received an appraisal at the time of the inspection. The human resources (HR) department provided monthly workforce reports to the emergency department for managers to action. Appraisals were also monitored operationally through HR Advisors and Managers meeting with senior managers and clinicians at budget and operational meetings whereby performance against the trust key performance indicator was discussed.

Nursing staff were positive about learning relevant to their role but were less positive about development opportunities.

Clinical supervision was available for medical and non-medical staff. This supervision was available for general day to day issues, However, specific safeguarding supervision was also undertaken. Information provided by the trust showed that compliance levels for supervision within the emergency department were 100%. Medical and nursing staff told us clinical supervision was available and they felt adequately supported. They gave examples of when debriefs had been arranged following significant incidents.

New nursing staff received emergency department specific training. Agency and bank staff received a local department induction on arrival to their shifts. We spoke with two agency staff members and they had both received a local induction and orientation to the department.

**Southport and Formby District General Hospital**

Southport and Formby District General Hospital had a 67.9% appraisal completion rate. A split by staff group can be seen in the graph below. None of the staffing groups met the trust completion rate target of 90%.

![Appraisal completion graph](source: Routine Provider Information Request (RPIR) P43 Appraisals)
Multidisciplinary working

Staff had good working relationships with other staff and disciplines within the hospital and trust. This included staff from medical and surgical specialities, psychiatric liaison and critical care. Nursing staff told us they had good relationships with consultants and doctors of different disciplines. We observed the senior consultants leading the department working closely with the nursing staff and senior managers to facilitate patient care and flow.

Staff told us they received support from pharmacists, physiotherapists, occupational therapists, social workers and diagnostic support. Staff working for an ambulance services told us they felt the staff in the department communicated effectively with them. We observed positive interactions between staff from the ambulance service and staff working in the department.

Staff in the department also worked closely with members of the medical and surgical specialities. This allowed patients awaiting beds in these specialities to be seen promptly.

Specialised support for patients with mental health conditions was available from the psychiatric liaison team which consisted of consultant psychiatrists, registered mental health nurses and mental health support workers. The psychiatric liaison service worked 24 hours a day, seven days a week with patients of all ages who presented to the emergency department. This service was provided by a neighbouring mental health trust.

Seven-day services

The department functioned fully 24 hours a day, seven days a week. Access to radiology services was available 24 hours a day, seven days a week including CT scanning. Consultants provided on call cover for 24 hours, seven days a week. At least two middle grade or registrar doctors were also present in the department 24 hours each day, seven days per week. Staff also had 24 hour access to mental health services.

We saw that staff had access to links with other services in the community when discharging out of hours. These services included community nursing and crisis intervention mental health teams. We saw that staff gave due regard to these needs.

Health promotion

Staff that we spoke with informed us that they were aware of how to access support for patients in relation to health promotion. Staff told us that they routinely undertook health promotion as part of their roles. An example given by a doctor working in the department was his advice to a patient to stop smoking as they had a lung condition. They had arranged for the patient to access smoking cessation. There were health promotional materials available and visible in the department including subjects such as healthy eating and smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were not fully aware and did not understand their obligations and duties under the Mental Capacity Act. Staff did however, display a limited understanding of the Deprivation of Liberty
Safeguards (DoLS). Evidence provided by the trust showed that there had only been one DoLS application for the urgent care service between 01 July 2016 and 30 June 2017.

There was a trust wide consent policy which contained sections on mental capacity. When we asked staff about this policy they were not aware of its existence or how to access it. An audit of compliance with this policy was undertaken in July 2017; However, the emergency department was not included in this audit.

We found that in most cases consent was sought from patients, However, in two cases we could not find evidence of consent being sought.

The emergency department record contained a Mental Capacity Act checklist which helped staff understand whether a patient needed a full mental capacity assessment. We found that 14 out of 19 patients reviewed did not have this checklist completed. We also found that zero out of 19 of these patients had a formal capacity assessment completed. In eight out of 19 cases the patient in question had a condition which may have altered their mental functioning. These included stroke, confusion and head injury. In one case a patient was rapid tranquilised and physically restrained without an MCA checklist, MCA assessment, risk assessment or best interest’s discussion documented. In another case a patient was listed for referral for major hip surgery and there was no evidence of an MCA assessment or best interest discussion.

On one occasion staff did not demonstrate an understanding of how and when to apply relevant legislation governing consent and decision-making, and they did not recognise the difference between lawful and unlawful restraint practices. In this case a patient was restrained by staff using physical restraint and medication. This patient had not had their mental capacity assessed despite presenting with initial confusion and being in the department for a number of hours prior to the incident of restraint. Staff we spoke with were unclear as to why this patient’s capacity had not been assessed and indicated they were restrained because of their mental health issues. On reflection the emergency department team decided the restraint was required in the patient’s best interests for his physical health. The staff involved in the restraint incident did not follow the trust policy on observation and restraint. Steps which were not undertaken included frequent observations, undertaking a risk assessment and completing an incident report.

The capacity assessment we observed for the same patient, which was undertaken by medical staff was brief and we noted was called a DoLS assessment by nursing staff. DoLS assessments are undertaken by local authorities’ usually by a best interest’s assessor and a mental health assessor and not by medical staff.

The safeguarding team (two nursing staff) were the main point of contact for issues relating to mental capacity and capacity assessment. They did not undertake regular information checks or audits in relation to mental capacity. The safeguarding leads’ roles were in their infancy and they recognised there was room for improvement in the records systems and communication with the wards.
No staff could identify a consultant psychiatrist to refer to for advice relating to mental health issues. All issues relating to mental health were referred to the liaison team from a neighbouring trust.

All security staff working for the trust received training in the practices of restraint and the trust's restraint and observation policy.

Southport and Formby District General Hospital reported that, from July 2016 to June 2017, Mental Capacity Act (MCA) level 1 training had been completed by 51.9% of all staff in within Urgent and Emergency Care:

The trust did not provide a target for the completion of this training prior to our inspection.

No information was provided by the trust on the completion of Deprivation of Liberty training within Urgent and Emergency Care.

(Source: Routine Provider Information Request (RPIR) P14/P49)

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

**Is the service caring?**

**Compassionate care**

We observed staff treating patients with kindness and compassion; However, we found that patient’s privacy and dignity was not always maintained. We observed that curtains were closed around patient’s bed areas in the major's areas when staff were providing care.

We spoke with eight patients, who all gave us positive feedback about how staff treated and interacted with them. However, two patients told us they felt uncomfortable about the arrangements for their dignity and privacy.

We also observed that patients were being held on the corridor in various states of condition and undress. We observed patients’ vomiting and in their night wear on trolleys. Patients who were stable and situated in Majors were relocated to the corridor to make space. In one case we observed a sleeping patient moved from the cubicle area to the corridor. The patient had been in the department for over eight hours.

We observed patients receiving clinical care in the corridor area including blood tests and insertion of cannulas. This was highlighted as an issue during the last inspection. However, we observed that the practice continued during this inspection. We also observed patients being transferred...
from trolley to trolley in the corridor and observed parts of their bodies and underwear being exposed.

Patients told us that they felt the escalation was not ‘ideal’ and felt exposed. We asked five staff if they would be happy for their relative to be treated in the escalation area or corridor and they all stated they would not. They told us it was undignified, unacceptable and made them feel ashamed to work in that area of the hospital.

We also found that the triage area was able to be overheard in the corridor area. We overheard staff talking about sensitive conditions and information whilst we were standing in this corridor.

The trust’s Urgent and Emergency Care Friends and Family Test performance (% recommended) fluctuated from August 2016 to July 2017 but was generally worse than the England average. In the most recent month, July 2017, the trust performance was 80.2%, compared to the England average performance of 85.9%.

A&E Friends and Family Test Performance - Southport and Ormskirk Hospital NHS Trust

Low response rates are common for A&E and inpatient friends and family tests, so scores should only be used for probing on inspection

(Source: NHS England Friends and Family Test)

Emotional support

Staff understood the importance of providing patients and their families with emotional support.

We observed staff providing reassurance and comfort to patients and their relatives. However, in the escalation area we observed bad news being broken to a patient who became very distressed. This interaction could be fully overheard by members of the public waiting for x-rays and they told us this made them upset and uncomfortable.

Patients and relatives did However, tell us that staff supported them with their emotional needs. Chaplaincy services were available on site to provide additional emotional support and staff were able to tell us how they would access these for patients.
Staff confirmed they could access management support or counselling services after they had been involved with a distressing event. Staff were included in de briefing sessions, following traumatic events.

### Understanding and involvement of patients and those close to them

The results of the CQC Emergency Department Survey 2016 showed that the trust scored worse than other trusts for one question (question 43) and about the same as other trusts on the remaining 23 questions relevant to caring.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>4.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
<td>----------</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>6.5</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

During our inspection the department was near to full capacity on occasions. We observed that during these times there were insufficient trolley and cubicle spaces to accommodate patients.

The majority of department was easily accessible for patients who required assistance with mobility, including patients who required the use of a wheelchair. However, the temporary area referred to as the escalation area was not.

The department had access to relatives’ rooms which were located within the department. These were comfortable areas in which relatives were able to wait while patients were being treated.

Patients and relatives also had access to vending machines and canteens in the hospital while in the department. Staff were unable to give any specific examples as to how the department tailored its services to the local population.

**Meeting people’s individual needs**

There were adequate facilities in the main department areas to allow access and use by disabled patients including wide corridors and rails in disabled bathrooms. However, this was not the case in the ‘escalation area’. Information leaflets about services available and discharge advice were
readily available in the department. Leaflets could also be provided in different languages or other formats, such as braille and audio, if requested.

Staff told us that they could access a language interpreter if needed and were able to show us how they would do this. Access to psychiatric support was readily available from a neighbouring trust under a service level agreement. There was also a designated room to accommodate patients with mental health problems. This room was fit for purpose and had been appropriately risk assessed.

Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity). The department also had a strategy to help and support individuals experiencing domestic violence including an assessment tool.

There was not a pathway in use for patients living with dementia. Staff told us that they were aware of techniques to help make a patient’s journey better such as treating patients in a calm manner in a quiet area of the department.

In the escalation area, patients with a reduced level of mobility had to use bed pans and bottles as there were a limited number of staff and the toilet near the area was not accessible. We observed one patient had urinated in the bed as they could not manage to use a bottle. When we spoke with three patients who used bottles and bed pans; all three patients told us that they would rather have used the toilet.

The trust scored “about the same as” other trusts for the three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey 30/09/2016)

Access and flow

During the last inspection we found that patients were experiencing unacceptable waits and the department was not meeting standards to ensure patients were seen and treated in a timely way. We told the department and trust that they must improve performance, particularly in relation to the department of health four hour standard, wait times and ambulance handovers. During this inspection we found that the trust and department had tried to implement measures to address this issue. However, patients were still experiencing long waits on a daily basis, performance against
the four hour standard was still below the expected standard and ambulance crews still experienced waits of up to four hours to hand over.

The trust had a bed management policy in place which was not in use during the last inspection. This policy had a published date of March 2016 and was due for review in October 2017. Senior staff within the urgent care directorate advised that this review was in progress but not completed at the time of this inspection. The policy outlined duties in relation to bed management for all staff members.

The policy outlined four levels of escalation green, yellow, amber and red with corresponding number one, two, three and four. There were action cards for each level with designated duties for staff to undertake. The action cards listed a number of criterion to meet these levels. These included the number of free cubicles in majors and resuscitation and the number of ambulance patients waiting to be offloaded. It was not clear in the action cards how many of the criterion needed to be met to reach the levels of escalation. The lead clinician for the emergency department, matron and head of nursing for urgent care advised that only one criterion needed to be met to activate the levels of escalation.

During this inspection we found that for three out of three days the department was at escalation level red four. This was due to the criteria admission cycle time (the amount of time it took to admit a patient to a hospital inpatient bed) was over four hours, no cubicles available in majors or resuscitation and more than five ambulance patients waiting to be brought through to the department.

We found that on all three days key actions outlined for the red level of escalation were not completed. These included not establishing a plan for additional nursing staff with on call managers, flow coordinator and directorate manager to be based in the department and the chief operating officer to provide urgent provision of additional nursing support.

The department staffing allowed for an additional twelfth nurse to act as a ‘floater’ and provide oversight of the waiting room and other areas, which were not easily observed by department clinical staffing. We found that on two out of three days this role was not filled. We observed that during these periods, patients in the waiting room who required close clinical observation did not receive the desired level of monitoring, intervention and observation. This included patients who had conditions such as stroke, abdominal pain and chest pain.

The policy also set out arrangements for additional bed capacity for patients in times of increased pressure. We observed that numerous additional areas were utilised during this inspection in various areas across the hospital. This included four additional beds in the corridor outside of the x-ray department and additional beds in the ambulatory care unit. Neither of these areas were outlined as designated escalation areas within the bed management policy.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust
consistently breached this standard from October 2016 to September 2017.

From December 2016 to March 2017 performance against this metric deteriorated. After a small improvement in performance in April 2017, performance declined again from May to September 2017. This differs from the national trend which showed an improvement in performance in February and March 2017 followed by fairly stable performance from April 2017 onwards.

Since May 2017, the trust has performed consistently worse than the England average. The poorest performance was seen in the most recent month, September 2017, when 85.7% of patients were admitted, transferred or discharged within four hours.

The service and trust had measures in place to ensure that any 12 hours breaches were investigated and reported appropriately. This included measures such as; the CCG to be informed when a patient reaches 8 hours and does not have a robust plan to admit within the 12-hour timeframe, notification of breaches, as and when they occur onto the national system and prompt receipt by CCGs/NHS England of initial timelines, within 48 hours of the breach.

During this inspection we found that the department was still not meeting this target and we observed that patients experienced lengthy waits. We found that on all three days of the inspection both majors and minors patients waited in excess of four hours to be admitted, transferred or discharged.

Four hour target performance - Southport and Ormskirk Hospital NHS Trust

![Chart showing four hour target performance](chart.jpg)

*Admitted, transferred or discharged

(Source: NHS England - A&E Waiting times)

From October 2016 to September 2017, Southport and Ormskirk Hospital NHS Trust’s monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was generally similar to or better the England average. However, in September 2017, there was a sharp deterioration in the trust’s performance when compared to the England average when 359 patients (20.4%) waited between four and 12 hours.

Performance against this metric has shown a trend of decline since May 2017.
This had however, shown an improvement from the last inspection when the department’s performance had generally been worse than the England average in the year preceding the inspection.

**Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted - Southport and Ormskirk Hospital NHS Trust**

![Graph showing percentage of patients waiting between four and 12 hours from the decision to admit until being admitted.](image)

<table>
<thead>
<tr>
<th>Time period</th>
<th>Number of patients between 4 and 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>135</td>
</tr>
<tr>
<td>Nov-16</td>
<td>112</td>
</tr>
<tr>
<td>Dec-16</td>
<td>127</td>
</tr>
<tr>
<td>Jan-17</td>
<td>276</td>
</tr>
<tr>
<td>Feb-17</td>
<td>283</td>
</tr>
<tr>
<td>Mar-17</td>
<td>259</td>
</tr>
<tr>
<td>Apr-17</td>
<td>140</td>
</tr>
<tr>
<td>May-17</td>
<td>129</td>
</tr>
<tr>
<td>Jun-17</td>
<td>177</td>
</tr>
<tr>
<td>Jul-17</td>
<td>202</td>
</tr>
<tr>
<td>Aug-17</td>
<td>178</td>
</tr>
<tr>
<td>Sep-17</td>
<td>359</td>
</tr>
</tbody>
</table>


**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from October 2016 to September 2017, 18 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours was in May 2017 (nine patients).
<table>
<thead>
<tr>
<th>Time period</th>
<th>Number of patients between 4 and 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-16</td>
<td>0</td>
</tr>
<tr>
<td>Nov-16</td>
<td>0</td>
</tr>
<tr>
<td>Dec-16</td>
<td>0</td>
</tr>
<tr>
<td>Jan-17</td>
<td>3</td>
</tr>
<tr>
<td>Feb-17</td>
<td>1</td>
</tr>
<tr>
<td>Mar-17</td>
<td>0</td>
</tr>
<tr>
<td>Apr-17</td>
<td>3</td>
</tr>
<tr>
<td>May-17</td>
<td>9</td>
</tr>
<tr>
<td>Jun-17</td>
<td>0</td>
</tr>
<tr>
<td>Jul-17</td>
<td>2</td>
</tr>
<tr>
<td>Aug-17</td>
<td>0</td>
</tr>
<tr>
<td>Sep-17</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

**Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment**

From October 2016 to August 2017 the monthly percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was generally better than the England average.

From April and August 2017 performance against this metric showed a trend of deterioration, peaking in July 2017 when the percentage of patients leaving the trust’s urgent and emergency care services before being seen for treatment was 3.6%, compared to the England average of 3.4%.

**Percentage of patient that left the trust without being seen - Southport and Ormskirk Hospital NHS Trust**

(Source: NHS Digital - A&E quality indicators)
Median total time in A&E per patient (all patients)

From October 2016 to August 2017 the trust’s monthly median total time in A&E for all patients was generally lower than the England average.

Performance against this metric was stable from October 2016 to April 2017, before deteriorating sharply in May 2017. The longest median time was seen in the most recent month, August 2017, when the trust’s monthly median total time in A&E for all patients was 171 minutes, which was longer than the England average of 144 minutes.

Median total time in A&E per patient - Southport and Ormskirk Hospital NHS Trust

(Source: NHS Digital - A&E quality indicators)

Learning from complaints and concerns

Complaints were well handled and opportunities for learning were identified.

Information on how to raise a complaint and contact details were prominently displayed around the emergency department. Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint from a patient.

We reviewed two completed complaints which related to the emergency department. These complaints had been investigated thoroughly and the responses to the complaints contained sufficient detail. The responses to these complaints were provided to the complainants in a timely way in both cases.

From July 2016 to June 2017 there were 94 complaints about Urgent and Emergency Care services. The trust took an average of 80.8 days (58.8 working days) to investigate and close complaints.

Six of the 76 closed complaints (7.9%) about Urgent and Emergency Care services were closed in over 180 days while three of the 18 complaints that remained open at the time of response were received in 2016 and therefore had been open more than six months. This does not meet the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The most common subjects of the complaints were all aspects of clinical treatment (55); and the attitude of staff (17).
The breakdown of complaints by site was:

- Southport and Formby District General Hospital: There were 79 complaints; the highest number of complaints (47) was about all aspects of clinical treatment.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

### Is the service well-led?

**Leadership**

The sisters within the department were visible and well respected. Staff told us that they provided good leadership and support. The matron had only recently been employed from another role. However, staff told us they found her visible and credible as a leader. Staff told us that they would frequently see the matron in the department helping out.

Staff spoke positively about their local managers and leaders. However, they were less positive when speaking about the divisional leadership team. During our inspections we found that local leaders within the department and some executive leaders were visible and competent in their roles. An example of this was staff told us that the divisional director was frequently in the department assisting staff. Local staff advised that they were unaware of who was who within the wider executive team. While we were in the department we observed staff unsure who executives were and witnessed one member of senior nursing staff mistake a director for an estates worker.

There were clearly defined and visible local leadership roles within the department leadership structure and a clear divisional leadership framework. Both the matron, divisional director and lead consultant were visible and accessible during our visit.

Staff spoke positively about the medical leadership in the department and medical staff told us their senior clinicians in the department supported them well and they had access to senior clinicians when they required.

Staff told us that they had been largely unaffected by the changes to the executive leadership team.

**Vision and strategy**

Staff we spoke with were unaware of any trust or local vision and strategy. They told us that they remembered something about five C’s but then advised this had been from a legacy organisation. We found no evidence that there was a local or trust wide vision and values. There was no local strategy for the urgent care services.

**Culture**

Staff told us they felt respected and valued and would feel secure raising a concern or issue with their line managers. We observed that the culture was focused on the timings of care and patients flow and not always on the quality of care provided to patients. One example of this was that the inspection team overheard senior staff referring to patients by conditions and the number of hours they had been waiting.
Governance
The department was part of the medicine division. The division had a clinical lead, supported by a
divisional business manager and head of nursing. Monthly and quarterly governance meetings
were held and attended by senior staff. Items included for discussion included risks, serious
incidents and incident trends, complaints and lessons learnt.

There was a governance structure in place and staff were able to tell us how this fed up and down
into the operational team.

Management of risk, issues and performance
Risks relating to the department were recorded on the divisional risk register. These risks were
reflective of some of the risks identified during the inspection. It also included control measures in
place to mitigate these risks. We found that this register was up to date. However, some risks
identified within the department were not present on this register or the control measures were no
longer in place. One example of this was the risk to patients being accommodated in the corridor
of the department. This risk had been mitigated by having a staff member in the corridor area to
care for patients. Since the escalation area had opened this staff member was no longer present
in the corridor. There was not an updated risk assessment and mitigation in place for this. Another
risk which was not listed was the risks identified in the escalation area. We also found that the
senior staff within the division were not sighted on the risks in this area and had incorrect
information such as that there were call bells when there were not.

Another example where risks had not been recognised was the use of the corridor as an
escalation area. At the time of the inspection there was no risk assessment or standard operating
procedure in place for this area. The trust subsequently provided an operating procedure for this
area. However, it was created after we raised concerns about this area. When we spoke with staff
after the implementation of this procedure, we found they were not aware of its existence.

There was a system in place that allowed managers to escalate risks to divisional meetings and
senior staff told us that they had previously escalated issues through this route. Audit and
monitoring of key processes took place in the department to monitor performance against
objectives. Senior managers monitored information relating to performance against key quality,
safety and performance objectives. This was provided to senior managers in the division in a
report format.

Information management
Staff within the department told us that they had access to information that was needed for them to
undertake their roles effectively. The different information systems used in the department were
used to collate and inform reports and intelligence for the department managers and the divisional
leaders.

The department used both electronic and paper based records. Staff told us that this did not affect
their ability to access and manage information.
Policies and procedures were readily available on the trust’s intranet site. They told us that pathways and guidelines for care and treatment were also readily available.

**Engagement**

Staff told us received regular communication from their managers and that they felt well engaged with their immediate line managers. Some staff told us that they did not feel engaged with the executive and senior team and they would know them ‘if they fell over them’. We found that team meetings were held and staff did attend although some meetings were poorly attended.

The trust undertook the NHS staff survey to understand staff engagement and experience. In total 3368 staff were surveyed across the trust and 1646 completed questionnaires were returned from the staff sample, this equated to a response rate of 49%. This compared favourably to the overall national response rate for Acute Trusts in England was 43%.

The response to the overall indicator of staff engagement was the ‘Staff Friends and Family test question,” this question looked at staff members’ willingness to recommend the Trust as a place to work or receive treatment”. The trust scored below (worse than) average compared with all combined acute and community trusts across England.

Another area looked at in this survey was ‘Staff motivation at work (the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs)’. This score showed a score of average (no change on 2015).

The question in the survey around staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work) which showed a below (worse than) average score compared with all combined acute and community trusts.

This survey data was not provided at a local level for the urgent care service.

We found limited evidence of patient engagement in the service or any efforts to undertake this. However, at a trust wide level a number of patient surveys had been undertaken. The department did participate in the NHS Friends and Family test and we saw that the results of this survey were discussed at meetings.

Information provided by the trust showed that individual staff performance was monitored and where poor performance was identified appropriate action was taken. In the period 01 July 2016 to 30 June 2017 four staff members were either suspended from practice or placed on supervised practice.
Medical care (including older people’s care)

Facts and data about this service

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

The hospital had 21,890 medical admissions between July 2016 and June 2017. Emergency admissions accounted for 10,617 (48.5%), 314 (1.4%) were elective, and the remaining 10,959 (51%) were day case.

Admissions for the top three medical specialties were:

- General Medicine: 13,564
- Clinical Haematology: 5,606
- Pain management: 1,689

(Source: CQC Insight)

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

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

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

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

Southport and Formby District General Hospital

There are 265 beds located within 11 wards:

Please note that the Spinal Unit has been excluded as this will be inspected separately.

Ormskirk and District General Hospital

There are 16 beds located within one ward (Ward A – Rehabilitation).

(Source: Routine Provider Information Request – Acute Sites)
Is the service safe?

Mandatory training

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has not provided any targets for the completion of mandatory training.

Southport and Formby District General Hospital

The service provided mandatory training in key skills to all staff, but had not made sure that everyone completed it.

At our last inspection in January 2016, we told the medical care services it must take action to improve in a number of areas. This included ensuring staff had the required skills and competencies and improve mandatory training completion.

During this inspection we found that the medical care services had failed to make significant improvements in relation to staff training. For example, training rates fell below 60% in areas such as resuscitation, infection prevention [level two], hand hygiene and manual handling.

Data supplied by the trust showed that mandatory training completion for medical and nursing staff was still low, particularly in areas such as resuscitation [2.8% completion rate] and Infection Prevention (Level 1) [0% completion rate].

The division had a mandatory training policy. This was based on training needs analysis that determined which training staff had to undertake based on their roles and responsibilities. They were required to undertake a range of general and role specific mandatory training modules in line with the policy and the mandatory training schedule. This also set out the frequency that each module was to be repeated. Subjects included equality and diversity, health and safety, infection prevention, hand hygiene and fire safety, and resuscitation.

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Medicine at Southport and Formby District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>40</td>
<td>45</td>
<td>88.9%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>36</td>
<td>45</td>
<td>80.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>36</td>
<td>45</td>
<td>80.0%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>36</td>
<td>45</td>
<td>80.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>33</td>
<td>45</td>
<td>73.3%</td>
</tr>
<tr>
<td>Name of course</td>
<td>Number of staff trained (YTD)</td>
<td>Number of eligible staff (YTD)</td>
<td>Completion (%)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 and 5 (Prevent Awareness) - 3 Years</td>
<td>29</td>
<td>45</td>
<td>64.4%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>26</td>
<td>44</td>
<td>59.1%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>25</td>
<td>44</td>
<td>56.8%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>22</td>
<td>45</td>
<td>48.9%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>13</td>
<td>44</td>
<td>29.5%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>10</td>
<td>45</td>
<td>22.2%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>1</td>
<td>36</td>
<td>2.8%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>0</td>
<td>4</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff was 57.7% from July 2016 to June 2017. Four modules had completion over 80% equality and diversity, information governance, health and safety (slips, trips and falls) and fire safety while no staff had completed the infection prevention level one module and only one of the 36 eligible staff had completed the resuscitation module over this time period.

From July 2016 to June 2017 the data provided by the trust showed that 2.8% of medical staff had completed their resuscitation training. This was an improvement from previous years which showed that 1.9% of medical staff at the hospital had completed resuscitation training in 2015/16 and 1.5% in 2016/17. The infection prevention level one module had been completed by 38.5% and 29.6% of medical staff in 2015/16 and 2016/17, respectively.

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>19</td>
<td>21</td>
<td>90.5%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>131</td>
<td>155</td>
<td>84.5%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>127</td>
<td>155</td>
<td>81.9%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>120</td>
<td>155</td>
<td>77.4%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>114</td>
<td>155</td>
<td>73.5%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>103</td>
<td>155</td>
<td>66.5%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 and 5 (Prevent Awareness) - 3 Years</td>
<td>101</td>
<td>155</td>
<td>65.2%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>97</td>
<td>150</td>
<td>64.7%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>91</td>
<td>152</td>
<td>59.9%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>88</td>
<td>155</td>
<td>56.8%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>86</td>
<td>155</td>
<td>55.5%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>82</td>
<td>155</td>
<td>52.9%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>13</td>
<td>162</td>
<td>8.0%</td>
</tr>
<tr>
<td>Prevent Awareness - 3 Years</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
For nursing staff at Southport and Formby District General Hospital, the overall completion rate was 62.3% from July 2016 to June 2017. Only 13 of the 162 eligible staff (8.0%) had completed the resuscitation module while neither of the two eligible staff members had completed the 3-year preventing awareness module.

Analysis of data for 2015/16 and 2016/17 found that 29.2% and 9.6% of nursing staff, respectively, had completed the resuscitation module. Neither of the two eligible staff members had completed the 3-year preventing awareness module in 2016/17 while no data was provided for 2015/16.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse.

There was a safeguarding policy in place that was accessible to staff. Staff we spoke with could explain what they would do if they had a concern about a patient or their family member and they understood the correct process to follow. There was a safeguarding lead to support staff.

The safeguarding team told us that they had delivered some training to ward staff. However, as records of who had undertaken the training and when training sessions had taken place were not kept, we could not confirm exactly how many staff had received this training.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust did not provide a target for the completion of safeguarding training or any data for the number of medical/dental or nursing staff within Medicine who were trained on the safeguarding adults and children level one modules.

**Southport and Formby District General Hospital**

Southport and Formby District General Hospital had an overall safeguarding training completion rate for all medical/dental and nursing staff of 89% from July 2016 to June 2017.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental and nursing staff in Medicine at Southport and Formby District General Hospital is shown below:
Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one: 93.9%
- Safeguarding adults level two: 92.8%
- Safeguarding adults level three: 94.2%
- Safeguarding children level one: 94.7%
- Safeguarding children level two: 90.9%
- Safeguarding children level three: 92.7%

However, this information was not broken down into the core services we inspected.

**Cleanliness, infection control and hygiene**
The service did not control infection risk well. They did not always use control measures effectively to prevent the spread of infection. Say how many infection outbreaks they had had.

Some of the wards we inspected did not appear to be clean and well maintained. For example, we found that some of the floors were visibly dirty. Most wards were cluttered with equipment; staff reported that wards were short of storage space. On wards 10B and 9B the sluice area was untidy with empty discarded packaging. For example, wrapping from dressing packs, empty boxes and general ward clutter.

Staff confirmed that side rooms were used as isolation rooms for patients identified as having a condition which may be contagious. However, we observed that there was no clear signage outside the rooms so staff and visitors were not always aware of the increased precautions they must take when entering and leaving the room. For example, on ward 10B we noted staff and visitors entering side rooms without personal protective equipment, we also noted that the door to the side room was left open.

We observed infection control and prevention practice and found that not all staff followed the PPE guidance such as wearing gloves and aprons when supporting patients or providing care. For example on ward 10B we saw a member of staff feeding a patient a sandwich without gloves. On ward 10A we noted another member of the nursing staff moving from providing care from one patient to another without washing their hands or using hand sanitizers and on ward 9B a member of the nursing staff was observed walking through the ward with a used bed pan without wearing gloves or an apron.

An infection prevention and control policy was in place and we found staff were aware of this policy. A range of infection prevention and control audits were conducted monthly. Infection prevention and control was classed as a component of mandatory training for clinical staff. There was adequate access to hand gels and handwashing sinks in clinical areas and also at the point of care. However, throughout our inspection, on five of 11 wards we visited, we found that staff were not adhering to policies and protocols.

**Environment and equipment**

There was insufficient storage for essential equipment on many wards in the medical directorate. This meant that corridors and bed bays in the wards were cluttered with medical care equipment, making it difficult for staff and patients to move freely around the wards. For example, we found two trolleys being stored in the seated waiting area of the GP assessment unit with a further four trolleys and wheelchairs being stored in the corridor outside. On ward 10B we observed two trolleys on the main ward corridor and on ward 10A we noted that the main ward corridor was cluttered, with items such as wheel chairs and a file cabinet. This lack of storage added to the general disorganised appearance of wards. This also posed a risk of unsteady patients falling over equipment as they moved around the ward.

There was a lack of space on most of the wards in the medical directorate with which to have private conversations with patients and families. The ward manager's office was frequently used.
for this purpose. This was an inappropriate space and also meant that there were often times when the ward managers could not use their offices.

Resuscitation trollies were available in all areas we visited and were tagged with tamper evident seals. We also noted that wards had Sepsis trollies, which were tagged with tamper evident seals. However, we noted that the tops of some trollies were cluttered, and dusty, for example we noted that on wards 10B, 10A and 9B the resuscitation trollies all had a large amount of clutter such as file boxes, medical tubing, and plastic containers.
Assessing and responding to patient risk

The service had arrangements in place to assess and respond to patient risk. Arrangements to recognise the development of sepsis known as the “sepsis 6 bundle” were implemented in April 2017 to assist in recognising changes in patients’ conditions.

At the last inspection we found that risk assessments within medical care services were not completed consistently for all patients when admitted to hospital or reviewed regularly. The last inspection also found that early warning scores were not always completed in a timely manner leading to the delayed escalation of deteriorating patient conditions.

At this inspection we reviewed 27 patient records and found that a range of assessment had been completed to identify patients' needs. Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. The risk assessments included falls, pressure ulcers and nutrition. Records showed early warning scores had been completed appropriately. However, we noted that one patient was in the discharge lounge, whilst obviously very unwell. We spoke with staff about this and were given assurance the patient would be moved. We returned later that day the patient had been moved to another ward.

Nurse staffing

At the last inspection we found there was not always sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of the patients. At this inspection we found that staffing levels remained a challenge, particularly nurse staffing.

The trust used an acuity tool to match the number of staff to the needs of patients. Numbers of registered nurses and health care assistants were displayed on boards when entering wards for patients, visitors and staff to view.

Nurse staffing establishment levels across all wards were variable. All wards we visited had vacancies that were being filled by either staff working extra hours or agency workers. All staff we spoke with reported concerns about staffing levels across medical services.

We noted that on the cardiology ward [7a] there were two trained nurses on a ward with 28 patients. We looked at the staff off duty and saw that this had often been the case over the last three months. We spoke with staff who confirmed that although there should be at least three trained nurses on the ward, there were usually only two. One member of staff told us that even on the days when they did have three nurses on shift, one would often be sent either on training or to support other wards that were short staffed. However, rotas’ we reviewed did not specifically show when a nurse had been moved to another ward or had gone on training.

The trust had implemented an electronic safe at all times system. This reviewed staffing three times a day, although the system relied heavily on up to date inputting of data and did not include such mitigating factors, as student nurse or band seven ward manager availability.
All managers reported staffing levels to be a risk and staffing was on the risk register. There were actions identified to mitigate the risk, such as a rolling programme of recruitment and any shortfalls in staffing were highlighted to senior managers daily. Managers regularly moved staff around the service to fill staffing shortages. Staff reported that this often left them short on their ward once staff were moved and potentially unbalanced the skill mix on the ward.

Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across medical services. Managers informed us that, to ensure patient safety, extra bank health care workers were used to fill the shortfalls and provide assistance to the nursing staff. However, this could risk an imbalance of skill mix and did not mitigate the need for trained nurses to be on shift to provide the care and treatment needed to unwell patients.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for nursing staff working in Medicine for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>235.5</td>
<td>185.7</td>
</tr>
<tr>
<td>May 2017</td>
<td>235.5</td>
<td>185.8</td>
</tr>
<tr>
<td>April 2017</td>
<td>237.5</td>
<td>186.5</td>
</tr>
<tr>
<td>March 2017</td>
<td>238.1</td>
<td>189.3</td>
</tr>
<tr>
<td>February 2017</td>
<td>237.1</td>
<td>187.8</td>
</tr>
<tr>
<td>January 2017</td>
<td>237.1</td>
<td>190.5</td>
</tr>
<tr>
<td>December 2016</td>
<td>235.5</td>
<td>194.8</td>
</tr>
<tr>
<td>November 2016</td>
<td>226.0</td>
<td>184.3</td>
</tr>
<tr>
<td>October 2016</td>
<td>224.0</td>
<td>176.1</td>
</tr>
<tr>
<td>September 2016</td>
<td>223.5</td>
<td>176.4</td>
</tr>
<tr>
<td>August 2016</td>
<td>218.4</td>
<td>166.2</td>
</tr>
<tr>
<td>July 2016</td>
<td>218.4</td>
<td>165.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

**Vacancy rates**

Southport and Formby District General Hospital reported from July 2016 to June 2017 there was an overall vacancy rate of 19.1%. The rate was over 15% in all months over this time period, with the highest rate being reported in July 2016 (22.5%).

The hospital reported a vacancy rate of 19.6% in June 2017. The highest rates were was found in the Discharge Lounge 51.1% vacant posts and the Frail Elderly Short Stay Unit 38.9% vacant posts).

**Turnover rates**

From July 2016 to June 2017, Southport and Formby District General Hospital reported a turnover rate for nursing staff in Medicine of 10.6%.
Sickness rates

From July 2016 to June 2017, Southport and Formby District General Hospital reported a sickness rate of 5.1% for nursing staff in Medicine:

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. We are aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported bank usage for registered nurses in Medicine of 1,972 shifts and agency usage of 2,048 shifts. There were 1,945 shifts unfilled by bank and agency staff in Medicine. This meant that bank and agency staff were used for 10.9% of shifts from April 2016 to March 2017. In the same time period the service were unable to fill 5.3% of shifts.

The trust stated that sickness absence was being managed in line with their Attendance Management Policy. Additionally they stated that they were recruiting a pool of Health Care Assistants to support patients who required one to one support, sickness absence and reduce the reliance on bank and agency staff.

Southport and Formby District General Hospital

Southport and Formby District General Hospital had 1,759 shifts in Medicine covered by bank staff from April 2016 to March 2017. The highest bank usage was in Ward 15A General Medicine (455 shifts).

There were 2,024 shifts at the hospital covered by agency staff. The highest agency usage was in Ward 9B Acute Medicine (607 shifts).

Over this time period, 1,899 shifts were unfilled by bank or agency staff. The highest numbers of unfilled shifts were in Ward 9B Acute Medicine (432 shifts) and Ward 7A Medical Cardiology (426 shifts).

The trust reported that bank and agency staff usage in Ward 15A General Medicine, Ward 7A Medical Cardiology and Ward 9B Acute Medicine could mainly be attributed to long term sickness.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing

Medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.
The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for medical and dental staff working in Medicine for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>80.6</td>
<td>78.4</td>
</tr>
<tr>
<td>May 2017</td>
<td>80.6</td>
<td>76.4</td>
</tr>
<tr>
<td>April 2017</td>
<td>80.6</td>
<td>78.4</td>
</tr>
<tr>
<td>March 2017</td>
<td>80.6</td>
<td>78.4</td>
</tr>
<tr>
<td>February 2017</td>
<td>80.6</td>
<td>76.9</td>
</tr>
<tr>
<td>January 2017</td>
<td>80.6</td>
<td>76.9</td>
</tr>
<tr>
<td>December 2016</td>
<td>80.6</td>
<td>77.7</td>
</tr>
<tr>
<td>November 2016</td>
<td>80.6</td>
<td>79.4</td>
</tr>
<tr>
<td>October 2016</td>
<td>80.6</td>
<td>77.4</td>
</tr>
<tr>
<td>September 2016</td>
<td>80.6</td>
<td>76.4</td>
</tr>
<tr>
<td>August 2016</td>
<td>80.6</td>
<td>84.5</td>
</tr>
<tr>
<td>July 2016</td>
<td>80.6</td>
<td>72.7</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From July 2016 to June 2017, Southport and Formby District General Hospital reported an overall vacancy rate for medical and dental staff in Medicine at 2.4%.

Turnover rates

From July 2016 to June 2017, Southport and Formby District General Hospital reported a turnover rate for medical and dental staff in Medicine of 9.7%:

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2016 to June 2017, Southport and Formby District General Hospital reported a sickness rate for medical and dental staff in Medicine of 1.2%:

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.

Matrons attended trust wide ‘safe at all times’ briefings three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients.

Recruitment events were planned for nurses where selection could take place at the same time.
During the inspection, senior managers told us there were between 15 and 20 vacancies across the division. This included both registered nurses and health care assistant vacancies.

Ward managers told us that gaps in rotas were being filled by bank and agency staff, many of which were nurses formerly employed by the trust. Nursing staff were offered overtime, although many nurses we spoke with said they couldn’t always take on over time as they already worked long – day shift patterns.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher. *Please note that this analysis includes staff in the Spinal Unit.*

**Staffing skill mix for whole time equivalent staff working in Medicine at Southport and Ormskirk Hospital NHS Trust**

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>33%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career</td>
<td>16%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>12%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>39%</td>
<td>22%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Workforce statistics (01/06/2017 - 30/06/2017))

**Records**

Staff kept appropriate records of patients’ care and treatment. Records relating to patient risk, medicines and medical intervention were clear, up-to-date and available to all staff providing care.

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. Most patients had an individualised care plan that had been reviewed and updated.

We reviewed 27 patient records and found them all to be legible and included the name of the doctor reviewing the patient; However, none of the records we reviewed contained a summarised care and treatment plan.
At the last inspection we found that records in medical care services were not always stored securely. During this inspection we found storage of patient records in some areas remain a concern. We found on ward 10B and 7B the notes trolleys had been left unlocked. Other important confidential nursing records were not kept locked away. For example on ward 9B, nursing files containing confidential patient information were housed opposite the nursing station in a filing unit. We also found that computers were not always locked when unattended to prevent data from being seen by unauthorised people.

There were whiteboards on each of the wards we visited, that included either the full names or initials patients on the wards. We were told by staff that only patients that had consented to their name being displayed were in full view. This was confirmed by patients and a relative we spoke to.

**Medicines**

Medicines were prescribed, administered, recorded and generally stored appropriately. Patients received the right medication at the right dose at the right time.

On all of the wards we visited we noted that medicines were stored in trolleys that were secured to walls when not in use.

We found that there were incomplete daily checks of clinical fridges or medicine room temperatures on all wards we visited. For example on ward 10B we found no recorded fridge temperature checks for the 12, 20 and 26 October 2017. We also found no recorded checks for the medicine room on ward 9B for November 2017.

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.

We saw no formal recorded evidence that fridge temperatures were being audited by managers overseeing the wards. This was an issue that was raised following our last inspection.

**Incidents**

Managers told us that they investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. However, records we reviewed showed that investigations weren’t comprehensive in all cases and all root causes weren’t always identified. We reviewed a sample of 10 incident reports. We found that these included information recorded within the trusts electronic incident reporting system. These showed that in six cases, the trust carried out an initial review followed by a root cause analysis and action plans in place to support improvement. However, in discussions with staff across the division, it was clear that these root cause analysis and action plans were not always included with the incident feedback given to staff.

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 types of incidents that should be recorded; they understood what constituted an incident.

However, some staff told us they did not always report near misses or incidents that caused no harm to patients. This meant there may be missed opportunities to learn from these types of incidents. Examples given included patient falls, development of pressure ulcers or insufficient staffing levels on the ward.

Records we reviewed confirmed that mortality reviews took place and incidents were considered as part of these reviews.

Staff were aware of the duty of candour and what this meant. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be classed as a never event.

From September 2016 to August 2017, the trust reported no incidents classified as never events for Medicine.

(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents in Medicine which met the reporting criteria set by NHS England from September 2016 to August 2017.

![Bar chart showing breakdown of serious incidents]

Of these, the most common type of incident reported was:

- Slips/trips/falls meeting the criteria with five (38.5% of total incidents).
- Pressure ulcer meeting the criteria with five (38.5% of total incidents).
• Diagnostic incident including delay meeting the criteria (including failure to act on test results) with two (15.4% of total incidents).

• Treatment delay meeting the criteria with one (7.7% of total incidents). 13 incidents

Site specific information can be found below:

• Southport and Formby District General Hospital: 10 incidents
• Ormskirk and District General Hospital: one incident
• Not specified: one incident

(Source: Strategic Executive Information System (STEIS)) 12 incidents where has the other one gone?

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month, a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, 10 falls with harm and 30 new catheter urinary tract infections from September 2016 to September 2017 for medical services.

Each ward displayed a colour-coded ‘safety cross’ each month. This included information regarding falls, pressure ulcers and care of any deteriorating patient. This information was displayed at the entrance to the wards, for staff, patients and visitors to view.

Please note that this analysis includes the Spinal Unit.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Southport and Ormskirk Hospital NHS Trust

![Graph of Total Pressure ulcers (23)]
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. In the main, managers checked to make sure staff followed guidance.

Medical care services participated in all relevant national audits they were eligible to complete.

The service used national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute for Health and Care Excellence guidance and were taking steps to improve compliance where further actions had been identified. For example, an action plan for improving diabetes in adults had been developed along with the recruitment of a diabetes specialist nurse to improve care and treatment for people with diabetes.

Stroke specialist nurses attended the accident and emergency department if a patient was admitted with a suspected stroke. Pathways were in place to ensure that patients who had suffered a stroke were treated quickly and moved to the high dependency unit or to the stroke unit for the correct care and treatment. However, during inspection we identified three cases where patients were suspected of having a stroke and had not been referred to the specialist stroke nurse. One patient was triaged in the Emergency Department, however, when we raised this patient with a member of the stoke team, it was clear that the patient had not been referred to the stoke team for further assessment. Another patient we identified had come through the Emergency Department and was an inpatient on the observation ward. Again in discussion with the stoke team it was clear that they were unaware of this patient. Following discussions with us a stroke nurse located that patient and undertook the appropriate assessment.

Staff did not consistently follow the trust Mental Capacity and Deprivation of Liberty Safeguards Operational Procedure. Staff we spoke with did not have a clear insight on how to assess patients’ capacity to make decisions about their care. Staff training relating to the Mental Capacity Act, and Deprivation of Liberty Safeguards, was not fully embedded within the trust.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The
patient records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition and we saw that these were reviewed at appropriate intervals. We found patients that were on food charts and fluid balance charts to monitor intake, had these were completed and updated routinely.

Following assessments, patients identified as requiring a further assessment by a dietician were not always referred in a timely manner. Some staff we spoke with told us that wards had limited access during the day to a dietician who could provide advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. Staff told us this was due to current staffing issues and we confirmed this with senior managers.

Medical wards had access to a diabetes specialist nurse who was available for advice for patients and staff. We saw evidence that blood glucose monitoring was undertaken at regular intervals and that patients whose readings were out of range were escalated appropriately. However, one of the relatives we spoke with on ward 15A raised concerns regarding the management of her father’s Type 1 diabetes. The relative we spoke with said: “They have no concept of Type 1 diabetes, the food comes at one time and the medications ages later. This causes my [relative] a lot of stress as he manages his diabetes and diet well at home.” Food and medication charts we reviewed relating to this patient confirmed that there was an extended period of time between meals and medication.

Most patients we spoke with reported that they enjoyed the food provided by the hospital. In the Patient Led Assessment of the Care Environment survey for 2013, 2014 and 2015 the hospital scored 87% in the quality of the food provided, which was the same as the England average.

Staff we spoke with confirmed that adjustments to the food available could be made to accommodate people’s individual needs, religious and cultural beliefs. However, on ward 10B we observed one patient who had slumped down in the bed and was therefore unable to reach his food. We raised this with ward staff, who immediately attend to the patient and made sure he was supported to sit upright to eat.

**Pain relief**

There was access to a range of medications for pain relief, this included patient controlled analgesia.

Pain relief was managed on an individual basis, and was regularly monitored. Pain scores were routinely collected and recorded by nursing staff through observation rounds. We also observed this information being discussed at nurse handovers.

Patients we spoke with told us that they had access to regular pain relief.

**Patient outcomes**

The Summary Hospital-level Mortality Indicator is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The indicator is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital.
The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected.

In March 2017, the trust’s SHMI was 119 which was higher (worse) than expected.

Hospital Standardised Mortality Ratio refers to the ratio of the actual number of acute in-hospital deaths to the expected number of in-hospital deaths. The mortality ratio for the period from April 2016 to March 2017 was higher (worse) than expected with a value of 117.1 (compared to 100 for England) this meant there were 789 deaths against expected 674. Weekend mortality ratio was also higher than expected for this time period.

Mortality and morbidity of patients was included in monthly meetings. We saw records which confirmed that there was some discussion, to both share good practice and drive improvement across directorates. Incidents, complaints and lessons learnt were discussed at monthly governance committee meetings.

**Relative risk of readmission**

*Please note that this analysis includes the Spinal Unit.*

**Trust level**

From June 2016 to May 2017, patients at the trust had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England average.

Elective admissions

- Patients in Clinical Haematology, General Medicine and Pain Management had lower than expected risks of readmission for elective admissions

Non-Elective admissions

- Patients in General Medicine and Cardiology had lower than expected risks of readmission for non-elective admissions

- Patients in Geriatric Medicine had a similar to expected risk of readmission for non-elective admissions

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES - Readmissions (01/06/2016 - 31/05/2017)

Southport and Formby District General Hospital

From June 2016 to May 2017, patients at Southport and Formby District General Hospital had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England average.

Elective admissions

- Patients in Clinical Haematology and General Medicine had lower than expected risks of readmission for elective admissions

Non-Elective admissions

- Patients in General Medicine and Cardiology had lower than expected risks of readmission for non-elective admissions
- Patients in Geriatric Medicine had a similar to expected risk of readmission for non-elective admissions

Elective Admissions - Southport and Formby District General Hospital

Non-Elective Admissions - Southport and Formby District General Hospital
Sentinel Stroke National Audit Programme (SSNAP)

Southport and Formby District General Hospital

Southport and Formby District General Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A to E, where A is best, the trust achieved an overall level of grade C in the latest audit, which covered the time period from December 2016 to March 2017. The overall score for the unit showed an improvement in this time period when compared to three previous time periods, January to November 2016, when the unit achieved an overall score of D.

Both patient centred and team centred performance have fluctuated from October 2015 to March 2017 with scanning and physiotherapy showing an improvement over this time period and the discharge process showing a deterioration.

The stroke unit had patient and team centred scores of E throughout the whole period, October 2015 to March 2017.

A stroke steering group has been established to monitor performance.

<table>
<thead>
<tr>
<th>Patient centred Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
</tr>
<tr>
<td>Oct-Dec 15</td>
</tr>
<tr>
<td>C↓</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
</tr>
<tr>
<td>D↓</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
</tr>
<tr>
<td>C↓</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team working</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>Patient-centred Total Key Indicator Level</td>
</tr>
<tr>
<td>C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Team centred Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
</tr>
<tr>
<td>Oct-Dec 15</td>
</tr>
<tr>
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<tr>
<td>Domain 2: Stroke unit</td>
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<tr>
<td>A</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
</tr>
<tr>
<td>C↓</td>
</tr>
</tbody>
</table>
Heart Failure Audit

Southport and Formby District General Hospital

In-hospital Care Scores

Results for Southport and Formby District General Hospital in the Heart Failure Audit covering the time period from April 2016 to March 2017 were worse than the England and Wales average for all four of the standards relating to in-hospital care.

<table>
<thead>
<tr>
<th>Cardiology inpatient (%)</th>
<th>24.2%</th>
<th>45.7%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input from consultant cardiologist (%)</td>
<td>49.1%</td>
<td>56.9%</td>
</tr>
<tr>
<td>Input from specialist (%)</td>
<td>72.2%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Received echo (%)</td>
<td>81.9%</td>
<td>90.1%</td>
</tr>
</tbody>
</table>

Discharge Scores

Results for Southport and Formby District General Hospital were better than the England and Wales average for all seven standards relating to discharge.
National Diabetes Inpatient Audit

The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital whatever the cause, and aims to support quality improvement.

The audit attributes a quartile to each metric which represents how each value compares to the England distribution for that audit year; quartile 1 means that the result is in the lowest 25 per cent, whereas quartile 4 means that the result is in the highest 25 per cent for that audit year.

The 2016 National Diabetes Inpatient Audit identified 59 inpatients with diabetes at Southport and Ormskirk Hospital NHS Trust. This was equal to 15.3% of the beds audited, which places Southport and Ormskirk Hospital NHS Trust in Quartile 2.

In Southport and Ormskirk Hospital NHS Trust, 94.8% of patients with diabetes in 2016 reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in Quartile 4.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

Southport and Formby District General Hospital

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 96.4% of nSTEMI patients were admitted to a cardiac unit or...
ward at Southport and Formby District General Hospital and 29.3% were seen by a cardiologist or member of the team compared to England averages of 96.2% and 55.8%, respectively.

The proportion of nSTEMI patients who were referred for or had angiography at Southport and Formby District General Hospital was 83.5% compared to an England average of 83.6%.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>nSTEMI patients seen by a cardiologist or a member of team</th>
<th>nSTEMI patients admitted to cardiac unit or ward</th>
<th>nSTEMI patients that were referred for or had angiography (incl after discharge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southport and Formby District General Hospital</td>
<td>140</td>
<td>140</td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>96.4%</td>
<td>29.3%</td>
<td>83.5%</td>
</tr>
<tr>
<td>England: overall</td>
<td>47,039</td>
<td>47,039</td>
<td>39,082</td>
</tr>
<tr>
<td></td>
<td>96.2%</td>
<td>55.8%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: National Institute for Cardiovascular Outcomes Research (NICOR))

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 75.0%, which did not meet the audit minimum standard of 90%. The 2015 figure was 79.0%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 26.7%. This was not significantly different from the national level of 24.0%. The 2015 figure was 21.0%.

The proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 53.6%; this was not significantly different from the national level of 64.0%. The 2015 figure was 54.0%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 75.0%; this was not significantly different from the national level of 69.0%. The 2015 figure was 58.0%.

The one year relative survival rate for the trust in 2016 was 32.6%, which was significantly worse than the national level of 38.0%.

(Source: National Lung Cancer Audit)

Following the audit, the trust have informed us that a new cancer nurse has been appointed who was reviewing service provision.

National Audit of Inpatient Falls

Southport and Formby District General Hospital

Southport and Formby District General Hospital had a multi-disciplinary working group for falls prevention where data on falls were discussed at most or all the meetings.

The falls risk assessment tool was under review at the time of inspection.

The crude proportion of patients who had a vision assessment (if applicable) was 69.0%; this failed to meet the national aspirational standard of 100%. 
The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 11.1%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 60.0%; this failed to meet the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 40.0%; this failed to meet the national aspirational standard of 100%.

Action plans were in place to address issues raised by national audits and risk rated using a red, amber, green system to monitor results from audits undertaken.

The trust undertook internal audits. These were reviewed at departmental meetings or joint cross divisional meetings.

**Competent staff**

New staff had an induction and their competency was assessed before working unsupervised. Agency staff confirmed that they had inductions before starting work.

The service had not made sure staff were competent for their roles. Managers had not appraised all staff’s work performance.

Senior managers recognised that appraisal rates had been below the trust’s target. From the trust’s dashboard in October 2017, on average, 60% of staff on the medical wards had undertaken a personal development review.

**Appraisal rates**

From July 2016 to June 2017, 63.7% of staff within Medicine at the trust had received an appraisal. This was below the trust’s target of 90%.

**Southport and Formby District General Hospital**

Southport and Formby District General Hospital had a 61.3% appraisal completion rate. A split by staff group can be seen in the graph below:
The qualified allied health professionals staff group met the trust completion rate target of 90%. Only 16.7% of NHS infrastructure support staff had completed an appraisal while the one member of support to scientific, therapeutic and technical (ST&T) staff had not completed an appraisal.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The medicine division services encompassed a range of disciplines. For example nursing and allied health professionals such Dietitians and Speech and Language Therapists [SaLT].

Regular multidisciplinary team meetings were held on the wards and at senior levels to discuss patient care.

We observed handovers, which included healthcare assistants, nurses and medical staff. We saw that there was effective communication and the handovers were generally well structured. Daily ward meetings were held on the medical wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge.

Medical patients who were being cared for and treated on surgical wards were not seen by the therapy team covering the surgical ward. This meant that there was a risk that these patients did not receive the therapy they required whilst on a surgical ward.

Mental health support was available from a mental health liaison team, which was provided by a neighbouring trust. The acute care assessment team provided a service for adults. The team
consisted of psychology, medical, nursing, and social work staff. This service was available 24 hours a day, 7 days a week.

**Seven-day services**

There was limited consultant cover on medical wards at weekends. Patients who were not acutely ill and did not require a daily review of their condition were not routinely seen by a consultant at weekends.

We were informed that the trust was looking at expanding the medical staffing to provide a seven day reviewing process. However, at the time of our inspection 90% of patients were seen within 14 hours by a consultant.

We reviewed the action plan for stroke services and while the service had improved since our last inspection, there was a further plan to recruit consultants to provide a full seven day service. Patients we spoke with told us that wards were quieter at weekends as there were less therapy staff.

Senior managers we spoke with confirmed that there was no access to some therapy services over the weekend. These included speech and language therapy [SaLT] and dietetics.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We observed staff gaining verbal consent before providing care or treatment. However, we noted that while Capacity, consent and Deprivation of Liberty Safeguards (DoLS) were considered, on some wards. This was not the case across the medical division, for example one person we spoke with said that they had received no carer support and we noted that three of the wards we visited [7B, 9A and 9B] had made no adjustments, for patients living with a cognitive impairment, such as dementia.

Staff did not consistently follow the trust Mental Capacity and Deprivation of Liberty Safeguards Operational Procedure. Staff we spoke with did not have a clear understanding on how to assess patients’ capacity to make decisions about their care. Staff training relating to the Mental Capacity Act, and Deprivation of Liberty Safeguards, was not fully embedded within the service.

Staff training relating to the was undertaken by the safeguarding team on an ad hoc basis in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff requested training from the safeguarding team. Staff we spoke with said that the safeguarding team would teach staff how to complete the forms. However, all of the staff we spoke with said there was no attached theoretical training in the Mental Capacity Act.

We reviewed records for two patients on ward 9B who had do not attempt cardiopulmonary resuscitation (DNACPR) forms in place. There was limited evidence of capacity assessments for both patients and no evidence of multidisciplinary discussion relating to DNACPR. Neither of the records we reviewed had any documented record of discussions with relatives.

The trust reported that Mental Capacity Act (MCA) level one training had been completed by 46.4% of all staff within Medicine from July 2016 to June 2017.
The trust did not provided a target for the completion of this training prior to our inspection.

No information was provided by the trust on the completion of Deprivation of Liberty training within Urgent and Emergency Care.
(Source: Routine Provider Information Request (RPIR) P14/P49)

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family Test response rate for Medicine at the trust was 20% which was worse than the England average of 25% from September 2016 to August 2017. The lowest rates were found on the Short Stay Unit (13%) and Stroke Unit (15%).

The percentage of patients recommending the service as a place to receive treatment was quite variable across the different wards. The lowest annual recommendation rate was found in Ward 11B – Gastroenterology (74%).

Patients were extremely positive about care from therapists including: “They are always ready to help me, all I have to do is ask.” Another patient told us; “I can’t fault them here, they are all so good to me and really pleasant.”

During our inspection, there were some ward changes. All staff we spoke to told us that they prioritised the care of the patients throughout the move. All the patients we spoke with told us that they were well informed and prepared for the move. Following the move we visited the new ward and noted that the patients appeared settled on the new ward.

We observed staff communicating with patients and their family members in a respectful, compassionate and considerate way.

Please note that the analysis for Ormskirk and District General Hospital only includes the Rehabilitation Unit. The remainder of the wards are at Southport and Formby District General Hospital.

Friends and family Test – Response rate between 01/09/2016 and 31/08/2017 by site
Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff we spoke with understood the emotional impact that care and treatment had on patients and their family members. We observed staff providing reassurance and comfort to patients.

A range of specialist nurses were available in medical services. This included stroke, diabetes and respiratory nurses, the specialist nurses provided additional information and emotional support, to both patients and staff.

We spoke with 30 patients who were very positive when they discussed the care they received. Some of the comment’s we received included; “Everything’s been wonderful,” another patient told us; “The staff are very pleasant, they treat me with dignity and respect.”
Understanding and involvement of patients and those close to them

The staff we observed were interacting in a positive way, with both patients and those close to them across surgical services. Staff spoke to families sensitively and appropriately.

Ward staff told us they encouraged relatives to complete passport documentation for patients living with dementia, although patient files we reviewed, showed that these were not always completed. The passport documentation included the patient’s preferences, for example personal likes and dislikes.

Staff explained care and treatment in a way that patients could understand and provided opportunities for them to ask questions in order to ensure that relatives were involved in decisions about care and treatment.

Patients told us they were given information about their treatment. They also told us that they were given opportunities to ask additional questions of nursing staff and consultants.

However, one family whose relative was living with dementia told us they had received conflicting information from different members of staff regarding their relative’s care. Another relative we spoke with said; “You have to go and find someone to ask them what is going on. The lack of information makes things stressful.”

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Patients could access medical care services via a number of routes. Patients were admitted to medical services via A and E, through GP referral to the Emergency Assessment Unit [AMU] or by pre-arranged appointments for elective admissions.

The Ambulatory Care Unit was being used as a bedded area for four patients due to the high demand for hospital beds. The patients in those beds had access to a toilet situated at each end of the unit, however, they did not have direct access to shower facilities. These patients were required to go through to the attached Emergency Assessment Unit [EAU] to shower as required. Staff we spoke with confirmed that medication and food for these four patients was also accessed the EAU.

All but one of the areas we visited were compliant with same-sex accommodation guidelines with allocated bathroom and toilet facilities. We found that the patients being care for on the Ambulatory Care Unit, had to use shower facilities on the Emergency Assessment Unit [EAU].

Access and flow

Bed occupancy, length of stay, and delayed transfers of care had an impact on the flow of patients throughout the hospital due to the demand for medical services.
Bed occupancy rates for the medical care services at Southport and Formby District Hospital had been consistently above 90% in the 6 months prior to our inspection.

At our last inspection we told the trust it must improve patient flow in medical services at the hospital to ensure patients are cared for on wards appropriate for their needs. At this inspection we found that the trust had not reduced the numbers of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). For example, we found six medical patients on the observation ward attached to the Emergency Department.

At the last inspection we found the process for monitoring and reviewing the care and treatment of outlying patients was not consistently implemented and followed. At this inspection we found that this had improved overall. For example we found that outlying patients on surgical wards underwent regular medical review and we saw completed individual risk assessments in patient care files.

We reviewed medical notes for the patients outlying on the observation ward and found that they had been reviewed by the responsible medical team.

However, we reviewed patient care records for medical patients who were being cared for and treated on surgical wards. We noted that these patients were not seen by the therapy team covering the surgical ward. Patients we spoke with confirmed that they did not see any therapy staff over the weekend. This meant that there was a risk that these patients did not receive the therapy they required whilst on a surgical ward.

Delayed discharges continued to be a problem for medical care services. Data showed that in the 12 months from 1 July 2016 to 30 June 2017 there had been 674 delayed discharges on the stroke unit, 973 delayed discharges on ward 11B (gastroenterology) and 1124 on ward 14B (general medicine). We noted that on average 55 stroke patients, 81 gastroenterology and 93 general medical patients experienced a delayed transfer of care each month.

For patients with complex care needs, discharge co-ordinators were available to support the discharge process. We were told that one of the discharge co-ordinators had been seconded to minimise delays in discharges for patients. Delays in patients identified as being at end of life had been highlighted and senior managers assured us that their discharge planning was being prioritised.

Information provided by the trust showed that no patients experienced more than one bed move during their hospital stay in the last 12 months prior to inspection. However, information from the trust showed that from 1 July 2016 to 30 June 2017 there were 1284 patient moves in medicine at night. For example, in October 2016 Ward 14B had 35 patients that were moved at night. In May 2017, the frail elderly short stay unit had 18 patients that were moved at night.

**Patient moves per admission**

From July 2016 to June 2017, most patients were cared for on the same ward during their admission. Trust data demonstrated that this was not the case for 1.1% of patients who were moved once or more.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>% of individuals not</th>
<th>% of individuals with one</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southport and Formby District General Hospital</td>
<td>99.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Ormskirk and District General Hospital</td>
<td>96.4%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Source: Routine Provider Information Request (RPIR) P50 – Bed Moves

Process for managing outliers

**Average length of stay**

*Please note that this analysis includes the Spinal Unit.*

The service continued to experience challenges in relation to patient flow. The number of patients experiencing a delayed transfer of care had increased when comparing data from 2016 to 2017.

**Trust Level**

From July 2016 to June 2017 the average length of stay for medical elective patients at the trust was 31.3 days, which is higher than the England average of 4.2 days. However, the high length of stay at the trust is likely to be due to the inclusion of data for the regional spinal injuries unit.

Average length of stay for elective specialties:

The average lengths of stay for elective patients in General Medicine and Clinical Haematology were higher than the England averages.

For medical non-elective patients, the average length of stay was 7.9 days, which is higher than the England average of 6.6 days.

Average length of stay for non-elective specialties:

The average lengths of stay for non-elective patients in General Medicine, Cardiology and Geriatric Medicine were higher than the England averages.

**Elective Average Length of Stay – Trust Level**

![Graph showing average lengths of stay for elective and non-elective patients in different specialties for the trust and England averages.](image-url)
Non-Elective Average Length of Stay – Trust Level

Southport and Formby District General Hospital

From July 2016 to June 2017 the average length of stay for medical elective patients at Southport and Formby District General Hospital was 36.4 days, which is higher than England average of 4.2 days. The high length of stay at the hospital is likely to be due to the inclusion of data for the spinal unit.

Average length of stay for elective specialties:

The average lengths of stay for elective patients in General Medicine and Clinical Haematology were higher than the England averages.

For medical non-elective patients, the average length of stay was 7.9 days, which is higher than England average of 6.6 days.

Average length of stay for non-elective specialties:

The average lengths of stay for non-elective patients in General Medicine, Cardiology and Geriatric Medicine were higher than the England averages.

Elective Average Length of Stay - Southport and Formby District General Hospital

Non-Elective Average Length of Stay - Southport and Formby District General Hospital
Ormskirk and District General Hospital

From July 2016 to June 2017 the average length of stay for medical elective patients at Ormskirk and District General Hospital was 2.7 days, which is lower than England average of 4.2 days.

Average length of stay for elective specialties:

The average length of stay for elective patients in General Medicine is lower than the England average.

The average length of stay for elective patients in Pain Management is higher than the England average.

For medical non-elective patients, the average length of stay was 12.7 days, which is higher than England average of 6.6 days.

Average length of stay for non-elective specialties:

The average length of stay for non-elective patients in General Medicine is higher than the England average.

Average length of stay for non-elective patients in Rehabilitation Service is lower than the England average.

Elective Average Length of Stay - Ormskirk and District General Hospital

Non-Elective Average Length of Stay - Ormskirk and District General Hospital

(Source: Hospital Episode Statistics)
Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2016 to August 2017, the trust’s referral to treatment time (RTT) for admitted pathways for medicine remained fairly consistent and was in line with or better than the England average in all 12 months.

As of August 2017, 100.0% of patients were treated within 18 weeks compared to the England average of 90%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Three specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>100%</td>
<td>93.4%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>98.2%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>94.7%</td>
<td>83.5%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>80%</td>
<td>94.1%</td>
</tr>
</tbody>
</table>

Dermatology, Geriatric Medicine, Neurology and Thoracic Medicine had no activity during the time period.

(Source: NHS England)

Meeting people’s individual needs

The service supported John’s Campaign which supports collaborative working between health care services and those close to patients with dementia, such as relatives and carers.

Passport documents were used with patients with dementia and patients with learning disabilities to identify additional support needs, communication methods, likes and dislikes. However, we noted that these were not always completed. When we discussed this with staff, we were told that this was for those close to patients to complete.

The trust used an electronic system to highlight any individual need such as a safeguarding concern, learning disability, mental health need or end of life programme.
We reviewed 27 patient care records and noted that in 18 of these there was limited personalisation of care plans. For example, in 18 of the patient care records we reviewed, we did not find any information regarding individual wishes or personal preferences. Plans were largely in the form of standardised risk assessment templates.

There was a chaplaincy service available; notices advising people of this were visible on the wards. We noted that the chaplaincy service offered 24/7 support. The service linked with other local faith communities including the Muslim and Jewish Community. There was also a quiet room that patients and visitors could attend.

Staff we spoke with told us that a patient with a learning disability would be cared for according to their individualised needs. However, we did not see any patients with a learning disability during our inspection.

Clinical nurse specialists, such as outreach nurses, diabetes and stroke nurses were available to provide support to patients.

Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the service.

There were leaflets available in wards. However, we noted that these were in English only. None of the staff we spoke to were clear if other formats were available, for example Braille, easy-read, languages other than English.

Learning from complaints and concerns

Summary of complaints

Learning from complaints was discussed at monthly governance meetings. The outcomes of these discussions was shared with ward staff.

From July 2016 to June 2017 there were 78 complaints about medical care. The trust took an average of 64.8 days (47.3 working days) to investigate and close complaints.

Seven of the 78 closed complaints (9.0%) about Medicine were closed in over 180 days while four of the 18 complaints that remained open at the time of response were received in 2016 and therefore had been open more than six months. This does not meet the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The breakdown of complaints by site was:
Southport and Formby District General Hospital: There were 74 complaints; the highest number of complaints (41) was about all aspects of clinical treatment.
Ormskirk and District General Hospital: There were four complaints.
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons...
from the results, which were shared with all staff. However, complaints were not always managed and closed in line with the trust's own policies. Between June 2016 and July 2017, there were a total of 74 complaints for the medical wards, 41 of these were complaints regarding clinical treatment and care.

Information leaflets regarding how to make a complaint were available in some public areas. For example, the main corridor on the ground floor of the hospital. However, we did not see information about how to make a complaint or comment on care on any of the wards we visited. We reviewed the trust website and noted that this did include details about how to contact the patient experience and complaints team.

Ward managers told us that complaints were recorded on the trust-wide system. Ward managers we able to take us through the complaints process and told us they were responsible for investigating complaints in their areas.

Records we reviewed confirmed that any lessons learnt from complaints were discussed at governance meetings. Ward staff told us they received feedback regarding complaint outcomes via email notifications or at ward meetings.

**Is the service well-led?**

**Leadership**

Leadership within the senior management team at executive level had changed since the last inspection. Staff we spoke with reported they were in a constant state of change as the senior management team had changed several times over the past four years. Staff informed us this changing of senior management created an uncertainty as to the future of their services.

Staff reported that members of the senior management were not visible and approachable; none of the staff we spoke with knew the interim executive team. Staff told us that senior management were not visible on the wards.

However, we saw some examples of good leadership at ward level. On three of the wards we visited we observed ward managers working alongside nursing staff providing support and guidance where necessary. However, on some wards staff told us that they received limited support from their managers.

**Vision and strategy**

The trust had several interim executive board leaders and so a new change in direction was in the process of being developed. This had not changed from our last inspection where we found that staff were unclear of the direction of the trust due to several changes in the senior management team. As a result, we found that there was no clearly defined vision or strategy for medical care services during this inspection.

There were clearly defined and visible leadership roles across the medical division. There was a senior management team in place which included an assistant director of operations, head of
nursing and medical director. Senior managers were supported by teams of directorate and operational managers, matrons and ward managers.

We noted that matrons were visible on the wards; this was confirmed as normal practice by staff. Matrons informed us that they attended trust 'safe at all times' briefings three times a day to review nurse staffing. Matrons told us that they did this to ensure safe numbers of staff for the acuity of patients.

In discussion with us medical and nursing staff told us, that they fully understood management reporting structures. All of the medical staff we spoke with told us they were well supported by their managers.

Despite the many changes to the senior management team, the staff reported that they were proud of the work they did, but felt under increasing pressure due to staffing shortages and the complexity of care required by some patients. Staff reported that staffing and lack of direction of the trust compromised patient care. We were told and records showed that due to short staffing across all medical wards, staff regularly worked extra hours to ensure the wards were adequately staffed.

**Culture**

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. In the 2017 NHS staff survey we saw that the score had dropped further to 3.49 out of 5. This worsened score reflected our findings that staff had concerns regarding the organisation as a place to work.

Managers reported that they had an open door policy to ensure staff were adequately supported. There was formal one to one supervision and staff reported that they could speak to their direct line manager at any time.

Nursing and medical staff said they felt supported by their direct line manager 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 'really good care and treatment'.

**Governance**

Senior staff were able to tell us how their ward performance was monitored and all ward managers had copies of the ward dashboard performance.

Ward managers informed us that alignment between the ward dashboard performance did not always match the actual figures of compliance. For example mandatory training and appraisal figures supplied via the trust own dashboard did not match figures that ward managers had collected. This was also found during the last inspection in 2016 and had not been rectified. This did not provide assurance that data supplied by the trust was accurate. The trust were aware of these issues but we saw no evidence of any actions taken.
There had been insufficient oversight of compliance with the Mental Capacity Act (2005). Monitoring of compliance with trust policy had been insufficient to identify failure to act in accordance with the law. This was an issue raised during our 2016 inspection and we found no evidence that actions had been taken to fully address this issue.

Unsuitable areas of the hospital were being used to provide bedded areas for patients. The Ambulatory Care Unit and the discharge lounge were not used effectively to ensure that patients were discharged promptly and added to the access and flow issues of the trust. This was identified as an area of concern at our last inspection in 2016.

We saw no formal evidence that all key required improvements identified at the last inspection in November 2014 or 2016 had been acted upon to improve medical services. For example, the percentage of staff completing mandatory training or receiving appraisals in a timely way was still inconsistent and in some areas below expected levels and the trust’s own target.

**Management of risk, issues and performance**

We reviewed the divisional risk register and saw that key risks within the service had been identified. However, we noted that risk mitigation actions were limited and there were no progress reviews.

Risks within some areas of the medical directorate were discussed at both ward and divisional level and escalated where necessary. We saw that the risk registers generally reflected the concerns of managers, the risks were reviewed and a level of risk assigned. For example, nursing and medical staffing, However, we noted that trust risk registers were not always consistent with those at trust/division level.

Senior staff knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.

**Information management**

The NHS staff survey for 2017 highlighted that communication between the senior management and staff was poor. Only 19.7% of staff felt communication between them was good. This score had worsened since the 2015 score of 21% of staff.

**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 [FFT] giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed that medical wards score varied from 40 to 98% for 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 noted that the news releases on the website were current and up to
The inpatient response scores to the FFT survey decreased from a low 20.8% in 2016 to 14.3% in 2017. This is below the overall national average of 25%.

**Learning, continuous improvement and innovation**

The medical services had not sufficiently improved since our last inspection in 2016. We found changes that we required the service to make had not been completed.

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**Surgery**

**Facts and data about this service**

The trust has the following surgical wards and departments:

**Southport and Formby District General Hospital**

- Ward 11A – Planned Investment Unit (14 inpatient beds)
- Ward 14A – Surgical Trauma and Orthopaedics (30 inpatient beds)
- Ward 15B – Surgical (24 inpatient beds)

(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)

The trust had 17,095 surgical admissions from July 2016 to June 2017. Emergency admissions accounted for 3,657 (21.4 %), 11,010 (64.4%) were day cases, and the remaining 2,428 (14.2 %) were elective.

(Source: Hospital Episode Statistics)

**Is the service safe?**

**Mandatory training**

**Mandatory training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has not provided any targets for the completion of mandatory training.

**Southport and Formby District General Hospital**

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Surgery at Southport and Formby District General Hospital is shown.
The overall completion rate for medical and dental staff was 58.6% from July 2016 to June 2017. Only the equality and diversity and information governance modules had completion rates of over 80%. One of the four eligible staff had completed the infection prevention level one module and 18% had completed the resuscitation module.

Analysis of the data provided by the trust found that 15.7% of medical staff at the hospital had completed resuscitation training in 2015/16 and 12.7% in 2016/17. The inspection prevention level 1 module had been completed by 22.2% and 12.5% of medical staff in 2015/16 and 2016/17, respectively.

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity</td>
<td>83</td>
<td>94</td>
<td>88.3%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>80</td>
<td>94</td>
<td>85.1%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>16</td>
<td>21</td>
<td>76.2%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>70</td>
<td>94</td>
<td>74.5%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>69</td>
<td>94</td>
<td>73.4%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>62</td>
<td>94</td>
<td>66.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>61</td>
<td>94</td>
<td>64.9%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>57</td>
<td>94</td>
<td>60.6%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 and 5 (Prevent Awareness) - 3 Years</td>
<td>56</td>
<td>94</td>
<td>59.6%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>48</td>
<td>94</td>
<td>51.1%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>47</td>
<td>94</td>
<td>50.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>37</td>
<td>94</td>
<td>39.4%</td>
</tr>
</tbody>
</table>
For nursing staff at Southport and Formby District General Hospital, the overall completion rate was 59.0% from July 2016 to June 2017. Only three of the 112 eligible staff (2.7%) had completed the resuscitation module.

Analysis of data for 2015/16 and 2016/17 found that 6.6% and 1.0% of nursing staff, respectively, had completed the resuscitation module.

The service provided mandatory training in key skills to all staff. However, not everyone had completed it.

Senior managers recognised that training compliance was low for some modules. They had scheduled more training sessions to increase compliance levels.

The average compliance for mandatory training for the wards and theatres, as reported on the trust’s dashboards in October 2017 was 73%.

Staff trained in basic resuscitation had improved by October 2017 with 100% compliance in theatres, ward 15B and PIU. Ward 14A had a compliance of 50%. However, this had improved from previous months. We were told that theatre staff had received training in immediate life support, though no evidence was provided.

In October 2017, for infection control (level 2) the average compliance for the wards was 61% and 43% for theatres. The average compliance for Ward 14A was 42%. For prevent training, average compliance was 72%. These had improved but were below the trust’s targets. For manual handing of a patient, the average remained low at 56% in October 2017.

We were told that the trust was implementing human factors training in December 2017.

### Safeguarding

#### Safeguarding training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust did not provide a target for the completion of safeguarding training or any data for the number of medical/dental or nursing staff within Surgery who were trained on the safeguarding adults and children level 1 modules.

**Southport and Formby District General Hospital**

Southport and Formby District General Hospital had an overall safeguarding training completion rate for all medical/dental and nursing staff in Surgery of 84% from July 2016 to June 2016.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental and nursing staff in Surgery at Southport and Formby District General Hospital is shown below:

| Resuscitation | 3 | 112 | 2.7% |
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Between August 2017 and October 2017, there were four safeguarding incidents identified with one that required further investigation by the trust.

From the trust’s dashboards, in October 2017, 100% of staff on ward 15B, PIU and in theatre had received safeguarding adults training, however, only 50% had received training on ward 14A.

Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one: 93.9%
- Safeguarding adults level two: 92.8%
- Safeguarding adults level three: 94.2%
- Safeguarding children level one: 94.7%
- Safeguarding children level two: 90.9%
- Safeguarding children level three: 92.7%

However, this information was not broken down into the core services we inspected.

**Cleanliness, infection control and hygiene**

The service did not always control infection risks. Staff kept themselves and the premises clean however, monitoring equipment was dusty.

At the time of inspection there was a three-way ward change for two surgical wards and a medical ward. The moves were simultaneous with no deep cleaning process between changes.
The cleaning staff were present at all times and the wards looked visibly clean.

Monitoring equipment that nurses were responsible for, such as blood pressure stands, were visibly dusty. Cleaning schedules were either absent or had not been completed.

We observed that doors to side rooms were left open. Not all patients had diagnosed conditions that required isolation, However, there were signs on doors for patients with infections and staff told us reasons for isolation. This meant there was a potential risk of infections spreading across the ward.

Ward curtains were not disposable. Staff we spoke to did not know how frequently these were changed. In theatre, disposable curtains were dated March 2017 and staff were unaware when they were due to be changed.

Staff adhered to ‘arms bare below the elbows’ guidance. Clinical sinks with wall-mounted soap dispensers included hand-washing guidance. Personal protective equipment (PPE) including gloves and aprons were available in all areas. Hand sanitiser gels were present at entrances and throughout the wards.

Waste bags were readily available, segregated and disposed of appropriately.

Sharps bins were available in all areas, were not overfilled and changed three times weekly.

Patients generally told us they thought ward areas were clean.

Between October 2016 and October 2017, there was one incidence of Methicillin-resistant staphylococcus aureus (MRSA), one incidence of Methicillin susceptible Staphylococcus aureus (MSSA) and three incidences of clostridium difficile (C.diff).

Records were provided by the trust to demonstrate that tests were carried out to identify any legionella in the water systems in theatres in accordance with recognised standards.

We requested information about infections, However, this did not include any details of surgical site infections.

The trusts infection prevention and control team monitored infection rates and produced monthly performance reports. The reports published between August 2017 and October 2017 showed that there was one incidence of Clostridium difficile (C. diff) and one incidence of Methicillin resistant staphylococcus aureus (MRSA) for surgery.

Monthly hand hygiene audits for 2017 showed that there was an average compliance of 96% for surgical wards and theatres for the three months prior to inspection. Weekly checks of commode cleanliness were carried out. For the same time period, there were 35 occasions when commodes were assessed to be clean out of 39 tests (90%).
Environment and equipment

The service did not always provide care in an environment that was suitable for patient’s needs.

All wards and theatres were accessed by swipe card or by staff responding to a door buzzer although green exit buttons were pressed to leave wards.

All rooms that stored medication or intra venous fluids were locked with key pad entrances. However, the sluice rooms were not locked and these included chemicals such as toilet cleaner and hand sanitiser.

At the time of inspection, there were multiple ward changes that included two surgical wards and a medical ward.

One of these wards did not include piped oxygen and suction for each patient on the ward. A risk assessment was carried out and it was agreed that any immediate post – operative patients would be nursed where oxygen and suction was available. Other emergency oxygen was available in portable cylinders. There were plans to increase the availability of piped oxygen and suction to all beds on the ward. The issue was reported in the governance committee meeting, in October 2017, as a second incident had occurred where a patient who had required oxygen was nursed in a bed where piped oxygen was not available. A portable oxygen cylinder was in situ but it was not turned on.

This ward did not have a dedicated room where pre-operative patients could be admitted prior to surgery. Staff were utilising a room close to the ward. However, this was not fit for purpose and was blocking a fire exit. We observed a patient awaiting surgery in a room that was away from the main ward and was therefore not visible to staff. The patient had arrived at 7.45am and attended theatre at 3pm. We raised our concerns with senior managers and as a result, it was agreed that the room would no longer be used. We did observe patients using the room the following day, although the following week signage was in place to indicate for relatives use only.

There was a lack of storage on all wards, with equipment on corridors that in some cases was blocking fire exits. We raised our concerns with the ward manager and exits were promptly cleared.

Oxygen cylinders were stored on corridors in designated carriers. An extra cylinder not secured was addressed on site and removed.

Resuscitation trolleys had a daily check with a tamper evident label attached. The trolleys were checked fully on a weekly basis. However, we found a number of out-of-date medicines and sundry items on trolleys in all ward locations. The theatre resuscitation trolleys had all been checked appropriately; everything was in date.

Monitoring equipment was generally well maintained with stickers indicating that checks had been carried out within the last 12 months. Weighing scales indicated that calibrations had taken place.
The theatres included four main suites, with one other with a lamina flow adjacent to the orthopaedic ward if needed.

In theatres, it was identified following the last inspection, that equipment needed upgrading. All staff we spoke with reported that the equipment functioned without incident and was well maintained. The equipment had been identified on the divisional risk register and was reviewed when needed. A five year plan, for the service, and across the trust, was in place to monitor equipment including cost of replacement.

A sample of records were provided by the trust to demonstrate the maintenance of ventilation systems in theatres within the last 12 months.

**Assessing and responding to patient risk**

Routine risk assessments were completed for patients on admission, as part of their surgery care bundle, such as venous thrombo embolism (VTE), risk of falls, Malnutrition Universal Screening Tool (MUST) and Waterlow (for pressure ulcers).

A trustwide audit of completion of VTE assessments was carried out in July 2017. It was found that assessments were being completed on admission However, they were not repeated 24 hours following admission which is in line with NICE guidance. Ward staff told us that risk assessments were routinely repeated weekly and we observed staff completing assessments.

On one ward, there were bays designated where there was a requirement for a member of staff to be present to observe patients at all times However, we observed that patients were on their own for periods of time. We observed that patients, who had been assessed as lacking capacity to make decisions and were assessed as a risk of falls, were being nursed with bed rails in place and beds at a high level from the ground. We saw that a patient had sustained a fall when sides were in place. We raised this as a concern with the trust during the inspection and action was taken to address the matter. The safeguarding team reviewed the patients on the ward and we observed that practises were changed appropriately.

Any allergies, such as medication, were assessed and recorded on prescription records.

Coloured wristbands were used trustwide for patients identified with allergies or assessed as at risk of falls.

Monitoring of vital signs was recorded in an electronic system using tablets / mobile devices. Results were displayed on a central consul either at the nurses’ station or in the main corridor. This showed all patient scores. We were told that the system was linked to the outreach service, thereby alerting any patient concern. However, doctors reported delays in escalating early warning scores 5-6 of up to 44 minutes and scores 7-8 of up to 77 minutes.

Patients attended preoperative assessment clinic prior to surgery. Any patient identified as American Society of Anaesthesiologists (ASA) level three (high risk) were admitted for surgery at Southport rather than Ormskirk.
Where possible, the preoperative assessment clinic offered a ‘one – stop shop’ where patients attended for their clinic appointment with the surgeon and then attended the preoperative clinic for any investigations and screening prior to surgery. Any patient identified as a potential anaesthetic risk or other concern was reviewed by an anaesthetist.

In theatre there was a huddle each morning that included recovery staff and ward staff attended safety huddles either during handover of patients or during the day.

We observed the World Health Organisation five steps to safer surgery checklist process and found it was generally applied appropriately, However, it was observed that the de-brief did not always take place. This had been highlighted in a departmental meeting in August 2017.

Following surgery, patients were escorted back to the ward by registered nurses in order to provide safe monitoring during transfer.

Sepsis trolleys were present on wards that included equipment to manage acute infections. We were told that sepsis 6 training was part of the Acute Illness Management Course (AIMS). There were four orthopaedic staff and one theatre member that were undergoing this course. In addition, we were told that the trust was reviewing training and undertaking training needs assessment.

We requested details regarding consultant / anaesthetist attendance at emergency theatre when the risk of mortality risk was assessed as more than 5%. The trust told us that any trauma list is always consultant led. In addition, in out of hours’ emergency theatre the trust uses a P Possum scoring system. (A score that is calculated to provide information on risk in terms of morbidity and mortality). The outcome of the score determines the need for consultant and / or level of anaesthetic cover during the surgery.

**Nurse staffing**

Nursing staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for nursing staff working in Surgery for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>153.0</td>
<td>135.3</td>
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<td>September 2016</td>
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<td>155.1</td>
</tr>
<tr>
<td>August 2016</td>
<td>178.7</td>
<td>151.2</td>
</tr>
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</table>
Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for nursing staff in Surgery of 13.3%. As at June 2017, the vacancy rate was 9.9%.

Southport and Formby District General Hospital

Southport and Formby District General Hospital reported an overall vacancy rate in Surgery of 12.2% from July 2016 to June 2017. The rate was over 10% in all months over this time period, with the exception of the latest month, June 2017, when the rate was 7.8%.

In October 2017, the vacancy rate was an average 15%, although; PIU was fully staffed. Theatres reported 10 vacancies (13%); ward 14A had eight vacancies (21%) and ward 15B had three vacancies (11%).

In October 2017, the turnover rate on the surgical wards was 0% and 2% in theatres.

Sickness rates

From July 2016 to June 2017, the trust reported a sickness rate of 8.0% for nursing staff in Surgery:

- Southport and Formby District General Hospital: 8.8%

In October 2017, the average sickness rate was 9%, although ward 15B was 4%.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. We are aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported bank usage for registered nurses in Surgery of 1,312 shifts and agency usage of 650 shifts. There were 658 shifts that were unfilled by bank and agency staff.

Southport and Formby District General Hospital

Southport and Formby District General Hospital had 1,120 shifts filled by bank staff from April 2016 to March 2017. The highest bank usage was in Ward 14A Surgical Trauma and Orthopaedics (348 shifts).

Over the same time period, the hospital reported agency usage for registered nurses in Surgery of 558 shifts. The highest agency usage was in Ward 15B Surgical (211 shifts).
There were 539 shifts that were unfilled by bank or agency staff, the highest number of which was in Ward 14A Surgical Trauma and Orthopaedics (219 shifts).

The service had enough staff with the right qualifications, skills and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust used an acuity tool to match the number of staff to the needs of patients. Numbers of registered nurses and health care assistants were displayed on boards when entering wards for staff, patients and visitors to view.

The trust had implemented an electronic safe at all times system. This reviewed staffing three times a day, although relied on consistent inputting of data and did not always include mitigating factors, such as band seven ward managers or student nurses availability.

Nurse staffing was managed across the surgical division, which included both locations at times, or cross divisions if necessary, to ensure safe numbers of staff.

Matrons attended trust wide ‘safe at all times’ briefings two or three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients.

Recruitment events were planned for nurses where selection could take place at the same time. During the inspection, senior managers told us there were approximately 13 vacancies across the division and this had been stable on the wards.

In theatres we were told there were 15 vacancies; they reported there had been difficulties recruiting operating department practitioners (ODPs). However, currently there were also scrub nurse vacancies. The trust was considering providing training for health care assistants to gain scrub competencies. In addition they were trying to encourage surgical first assistants to join the trust bank.

Gaps in rotas were being supplemented by bank staff, although many of these were nurses formerly employed by the trust. Regular staff were offered overtime, although many nurses worked long – day shift patterns.

For the planned care division, from August 2017 to October 2017, there were between 434 and 441 substantive nurses. There were between 38 and 47 bank nurses employed as well as between 10 and seventeen agency nurses for the same time period. Of the bank and agency nurses requested, for wards and theatres, between April 2017 and October 2017, there was an overall fill rate of 94%.

All patients and those close to them that we spoke to felt there were sufficient numbers of staff to meet their needs.

Medical staffing
Medical staffing information is routinely requested within the universal provider information
request spreadsheets, to be completed within a standard template.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for medical and dental staff working in Surgery for the period from July 2016 to June 2017. These figures were not provided at site level.

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<thead>
<tr>
<th>Month</th>
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<th>Number in post</th>
</tr>
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<tbody>
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<td>June 2017</td>
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<td>106.9</td>
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</tr>
<tr>
<td>July 2016</td>
<td>134.5</td>
<td>113.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for medical and dental staff in Surgery of 17.4%. As at June 2017, the vacancy rate was 18.5%.

Southport and Formby District General Hospital

Southport and Formby District General Hospital reported an overall vacancy rate for medical and dental staff in Surgery of 18.4% from July 2016 to June 2017. The rate was highest in the three most recent months, April to June 2017, when it was over 21%. The high rates were among general surgery and orthopaedic staff.

In the latest month, June 2017, the vacancy rate at the hospital was 21.8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2016 to June 2017, the trust reported a turnover rate for medical and dental staff in Surgery of 17.3%:

- Southport and Formby District General Hospital: 32.3%
- Ormskirk and District General Hospital: 6.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates
From July 2016 to June 2017, the trust reported a sickness rate for medical and dental staff in Surgery of 0.3%:

- Southport and Formby District General Hospital: 0.2%
- Ormskirk and District General Hospital: 0.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

For the planned care division, between August 2017 and October 2017, there were a total of 45 or 46 consultants, of which three or four were locum staff. There were between 87 and 89 other grades of medical staff, in the same time period, of which seven or eight were locum doctors.

Staffing skill mix

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the whole time equivalent staff working at Southport and Ormskirk Hospital NHS Trust

(Source: NHS Digital Workforce Statistics)

Senior managers told us there were consultant vacancies for a chronic pain specialist and dermatologists. The trust had appointed 10 physician’s assistants that included allocations to general and orthopaedic surgery. There were plans to develop a medical bank although two locum staff (FY2 level) were currently in post.

Records
Staff kept records of patients’ care and treatment. However, they were difficult to navigate and not stored securely.

There were whiteboards in each area that included names of patients on the wards. These were either full names or initials. We were told that only patients that had consented to their name being displayed were in full view.

The electronic system that displayed patient vital signs displayed full patient names; some monitors were positioned in areas visible to visitors. We were told that the information technology support team had applied screen covers that were visible only if directly viewing. However, names were easily viewed. We addressed this on-site and the screen was turned off temporarily.

Patients’ medical care records were stored in trolleys with locks. However, we found they were not locked during the inspection. Medical records were not always signed and dated or included a GMC stamp to identify the doctor clearly.

Nurses recorded care and treatment in paper records, other than the medical notes. Additional records were at the patient bedside and included fluid charts and two hourly intentional rounding. Vital signs were recorded electronically, via tablet / mobile devices. We were told by allied health professionals that care was recorded in multiple locations, although not always accurate. This meant that patient care was either recorded more than once by health professionals or important monitoring information could be missed when caring for patients.

**Medicines**

The service prescribed medicines well. However, there were occasions when not all medication was recorded and checks had not been completed consistently.

Medicines were stored in trolleys that were secured to walls when not in use. During medicine rounds, staff displayed signs requesting not to be disturbed in case of a distraction and potential medication error.

Pharmacists checked paper-based prescription charts of new patients daily and reconciled their medication. We were told that 90% of patients had their medicines reconciled during their stay; 58% in 24 hours and 76% in three days. Pharmacy technicians reviewed stock levels of medicines.

The last inspection found that oxygen given to patients was not being prescribed. During this inspection, we found that oxygen was prescribed. However, it was not being signed that it was being administered by nursing staff.

We observed a patient that had not received a medication prescribed once daily at night. It was omitted for two nights but there was no explanation included in the prescription chart. The relatives had also expressed a concern that they thought that not all prescribed medication had been given. This was addressed on-site and we were told this had now been reported as an incident.
For another patient, the prescription chart included multiple refusals of medicines. There was no record of the refusals in the patient’s medical notes or monitoring associated with one of the medicines. This was addressed on-site.

There were occasions when controlled drugs had been checked (both as part of routine daily checks of stocks and when administered to patients), when only one signature was seen in the controlled book. This was not in line with the trust policy for the management of controlled drugs which states “A minimum requirement is to check balances of controlled drugs every 24 hours by two nursing staff.”

In theatre, controlled drugs were stored in one location for five theatres. There were omissions in the theatre controlled drug book for countersigning of destroying wasted controlled medication. Any wasted medication was currently being disposed into sharps bins, as per the trust policy. We were told, by the senior management team, that there were plans to review the disposal of wasted controlled medication trustwide. The trust’s controlled drug policy was due for review November 2017, However, the chief pharmacist position was vacant at the time of inspection.

We observed that liquid oral medications, including oral morphine, were not always labelled to indicate date of opening and date to discard. We observed an open bottle of methadone that had been dispensed March 2017.

We found that there were omissions in daily checks of clinical fridges in all areas. No room temperatures were recorded in ward areas. In theatres one and three and the recovery area, we observed that the room temperature was checked daily, However, not in the central store room for medicines other than controlled drugs. This meant the effectiveness of the medicine, stored in cupboards may have been reduced.

In theatres, we observed that there were pre-filled syringes. The syringes were labelled with the drug name but no strength or date the drug was drawn up. We were told that the syringes were filled each morning and discarded each night but there was no clear recorded evidence to support this.

The trauma nurse manager was also a nurse prescriber and could prescribe take home medications if a doctor was not available at weekends prior to the pharmacy closing at lunchtimes.

We were told that there was a microbiology round every Thursday when antibiotic treatments were reviewed.

Monthly antibiotic prescribing audits were carried out for the planned care division. For the three months prior to inspection it was found that allergy status was recorded in 98% of records and stop/review dates and indications, on average, were recorded on 92% of occasions. Prescriber details documentation However, showed an average compliance of 67%.

Incidents

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2016 to August 2017, the trust reported no incidents classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

During the inspection period, the trust reported a never event that was classified as wrong-site surgery. The incident occurred in July 2017 but was not initially identified as a never event.

Breakdown of serious incidents reported to STEIS

The service managed patient safety incidents well, although there was recognition of under reporting. Staff did not always recognise incidents or report them appropriately. Senior managers told us that reporting had increased. They were encouraging staff to include compliments and found these were greater than complaints for the month prior to inspection.

The trust used an electronic reporting system. Staff could describe the process for reporting incidents and felt confident in doing so. Staff could request feedback from incidents and they were discussed in monthly meetings as well as displayed on lessons learned posters across the trust to share and learn lessons from incidents.

Staff were aware of the types of incident they should report and were able to give us examples, such as pressure ulcers and patient falls.

Managers investigated serious incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support. We reviewed a sample of incident reports. These included the information recorded within the trusts electronic incident reporting system. These showed that the trust carried out an initial 72 hour review followed by a root, cause analysis approach with action plans in place to drive improvement. However, these were not included with the incident forms.

When speaking to staff some had reported recent incidents but for others it was a longer period of time since they last reported an incident. They did not all understand the term 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).

Mortality and morbidity of patients was included in monthly audit meetings. There was evidence of discussion to both share good practice and drive improvement across directorates. Incidents, complaints and lessons learnt were discussed at monthly governance committee meetings.

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (Sis) in Surgery which met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common type of incident reported was

- Diagnostic incident including delay meeting SI criteria (including failure to act on test
results) with three (33.3% of total incidents).

- Surgical/invasive procedure incident meeting SI criteria with two (22.2% of total incidents).
- HCAI/Infection control incident meeting SI criteria with one (11.1% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (11.1% of total incidents).
- Slips/trips/falls meeting SI criteria with one (11.1% of total incidents).
- Pressure ulcer meeting SI criteria with one (11.1% of total incidents).

Site specific information can be found below:
- Southport and Formby District General Hospital: four incidents

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Each ward displayed a colour-coded ‘safety cross’ each month. This included information about the number of falls, pressure ulcers and care of any deteriorating patient. It was displayed for staff, patients and visitors to view.

Wards collected data on dashboards, about performance, although the accuracy needed to be confirmed due to ward changes prior to and during the inspection period.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given.
but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported six new pressure ulcers, eight falls with harm and five new catheter urinary tract infections from September 2016 to September 2017 for Surgery.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Southport and Ormskirk Hospital NHS Trust

Total Pressure ulcers (6)

Total Falls (8)

Total CUTIs (5)

(Source: Safety thermometer – Safety Thermometer)

Major Incident Planning

There was a major incident plan and staff we spoke to could explain the process.

Staff told us there had been a practice plan prior to inspection.

Is the service effective?

Evidence-based care and treatment

Patients received care and treatment that was delivered in line with evidence-based practice and national guidelines such as those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges.

Staff on the surgical wards used care plans and recovery pathways, in line with national guidance. Standard operating procedures were in place to ensure the smooth transition of
patients between theatres and wards.

When considering the order of theatre lists, a patient’s medical condition was taken into account. For example, patients with a diagnosis of diabetes were allocated first on operating lists or there was a patient identified as the golden patient in line with best practice guidance. This was a patient identified on the next day's trauma-list, medically optimised for surgery and reviewed by an anaesthetist the previous day. This meant that any delays in theatre starts were reduced.

Policies and procedures were accessible via the trust’s intranet, although we saw some were overdue for review.

Best practice was shared and reflective practice was carried out at monthly departmental meetings.

**Nutrition and hydration**

Patients were provided with information prior to admission which told them how long they would need to fast before surgery to avoid complications.

Patient records included an assessment of a patient’s nutritional requirements (malnutrition universal screening tool - MUST) as well as fluid and food charts which were reviewed and updated regularly. This included weekly weighing for long-term patients.

An incident had occurred where a patient had lost weight during admission. Following this, the wards introduced extra nutritional supplement rounds each day to support patients if needed.

Records showed regular dietician involvement with patients who were identified as being at risk of dehydration/malnutrition, although MUST scores were recorded on paper nursing records as well as the trust’s electronic system. This meant there was a risk that not all records would be completed in order to provide appropriate care.

Patients with difficulties eating and drinking were placed on special diets and those who required support and assistance with eating and drinking were identified by the bedside patient information boards.

For patients with dementia, we did not see any special plates or trays, although there were a variety of cups available and mealtimes were protected on the wards.

There was a choice of meals to choose from on a daily basis with patients telling us they enjoyed the food offered.

Water jugs were at patient bedsides and a range of drinks and snacks were also readily available throughout the day, in particular for patients following surgery.

During the inspection a relative of a patient was concerned that they were quieter than usual and
fluid intake was low for the day. The doctor reviewed the patient and intravenous fluids were promptly given to the patient.

**Pain relief**

Patients were assessed pre-operatively for their preferred post-operative pain relief and staff used pain scores to monitor pain symptoms at regular intervals.

Patient records showed that patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.

Patients told us staff gave them pain relief medication when needed.

**Patient outcomes**

**Relative risk of readmission**

*Please note that this analysis includes the Spinal Unit.*

**Trust level**

From June 2016 to May 2017, patients at the trust had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England average.

**Elective admissions**

- Patients in General Surgery and Urology had lower than expected risks of readmission for elective admissions when compared to the England averages
- Trauma and Orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average

**Non-Elective admissions**

- General Surgery and Urology patients at the trust had lower than expected risks of readmission for non-elective admissions when compared to the England averages
- Trauma and Orthopaedics patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: HES – Readmissions (01/06/2016 – 31/05/2017))

**Southport and Formby District General Hospital**

From June 2016 to May 2017, all patients at Southport and Formby District General Hospital had a higher expected risk of readmission for elective admissions when compared to the England average.

**Elective admissions**

- General Surgery and Urology patients had higher expected risks of readmission for elective admissions when compared to the England averages
- Ophthalmology patients had a similar to expected risk of readmission for elective admissions when compared to the England average

All patients at Southport and Formby District General Hospital had a lower expected risk of readmission for non-elective admissions when compared to the England average.

**Non-Elective admissions**

- General Surgery and Urology patients had lower expected risks of readmission for non-elective admissions when compared to the England averages
- Trauma and Orthopaedics patients had a similar expected risk of readmission for non-elective admissions when compared to the England average

**Elective Admissions – Southport and Formby District General Hospital**

**Non-Elective Admissions – Southport and Formby District General Hospital**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite.

Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics)

The trust participated in internal audits. These were presented at departmental meetings such as for general surgery, trauma and orthopaedics, anaesthetics or joint meetings.

Action plans were in place and risk rated using a red, amber, green system to monitor results from audits undertaken.

An internal audit of patients admitted with a fractured hip, following standards outlined in a best practice tariff, showed improvement in 2016/2017 to 46.1% from the previous year of 32.4%. This included monitoring of patients including time to surgery, time to be seen by an Orthogeriatrician and falls assessment.

**Hip Fracture Audit**

In the 2017 Hip Fracture Audit, which covers the period from January to December 2016, the risk-adjusted 30-day mortality rate was 8.3% which was within the expected range. The 2016 figure was 9.1%.

The proportion of patients having surgery on the day of or day after admission was 77.5%, which was worse than the national standard of 85%. The 2016 figure was 73.8%.

The perioperative medical assessment rate was 51.3%, which failed to meet the national standard of 100%. The 2016 figure was 51.5%.

The proportion of patients not developing pressure ulcers was 98.7%, which falls in the top 25% of trusts. The 2016 figure was 100%.

The length of stay was 20.9 days, which falls in the middle 50% of trusts. The 2016 figure was 19.4 days.

(Source: National Hip Fracture Database 2016)

**Bowel Cancer Audit**

In the 2016 Bowel Cancer Audit, 75.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was higher than the national aggregate of 69%. The 2015 figure was 75.3%.

The risk-adjusted 90-day post-operative mortality rate was 0% which was within the expected range. The 2015 figure was also 0%.

The risk-adjusted 2-year post-operative mortality rate was 23.7% which was within the expected range. The 2015 figure was 18.6%.
The risk-adjusted 30-day unplanned readmission rate was 10.1% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 39.2% which was within the expected range. The 2015 figure was 48.8%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not submit any data to the 2016 National Vascular Registry (NVR) audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0%. This placed the trust within the top 25% of all trusts for this measure. The 2015 figure was 1.3%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 45.0% which was higher than the national aggregate of 37.6%. The 2015 figure was 44.9%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used as a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

Southport and Formby District General Hospital

In the 2016 National Emergency Laparotomy Audit (NELA), which covered the period from December 2014 to November 2015, Southport and Formby District General Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 102 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 88 cases.

The hospital achieved a red rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 55 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 34 cases.

The risk-adjusted 30-day mortality for the hospital was within expectations, based on 195 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

From April 2016 to March 2017, the trust had higher proportions of patients who reported they felt worse after a procedure than the England average for all of the four procedures.

*(Source: NHS Digital)*

The Board meeting in October 2017 acknowledged challenges in discharging patients including when medically fit particularly following a reorganisation of community services locally. Daily discharge meetings have taken place and there has been guidance sought from external stakeholders. There was a quality improvement plan in place but recognition that governance processes were not embedded.

**Competent staff**

Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.

Senior managers recognised that appraisal rates had been below the trust’s target. From the trust’s dashboard in October 2017, on average, 52% of staff on the surgical wards and theatres had received a personal development review.

We were told that ward-based training sessions took place such as therapists guiding nurses on the orthopaedic ward or the dietician providing refresher sessions about diabetes.

For medical staff there were two structured lunchtime teaching sessions. However, ward pressures dictated attendance at the sessions.

In theatres, there was a new starter pack, a preceptorship programme and scrub practitioner
competencies were assessed.

On the wards, band three health care assistants supported staff by monitoring patients including electro cardiograms (ECG’s). We were told they had received training to undertake this role and each ECG was checked by medical staff.

A doctor reported that nurses were very helpful but training in cannulation would ease the workload of the junior staff.

Appraisal rates

From June 2016 to June 2017, 65.6% of staff within Surgery at the trust had received an appraisal compared to a trust’s target of 90%.

Southport and Formby District General Hospital

Southport and Formby District General Hospital had a 50.6% appraisal completion rate. A split by staff group can be seen in the graph below:

![Appraisal completion graph](image)

None of the staff groups met the trust completion rate target of 90%. Only 31.0% of support to scientific, therapeutic and technical (ST&T) staff and 30.6% of other qualified scientific, therapeutic and technical staff had completed an appraisal. None of the three NHS infrastructure staff had completed an appraisal.

Multidisciplinary working

There was internal multidisciplinary team (MDT) working that included therapists, dietetics, speech and language, and pharmacists as well as doctors and nurses. On ward 14A, physiotherapy and occupational therapy staff were based on the ward. Although during the inspection we did not observe any joint meetings or care. When the call bells were sounded by patients, we observed that only nurses responded. Doctors reported effective MDT working with allied health professionals.

A mental health liaison team was available from a neighbouring trust. The acute care assessment
team provided a service for adults. The team consisted of medical, nursing, psychology and social work staff and was available on a 24 hour, 7 days a week basis. They were based off-site although there were plans for a base within the hospital.

Records were kept in a number of ways with health professionals maintaining their own records about patient care and treatment, although there was not always evidence of family involvement or consultation. Discharge co-ordinators completed electronic records based on documentation provided.

Seven-day services

Acute and emergency surgical services were available seven days a week. Medical and anaesthetist cover was provided outside of normal working hours and nursing staff told us they felt supported during these periods.

There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on promptly.

Junior and middle grade doctors provided out of hours medical care to patients on the surgical wards during out of hours periods. There was also on-call cover provided by consultant surgeons who could be contacted by telephone.

Microbiology, imaging (for example x-rays and scans), physiotherapy and pharmacy support was available on call outside of normal working hours, although no phlebotomy service.

On ward 14A, there was a nurse prescriber who could support ward staff outside of routine pharmacy weekend hours.

There was no current designated emergency surgical assessment unit available to assess patients who may require emergency surgery, although an area in the hospital had been allocated for future use.

Patients reported that wards were generally quieter at weekends with less therapy staff.

Health promotion

Patients told us there was a good choice of healthy food choices available, especially the soups. Water was available to all patients.

In the trust restaurant, there was a range of healthy options available and all fizzy drinks were sugar-free.

Patients were encouraged to mobilise as soon as possible. There were a range of leaflets available to support patients’ recoveries.

There was a trust wide smoking cessation campaign with champions allocated to wards to
support patients.

**Access to Information**

Staff told us that information about patients they cared for was easily accessible, although we observed care records in multiple locations. Staff recorded details about the care they delivered in paper records but some information was recorded electronically.

Staff could access information such as policies and procedures from the trust’s intranet.

Patients’ medicines were recorded on paper prescription charts rather than electronic. This meant it was time-consuming for doctors to amend or re-write them.

Pathology requests were made on paper, such as blood or urine tests. This meant it was sometimes difficult to monitor which patients had been completed.

Patient information that was required to deliver care and treatment was readily available and accessible, although staff reported that computer systems could be slow which meant delays in accessing investigation results.

Information about quality and performance were displayed both for staff, patients and visitors.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Capacity Act (MCA) level 1 training had been completed by 40.5% of all staff within Surgery from July 2016 to June 2017. No target was provided for the completion of this training.

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

No information was provided by the trust on the completion of Deprivation of Liberty training within Surgery.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

We observed staff gaining verbal consent before providing care or treatment. Capacity, consent and Deprivation of Liberty Safeguards (DoLS) were considered and adjustments, such as access to specialist support, flexible visiting, carer support and environmental considerations were applied for patients living with a cognitive impairment, such as dementia, or for those patients living with a learning disability. However, we were not clear if staff fully understood their responsibilities in relation to the Mental Capacity Act and DoLS.

We were told that Mental Capacity Act (MCA) and Deprivation of Liberties (DoLs) were included in safeguarding training. However, staff we spoke to did not fully understand their responsibilities or the application of these or of the Mental Health Act (MHA).
We reviewed records for three patients on ward 15B who had do not attempt cardiopulmonary resuscitation (DNACPR) forms in place. Each had forms that were transferred from the community form to the hospital form without apparent review. There was some evidence of capacity assessments for all three patients, although no evidence of multidisciplinary discussion relating to DNACPR. There was only one record of any discussion with relatives although this related to the community form. There was no evidence of review of the decision about cardiopulmonary resuscitation based on a change in an individual’s circumstances. One patient’s mental health and capacity had changed significantly from admission but this did not trigger a review as suggested in the hospital’s policy guidance and good practice.

We reviewed records for six patients on ward 14A. This ward had dedicated beds for patients with a diagnosis of dementia. The records reviewed showed capacity assessments were followed in relation to hospital policy, although for one patient’s records it was unclear if the nurse who assessed the patient understood how to apply the Mental Capacity Act and the MHA (The form questioned whether the patient was subject to the MHA and dementia was cited as a reason for this).

Staff training was undertaken by the safeguarding team on an ad hoc basis in relation to requests from staff for support. They would teach staff how to complete the forms, there was no attached theoretical training in the Mental Capacity Act; this information was available as a grab pack in the ward area as a reference for staff.

We spoke to the ward manager on ward 14A who detailed the referral process for the deprivation of an individual’s liberties. The team used an email address to refer new patients for DoLs assessments; this was directed to the safeguarding team. This was monitored on a daily basis on the ward and a list was made, not all patients on this list were on the safeguarding teams’ database. The ward sister informed us that the local authority would always come to the ward and undertake a Dolls assessment but the Lancashire authority rarely came to undertake assessments, any patients without capacity who went over the emergency time limits for Dolls from Lancashire would then be subject to best interests decisions.

Do not attempt cardiopulmonary resuscitation (DNACPR) trust policies include that relatives or those close to the patient should be consulted in any discussions. However, there was no evidence of this in patient records. The planned care division had implemented the inclusion of DNACPR status on a medical record form completed by doctors when on call.). An audit of compliance, as reported in a departmental meeting in November 2017, found that only 62% of the notes audited had the patient’s DNACPR status documented.

Patients were consented for theatre at clinic prior to surgery. Staff reconfirmed consent on the day of operation. This was in line with best practice guidance. Interpreters were available and pre-booked if a patient whose first language was not English required consent for a procedure.

Is the service caring?

Compassionate care

We observed compassionate care and positive interactions in all areas inspected, including wards and theatres.
Staff treated patients, and their families, with respect and dignity. They were aware of patients’ care needs and communicated in an appropriate and professional manner.

We spoke to 20 patients and six relatives. They described care as being exemplary with excellent care from all staff. This included nurses, health care assistants, (including bank and agency staff), student nurses, doctors, therapists, porters and administrative staff.

All staff introduced themselves and communicated well to ensure patients fully understood. Relatives we spoke to said that if they approached staff for information, they were provided with prompt responses. One patient said: “You can ask them anything.”

One patient told us they frequently dropped their call bell However, they were always able to call a nurse. Another patient said that: “they come if you call – they are very good at that.”

Several patients were very complimentary about the maturity and respectfulness of staff, such as: “young staff are respectful and speak to people in their seventies in a nice way” and “young staff are very helpful”.

Patients described staff as kind, caring, and lovely: “Care when I need it and with dignity”, “very careful to keep you covered” and “always make sure curtain is closed – nursing staff and doctors.”

Patients were very positive about care from therapists including: “treat me really well – always ready to help. It’s a lovely hospital. Physios also really good - they come to me every day including weekend.”

Other comments from patients included: “quality of care is excellent”, “nice place to be if you are ill”, “nothing is too much trouble – have patience and understanding”, “I haven’t enough praise for them”, “I’m treated beautifully”, “nice atmosphere”, “they make you feel important” and “said I was cold and they brought me a shawl.”

At the time of inspection, there were some ward changes. All staff we spoke to prioritised the care of the patients during the moves. All patients were prepared for the move and settled well in their new environment. Patient bays were calm the day following the moves. One patient commented that: “the atmosphere is amazingly good with the move.”

One patient, aged 79 years described how she was desperate to have a haircut. The receptionist offered to cut it as she was a trained hairdresser. The patient said that: “she cut it and washed it and now I feel like a new woman.”

Another patient explained how she had had a poor experience on a previous admission but was extremely happy with the current admission.

A short observational framework for inspection (SOFI) was undertaken on ward 14A in a bay with eight patients, six were in their beds and two sat in chairs. There were three relatives in attendance throughout the half hour period this was undertaken at lunchtime. All the patients were elderly female patients. One staff was in attendance in this bay at the time and moved in and out of the area to transport food from the corridor. She was later joined by another staff after
10 minutes and then a further ward sister after 20 minutes.

There were two patients who required support to eat, the staff seemed aware of their needs although the hospital policy on the use of red cups, jugs and food mats to identify these patients was not in use. Both patients were helped to eat their meals. There were periods of up to four minutes where no staff were in the room whilst patients were eating. The atmosphere was calm and quiet and the hospital had a protected meal time policy although for a period of about 10 minutes two cleaners entered the room and began to mop the toilet area and look around the bay whilst patients were eating their lunch.

Friends and Family test performance

The Friends and Family Test response rate for Surgery at Southport and Ormskirk Hospital NHS Trust was 8.5% which was worse than the England average of 29% from September 2016 to August 2017.

The percentage of patients recommending the service as a place to receive treatment was quite variable across the different wards. The lowest annual recommendation rate was found in Ward 14A – Surgical Trauma and Orthopaedics (72%).

A breakdown of response rate by site can be viewed below:

**Friends and family test response rate at Southport and Ormskirk Hospital NHS Trust, by site**

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Avg. Response Rate</th>
<th>Percentage of patients recommending the service as a place to receive treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT / Eye Unit</td>
<td>1</td>
<td>0%</td>
<td>Sep-16: 96% Oct-16: 65% Nov-16: 71% Dec-16: 75% Jan-17: 83% Feb-17: 67% Mar-17: 100% Apr-17: 91% May-17: 100% Jun-17: 100% Jul-17: 100% Aug-17: 100% Annual performance: 99%</td>
</tr>
<tr>
<td>Ward C</td>
<td>2</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Ward H</td>
<td>71</td>
<td>1%</td>
<td>Sep-16: 100% Oct-16: 100% Nov-16: 100% Dec-16: 100% Jan-17: 83% Feb-17: 100% Mar-17: 100% Apr-17: 91% May-17: 100% Jun-17: 100% Jul-17: 100% Aug-17: 100% Annual performance: 99%</td>
</tr>
<tr>
<td>Ward 14A</td>
<td>102</td>
<td>1%</td>
<td>Sep-16: 100% Oct-16: 100% Nov-16: 100% Dec-16: 67% Jan-17: 67% Feb-17: 66% Mar-17: 86% Apr-17: 91% May-17: 100% Jun-17: 73% Jul-17: 17% Aug-17: 75% Annual performance: 72%</td>
</tr>
<tr>
<td>Ward 15B</td>
<td>137</td>
<td>1%</td>
<td>Sep-16: 100% Oct-16: 100% Nov-16: 100% Dec-16: 67% Jan-17: 67% Feb-17: 66% Mar-17: 86% Apr-17: 91% May-17: 100% Jun-17: 73% Jul-17: 17% Aug-17: 75% Annual performance: 72%</td>
</tr>
<tr>
<td>PIU</td>
<td>205</td>
<td>1%</td>
<td>Sep-16: 100% Oct-16: 100% Nov-16: 100% Dec-16: 67% Jan-17: 67% Feb-17: 66% Mar-17: 86% Apr-17: 91% May-17: 100% Jun-17: 73% Jul-17: 17% Aug-17: 75% Annual performance: 72%</td>
</tr>
<tr>
<td>Ward F</td>
<td>241</td>
<td>12%</td>
<td>Sep-16: 100% Oct-16: 100% Nov-16: 100% Dec-16: 100% Jan-17: 100% Feb-17: 100% Mar-17: 100% Apr-17: 100% May-17: 100% Jun-17: 100% Jul-17: 100% Aug-17: 100% Annual performance: 100%</td>
</tr>
<tr>
<td>Ward G</td>
<td>251</td>
<td>14%</td>
<td>Sep-16: 97% Oct-16: 97% Nov-16: 97% Dec-16: 97% Jan-17: 97% Feb-17: 97% Mar-17: 97% Apr-17: 97% May-17: 97% Jun-17: 97% Jul-17: 97% Aug-17: 97% Annual performance: 97%</td>
</tr>
</tbody>
</table>

20171116 900885 Post-inspection Evidence appendix template v3 Page 153
(Source: NHS England Friends and Family Test)

From the trust’s dashboards in October 2017, the percentage of patients that would recommend the surgical wards was an average of 76%: PIU was 94%, ward 15B was 79% and ward 14A was 55%, However, these did not include details of response rates.

Emotional support

We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.

A mental health liaison team of professionals were available and we were told they responded in a timely manner when requested.

Clinical nurse specialists, such as stoma nurses, urology, vascular, trauma and outreach nurses were available to provide support to patients in times of need.

Understanding and involvement of patients and those close to them

We observed staff interacting positively with patients and those close to them across surgical services. Staff spoke to families sensitively and appropriately dependent on individual need.

Staff respected patient choices and delivered their care with an individualised person-centred approach. Patients’ care records were individualised to take into account personal wishes.

Patients and those close to them told us they received information about care and treatment in a manner they understood.

One relative of a patient told us that although they considered the orthopaedic care, on ward 14A had been excellent; they were concerned that not all other co-morbidities were managed as well. This had been raised with ward staff who were monitoring the care.

Ward staff encouraged families to complete passport documentation for patients living with dementia, although these were not all completed. The documentation included the patient’s preferences, for example food likes and dislikes.

Is the service responsive?

Service delivery to meet the needs of local people

Surgical services were planned to meet the needs of local people. There were service level
agreements in place with neighbouring independent health providers to meet the demands of the local population.

Arrangements were in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital.

There was an emergency theatre available for emergency general and trauma surgery that was staffed 24 hours, seven days per week so that operations could be performed for patients that required emergency surgery at any time of the day or night.

A range of elective surgical procedures were available, some of which were able to be done as day case procedures (meaning that patients could be discharged on the same day as the procedure).

Patients who were booked for planned surgery attended health checks prior to the operation to assess their fitness for surgery and screen for infections. These pre-operative assessments took place in a dedicated area of the main outpatient department. Any patient assessed as high risk according to the American Society of Anaesthesiologists (ASA grade three or higher), were assigned this location, rather than Ormskirk, in order to provide safe monitoring following surgery.

The areas we visited were compliant with same-sex accommodation guidelines with allocated bathroom and toilet facilities.

**Average length of stay**

**Trust Level – elective patients**

From July 2016 to June 2017, the average length of stay for all elective patients in Surgery at the trust was 2.8 days, which is lower compared to the England average of 3.3 days.

The average length of stay for Trauma and Orthopaedics elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.4 days.

The average length of stay for General Surgery elective patients at the trust was 3.4 days, which is as expected compared to the England average of 3.3 days.

The average length of stay for Urology elective patients at the trust was 1.6 days, which is lower compared to the England average of 2.0 days.

**Elective Average Length of Stay – Trust Level**

(Source: Hospital Episode Statistics)

**Trust Level – non-elective patients**
The average length of stay for all non-elective patients in Surgery at the trust was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery non-elective patients at the trust was 4.9 days, which is higher compared to the England average of 4.0 days.

The average length of stay for Trauma and Orthopaedics non-elective patients at the trust was 10.6 days, which is higher compared to the England average of 8.9 days.

The average length of stay for Urology non-elective patients at the trust was 3.8 days, which is higher compared to the England average of 3.0 days.

### Non-Elective Average Length of Stay – Trust Level

<table>
<thead>
<tr>
<th></th>
<th>This Site</th>
<th>England Avg.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>6.4</td>
<td>5.1</td>
</tr>
<tr>
<td>General Surgery</td>
<td>4.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>10.6</td>
<td>8.9</td>
</tr>
<tr>
<td>Urology</td>
<td>3.8</td>
<td>3.0</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

### Southport and Formby District General Hospital - elective patients

From July 2016 to June 2017 the average length of stay for all elective patients in Surgery at Southport and Formby District General Hospital was 3.4 days, which is as expected compared to the England average of 3.3 days.

The average length of stay for General Surgery elective patients at Southport and Formby District General Hospital was 4.2 days, which is higher compared to the England average of 3.3 days.

The average length of stay for Urology elective patients at Southport and Formby District General Hospital was 1.7 days, which is lower compared to the England average of 2.0 days.

The average length of stay for Trauma and Orthopaedics elective patients at Southport and Formby District General Hospital was 7.2 days, which is higher compared to the England average of 3.4 days.

### Elective Average Length of Stay - Southport and Formby District General Hospital

(Source: Hospital Episode Statistics)

### Southport and Formby District General Hospital - non-elective patients

The average length of stay for all non-elective patients at Southport and Formby District General Hospital was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for General Surgery non-elective patients at Southport and Formby District General Hospital was 4.9 days, which is higher compared to the England average of 4.0 days.
days. The average length of stay for Trauma and Orthopaedics non-elective patients at Southport and Formby District General Hospital was 10.8 days, which is higher compared to the England average of 8.9 days.

The average length of stay for Urology non-elective patients at Southport and Formby District General Hospital was 3.8 days, which is higher compared to the England average of 3.0 days.

Non-Elective Average Length of Stay - Southport and Formby District General Hospital

![Average Length of Stay Graph](image)

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

We observed that patients had access to their individual nurse call bells, However, these were not always answered promptly on ward 14A. We observed up to nine minutes wait for the nurse buzzer and also a mattress alarm for 17 minutes. The ward included therapy staff, However, it was the nurses who responded to the call bells.

The trust supported Johns Campaign for caring for patients identified with dementia needs. Passports for patients with dementia, However, not always completed. We were told that this was for those close to patients to complete. There was a dementia specialist therapist, on one ward. A range of resources had been gathered including games and memory boxes to support patients. Volunteers provided knitted twiddle muffs with a variety of textures. The date and weather forecast were display and changed daily. Pictures were changed dependent on the current season. Doors and walls of bays had been painted in colours to contrast white walls. Toilets had blue hand rails and seats and the showers were easy to access.

During Dementia Awareness week, one of the therapists organised a stall on ward 14A to support care on the ward.

There was an electronic system that highlighted any individual need such as a safeguarding concern, learning disability, mental health need or end of life programme.

The therapists on ward 14A provided an outreach service where they could support staff in nursing homes to care for patients immediately post discharge to continue appropriate care. In addition they offered escorted discharge for patients with a limited support network.

We were told that a patient with a learning disability would be cared for according to their individualised needs, However, we did not see any patients during our inspection.
There was a chaplain service available; these were visible on the wards. The service offered 24/7 support if needed. The service linked with other local faith communities including the Muslim and Jewish Community. There was also a quiet room that patients and visitors could attend.

There was a trust-wide interpreter and translation service available if needed.

We observed that a patient with a hearing impairment used a whiteboard to communicate with staff.

There were leaflets available in wards, however, these were in English only. Staff we spoke to were unclear if other formats were available, for example Braille, easy-read, languages other than English.

Clinical nurse specialists, such as stoma nurses, urology, vascular, trauma and outreach nurses were available to provide support to patients in times of need.

Accessibility to all facilities and areas was good and staff could access appropriate equipment such as beds to support bariatric patients (patients who are clinically obese).

**Access and flow**

Patients could be admitted for surgical treatment through a number of routes, such as pre-planned surgery, via accident and emergency or via GP referral.

Patients admitted via accident and emergency were reviewed on wards following admission. Elective patients were reviewed by the surgeon and anaesthetist on the day of surgery to ensure medically fit for the procedure.

Senior managers recognised that there had been delays in surgery due to capacity issues. We observed a patient awaiting theatre, in a room that was outside the main ward area. The patient told us that, as a diabetic, blood glucose levels were checked prior to admission. The patient was not monitored until theatre called for them two hours later.

We found that there had been delays in follow-up appointments that affected surgical wait times. During the inspection, information provided by the trust, showed that there were delays across a number of specialities, across the trust including trauma and orthopaedics.

We were told that, along with the ward changes, a dedicated surgical assessment unit (SAU) is planned where patients can wait and be monitored appropriately.

For patients with complex care needs, discharge co-ordinators were allocated to support this process. We were told that one of the discharge co-ordinators had been seconded temporarily to help minimise delays in discharges for these patients. Delays in patients identified as being at end of life had been highlighted and we were told that their discharge planning was being prioritised.
At the time of inspection, there were patients classed as outliers on other wards. Between August 2017 and October 2017, the trust identified 420 occasions when medical patients were on surgical wards and also 117 occasions when surgical patients were on medical wards. The resident orthopaedic doctor reviewed all patients daily, including those on other wards. There were also two trauma nurses who monitored patients throughout the hospital as well as being supported by therapy staff. An Orthogeriatrician consultant also reviewed all patients that met these criteria within 24 hours of admission.

The trust told us that in the three months prior to inspection, there were a total of 818 bed moves in the planned care division. However, there was no data provided for individual patient moves. We were therefore unable to judge if patients had been moved multiple times during their stay.

The trust told us that between April 2016 and March 2017, for emergency, ENT, general surgery and orthopaedics, there were 53 cancelled operations and from April 2017 to November 2017, there were 33 cancelled operations for these specialities. It was not clear if these cancellations had occurred on the day of operation and if patients had been re-booked in a timely way. We were also told that delays in operations on the day of surgery were not recorded.

Between November 2016 and October 2017, data provided by the trust showed that there was an average theatre utilisation of 63% with the lowest in January at 48% and the highest usage in February at 74%. For the same time period bed occupancy was on average 83% ranging between 71% and 90%. However, this data was for the whole planned care division. We were told that there were plans in place to split the data going forward.

The trust had intruded a golden patient system. This was a patient identified on the next day’s trauma-list, medically optimised for surgery and reviewed by an anaesthetist the previous day. This meant that any delays in theatre starts were reduced.

From 1 July 2016 to 30 June 2017 there were 349 moves at night (between 22:00 and 08:00).

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery remained fairly consistent and was in line with or better than the England average in all 12 months.

As of August 2017, 76% of patients were treated within 18 weeks compared to the England average of 70%.

*(Source: NHS England)*
Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, three of specialties were above the England average and three specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>91.9%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.1%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>77.7%</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>69.1%</td>
<td>72.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>63.9%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>46.8%</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

Cardiothoracic Surgery, Neurosurgery and Plastic Surgery had no activity during the time period.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the trust performed consistently better than the England average for treating cancelled patients within 28 days and was generally better than the England average for cancellations as a percentage of elective admissions. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

All of the cancellations were treated within 28 days over this time period.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Southport and Ormskirk Hospital NHS Trust

Cancelled Operations as a percentage of elective admissions - Southport and Ormskirk Hospital NHS Trust
Learning from complaints and concerns

Summary of complaints

From July 2016 to June 2017 there were 79 complaints about Surgery. The trust took an average of 59.1 days (43.3 working days) to investigate and close complaints.

One of the 79 closed complaints (1.3%) about Surgery was closed in over 180 days while one of the 12 complaints that remained open at the time of response were received in 2016 and therefore had been open more than six months. This meets the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The most common subjects of the complaints were all aspects of clinical treatment (41); and attitudes of staff (11).

The breakdown of complaints by site was:

- Southport and Formby District General Hospital: There were 53 complaints; the highest number of complaints (28) was about all aspects of clinical treatment.
- Ormskirk and District General Hospital: There were 26 complaints; the highest number of complaints (13) was about all aspects of clinical treatment.

(Source: Routine Provider Information Request (RPIR) P61 – Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Information leaflets were available in all areas. However, we did not see information about the complaints procedures in the wards we visited or how to contact the hospital to share comments about their stay. The trust website included details about providing feedback to the patient experience and complaints team.

Complaints were recorded on the trust-wide system. Local ward managers were responsible for investigating complaints in their areas.

Between August 2017 and October 2017, there were a total of five complaints for the surgical wards, However, there was a total of 36 compliments received (31 were for ward 15B).
Lessons learnt from complaints were discussed at governance meetings. Staff told us they received feedback either via email notifications or at ward meetings.

**Is the service well-led?**

**Leadership**

The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care.

There was visible leadership roles across the surgical division. The senior management team included an assistant director of operations, head of nursing and associate medical directorate. The leads were supported by teams of directorate and operational managers, matrons, ward and theatre managers. However, there had been some turnover in managers. This meant we were not always assured about stability and continuity.

Staff told us and we saw during the inspection, that matrons and head of nursing were visible on the wards. Matrons attended trust wide ‘safe at all times’ briefings two or three times daily to discuss nurse staffing to ensure safe numbers of staff for the acuity of patients.

Medical and nursing staff understood reporting structures and told us they were generally supported by their managers.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients. However, there was no strategy in place to achieve this vision.

Following the inspection, a presentation of the plan for the surgical strategy was forwarded that highlighted plans for surgery on both sites including clear aims and dates for completion. It included plans for ‘safe at all times’ and for changes to surgical services over the coming months. We were told that a full strategy was being developed in line with the trust strategies.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff. However, appraisal rates were below the trusts target.

There was a culture that encouraged the reporting of incidents in order to learn from them and improve quality for people in the local population.

Staff reported good team working and a sense of pride in serving the local community. Many of the staff we spoke to had been employed for several years at the trust and demonstrated strong commitment to the hospital.

Junior doctors told us they felt reasonably well supported but sometimes there was difficulty...
accessing middle grade / seniors if in theatres.

Some allied health professionals reported they didn’t always feel valued, supported or included at times by their managers.

Ward managers told us that they were proud of their teams and some staff told us they were able to work flexible hours in order to manage other commitments.

**Governance**

The trust did not use a systematic approach to continually improving the quality of its services. Focus for improvement was on external reports including CQC’s previous inspection report rather than a proactive internal approach to sustainable improvement.

Monthly divisional governance meetings were held that linked in with trust-wide clinical effectiveness committee meetings. It was evident that this information was shared and discussed from meeting minutes we reviewed. From the draft clinical effectiveness minutes in October 2017 However, it was minuted that the planned care report was not as comprehensive as other divisions.

Agenda items from these were discussed at monthly quality and safety committee meetings.

**Management of risk, issues and performance**

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, it was not clear how effective the systems were.

The planned care division had a risk register and there was also a corporate risk register. Items on the risk register were discussed in governance meetings and updated as needed.

We reviewed the risk registers: Some risks had been present for a number of years; However, most had been reviewed within six months prior to inspection. The registers included control measures to mitigate risks; However, we found that not all ward managers were aware of the risks identified.

Senior managers told us that they had allocated two additional staff, independent of the risk reviewers, to ensure that risks were being monitored in a timely way.

We were told by senior managers that any serious incidents were discussed weekly to review the level of harm, However, we found that there had been delays in reporting of serious incidents.

**Information management**

The trust collected, analysed, managed but did not use information well to support all its activities, using secure electronic systems with security safeguards, for example staff told us that information was not always consistent and accurate due to multiple systems in use.
Each ward monitored performance on electronic dashboards; however, due to changes in wards, data needed checking with information technology staff to ensure accuracy.

**Engagement**

The trust did not always engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively.

Senior managers told us that information from senior management meetings was fed back to operational teams and then to clinical teams. We requested minutes from theatre and ward meetings. However, only theatre minutes were provided.

Ward staff told us that ward meetings were planned monthly; however, staff were not always able to attend due to ward pressures.

Matrons from planned care met and attended ward managers meetings. This meant that information could be shared across all staff.

Staff told us that they received information from senior managers via emails, intranet and monthly staff bulletins.

The junior student nurses, we spoke to, said they felt supported on the wards and all had mentors allocated. During the inspection, we saw a tutor visiting a group of students.

In the 2016 national NHS staff survey the trust scored 3.66 out of five (which is less than the national average of 3.80) for overall staff engagement staff. This was a decrease on the previous 2015 survey. This information was trust-wide and not specific to surgical services.

There was a low response rate for the NHS Friends and Family Test at 8.5%. During the inspection we did not see any boxes, on the wards, where patients and visitors could submit any feedback. In addition, there were leaflets displayed, however, these did not include how to complain via the PALS system.

**Learning, continuous improvement and innovation**

There were plans in place for surgical services that included changes to wards and recruitment of dedicated staff.
Urgent and emergency care

Facts and data about this service

Details of emergency departments and other Urgent and Emergency Care services

The Trust provides a dedicated children’s emergency department located in Ormskirk and District General Hospital that is open 24 hours a day, seven days a week. The unit has been open since 2004 and sees children under the age of 16 years. Staff refer any child aged 16 years or over to the adult emergency department at Southport and Formby District General Hospital. The unit comprises of a resuscitation area with two curtained bays, a minor injuries area with three curtained bays and an examination room. In addition there is a large children’s playroom and a room specially designed to care for children with mental health needs.

The emergency department shares facilities such as the dirty utility room, clean utility room and treatment room with the adjoining children’s outpatient department. There is a six bedded assessment unit adjoining the unit that receives GP referrals and provides extended care up to 24 hours for patients seen in the emergency department. For longer stays in hospital, there is a children’s ward also adjoining the emergency department.
Activity and patient throughput

Total number of urgent and emergency care attendances at Southport and Ormskirk Hospital NHS Trust compared to all acute trusts in England

There were 134,973 attendances from April 2016 to March 2017 at Southport and Ormskirk Hospital NHS Trust as indicated in the chart above. 
(Source: NHS England)

There were 27,545 paediatric emergency care attendances from July 2016 to June 2017 at Ormskirk and District General Hospital.
(Source: RPIR Universal Final, Children tab)
Urgent and Emergency Care attendances resulting in an admission

Attendances resulting in an admission, October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital

The number of attendances at the paediatric A&E department at Ormskirk and District General Hospital that resulted in an admission peaked in the most recent month, September 2017.

Please note that we have been unable to calculate the monthly percentages of all attendances that resulted in an admission as we do not have access to data for the monthly total numbers of attendances at the Paediatric A&E department at Ormskirk and District General Hospital.

(Source: Trust data)

Urgent and Emergency Care attendances by disposal method

Urgent and Emergency Care attendances by disposal method, October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital

(Source: Trust data)
Is the service safe?

Mandatory training

Mandatory training levels for nursing staff had improved since the last inspection.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust has not provided any targets for the completion of mandatory training.

Ormskirk and District General Hospital

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Urgent and Emergency Care at Ormskirk and District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Handling - People</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 &amp; 5 (Prevent Awareness) - 3 Years</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>4</td>
<td>5</td>
<td>80.0%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>3</td>
<td>5</td>
<td>60.0%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>2</td>
<td>5</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at Ormskirk and District General Hospital was 66.7% from July 2016 to June 2017. However, this analysis is based on five eligible staff.

At the time of inspection, of the nine medical staff working in the emergency department, five were up-to-date with advanced paediatric life support (APLS) and four were up-to-date with training and APLS instructors.
A breakdown of completion rates for nursing staff in Urgent and Emergency Care is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
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<tr>
<td>Information Governance</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
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<tr>
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<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff at Ormskirk and District General Hospital was 94.0% from July 2016 to June 2017. However, this analysis is based on only four eligible staff. *(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

At the time of inspection, there were 20 nursing staff in the paediatric emergency department. Of these, 15 staff were trained in advanced paediatric life support (APLS), two staff were trained in paediatric life support (PLS) and three in basic paediatric life support. The department held four PLS courses over the year led by the paediatric APLS instructors.

**Safeguarding**

**Ormskirk and District General Hospital**

There were clearly defined and embedded systems to manage child safeguarding. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The safeguarding children policy and procedures was current and accessible to staff. All nursing, medical and support staff we spoke to had completed level three child safeguarding training. Whilst the training levels reported below are for 2016/2017, the unit manager stated that compliance for nursing staff was 98% at the time of inspection (November 2017). Nursing staff told us they were aware of the indicators for safeguarding referrals and the procedures to follow if they suspected a safeguarding concern.

Procedural pathways were clear for referral to the local authorities when necessary. The electronic patient administration system had a flagging system to identify children on child protection plans and procedures were in place to identify and manage female genital mutilation and child sexual exploitation. Staff were aware of how to contact the safeguarding team in the trust and the child safeguarding lead attended the paediatric unit ‘Harm’ meetings to review incidents.
Staff focussed on early identification of safeguarding concerns. Staff screened each patient for any safeguarding concerns and nurses documented this on the urgent care assessment form. We saw that nurses completed the safeguarding section in seven out of the nine records we reviewed. The assistant matron audited documentation on the urgent care assessment form monthly and the unit manager told us that nursing documentation on safeguarding was an area of focus for improvement.

Doctors were also required to document they had considered safeguarding concerns for each child. We saw that medical documentation on safeguarding was not consistent (two out of nine records completed) but monitored monthly and reported to the lead consultant. The unit manager planned to revise the assessment template to make the safeguarding section more prominent and continue to audit performance.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not provide a target for the completion of safeguarding training. Ormskirk and District General Hospital had an overall safeguarding training completion rate for medical/dental and nursing/midwifery staff of 77.8% July 2016 to June 2017.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental and nursing/midwifery staff in Urgent and Emergency Care at Ormskirk and District General Hospital is shown below:

![Safeguarding training completion by module](image)
Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one 93.9%
- Safeguarding adults level two 92.8%
- Safeguarding adults level three 94.2%
- Safeguarding children level one 94.7%
- Safeguarding children level two 90.9%
- Safeguarding children level three 92.7%

However, this information was not broken down into the core services we inspected.

**Cleanliness, infection control and hygiene**

The service managed infection risk well. There was a single room in the minor injuries area which staff used to isolate a patient from others if suspected of having an infectious condition. Information about sepsis identification and management was accessible with a clear care pathway following national guidance. We spoke to the cleaner who was aware of the deep cleaning procedures used to prevent the spread of infection and we saw staff cleaning trolleys down between patients. There were no incidences of reportable infections such as methicillin resistant staphylococcus aureus or clostridium difficile in the department from November 2016 to October 2017.

Staff kept equipment and premises clean and used control measures to prevent the spread of infection. We observed staff wash or cleanse hands between patients and appropriate clinical handwashing facilities and hand gel dispensers were available in all the areas. We saw that staff used personal protection equipment such as aprons and gloves as required and managed clinical waste according to trust policy. Staff conducted observational hand hygiene audits and compliance was 100%. The environment was visibly clean and tidy. We saw the cleaning services manager completed a cleaning audit twice a month and that the paediatric emergency department achieved 98.5% for cleanliness in September 2017. Toys used in the playroom were wipeable and cleaned after use.
Environment and equipment

The environment was visibly clean in all areas inspected. The service had suitable premises and equipment was clean and well-maintained.

The layout in the department facilitated the easy flow of patients from reception to triage and treatment; However, we noted that the receptionist worked in an enclosed area behind the reception desk and out of view of the patients waiting area or new arrivals. A sign on the desk asked parents or carers to ring a bell to call the receptionist to the desk. The triage room was adjoining the reception area but also had no facility to observe the waiting room. Several nurses confirmed that it was common practice for one of them to walk through the waiting room at intervals to observe patients for any change in condition.

The resuscitation room had two bays with trolleys and was fully equipped to deal with children requiring emergency care. The department had an emergency stand-by phone and staff used this to receive calls prior to the arrival of an emergency ambulance or GP referral. The minor injuries unit had three bays with trolleys and a single room. The single room in minor injuries was used for patients with a suspected infection or for those that required a quiet room. Other rooms were available for flexible use on the unit.

The room in minor injuries met specifications for keeping patients with mental health conditions safe. For example, if used for that purpose, there were no ligature points in the room and an accessible alarm. When required, staff removed all portable equipment and tubing from the room and could monitor the patient through an observation pane. The trust had recently completed building a new room for children and young people with mental health needs within the department but away from the minor injuries area.

Staff checked all equipment prior to the start of each shift. The resuscitation equipment was specifically for paediatric patients and we saw evidence of regular checks of the equipment and critical drug expiry dates. We saw evidence of regular portable appliance electrical safety testing (PAT) and servicing except for one set of baby weighing scales and a bedside monitor in the assessment unit, both of which were out of date. Staff acted on this as soon as we notified them of these findings. The unit manager told us that she was in the process of reviewing the maintenance monitoring system.

There was a large children’s playroom and we saw children with parents making use of this facility. There was a range of toys and the healthcare assistants completed daily cleaning schedules to keep the room clean and tidy. We saw the plaster room was also clean and tidy in preparation for children who needed a plaster applied. Access to the emergency department was restricted between 10pm and 7am to the ambulance entrance managed from inside the department by swipe card access.

Assessing and responding to patient risk

A proactive approach to anticipating and managing risks to children was embedded and recognised as the responsibility of all staff. A trained nurse conducted the triage screening process and completed the assessment form. Staff told us that when up to four patients were waiting for triage, the triage nurse would ask a colleague to assist with triaging patients in another examination room so that parents and children were not waiting long periods. Patients were triaged according to their paediatric early warning score (PEWS). Staff calculated the score
based on indicators such as neurological observations, temperature and pulse rate and the score determined the frequency of subsequent observations and priority of care.

Staff recognised and responded appropriately to changes in risks to children. Staff were trained to recognise and act upon symptoms of serious illness such as meningitis and sepsis. A copy of the sepsis bundle was accessible in the triage room and staff we spoke to were familiar with the signs to look for in a child. There was a sepsis tray in the department with the essential equipment to start immediate screening by taking blood samples and placing the sepsis pathway sticker in the case notes. Children with suspected sepsis had direct access to the consultant medical paediatrician on call for support in escalating their care.

Staff maintained the safety of children with mental health needs. Staff triaged children in the single room in minor injuries and referred them to the paediatric medical service and to the Child and Adolescent Mental Health Service (CAMHS) to assess their mental health needs if required. Staff admitted children to the paediatric ward to await CAMHS assessment. Recently the trust had built a designated room in the paediatric emergency department to the specifications required to provide safe care for children and young people with mental health needs while they awaited CAMHS assessment or needed a quiet room.

There was inequality of CAMHS provision across the two localities in the region; one locality provided 24-hour access and the other had limited access out-of-hours. Management had escalated this risk to the corporate risk register and were working with the agencies to improve CAMHS access. The service transferred two children (July 2016 to June 2017) to a regional children’s hospital due to lack of CAMHS availability out-of-hours.

Paediatric staff held a safety huddle at the beginning of each day to discuss safety issues across the unit including urgent care. Topics covered included children to be monitored for potential deterioration, PEWS scores, duplicate names and any other potential risks to be aware of during the day. The huddle included the ward consultant, doctors and nurses from across the paediatric unit, physiotherapy and dietetics.

When the department became extremely busy, the manager escalated concern to the bed manager and first director on-call. When necessary, the consultant reviewed all the patients in the paediatric unit and considered which might be eligible for early discharge to relieve pressure on the emergency department. When a child required a higher level of care for any condition, the emergency department transferred the child to one of two regional NHS trusts with paediatric intensive care via a specialised NHS transport service for paediatric patients.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The paediatric Accident and Emergency Department at Ormskirk and District General met the standard for 10 months over the 12 month period from October 2016 to September 2017.

In the most recent month, September 2017, the median time to treatment was 58 minutes which was the same as the England average and below the standard.

*Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable paediatric A&E departments nationally.*
**Median time to treatment from October 2016 to September 2017 (all patients), Paediatric A&E department at Ormskirk and District General Hospital**

![Median time to treatment graph](image)

1. 95% of patients should be seen within these times

(Source: Trust data)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

Patients arriving at the paediatric emergency department at Ormskirk Hospital rarely arrived by ambulance but more commonly arrived independently accompanied by a parent or carer. We reviewed nine records of patients arriving independently and noted that staff achieved triage within a period of 0 – 34 minutes with the average wait being within 13 minutes of arrival and booking by the receptionist.

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

The trust did not provide the percentage of ambulance journeys with turnaround times over 30 minutes but actual numbers were very low. From October 2016 to September 2017 there were six ambulance journeys with turnaround times over 30 minutes for the Paediatric A&E at Ormskirk and District General Hospital, four of which occurred in October 2016. The other two instances were in December 2016 and June 2017.

(Source: Trust data)

**Number of black breaches for this trust**

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From October 2016 to September 2017 the Paediatric A&E at Ormskirk and District General Hospital reported no “black breaches”.

(Source: Trust data)

**Nurse staffing**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported the following overall planned and actual whole time equivalent (WTE) staffing figures for nursing staff working trust-wide in Urgent and Emergency Care as at November 2017. Please note that this data was not provided at location level.
<table>
<thead>
<tr>
<th>Month</th>
<th>Planned WTE Staff</th>
<th>WTE in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>107.9</td>
<td>85.6</td>
</tr>
<tr>
<td>May 2017</td>
<td>107.9</td>
<td>84.7</td>
</tr>
<tr>
<td>April 2017</td>
<td>107.7</td>
<td>83.4</td>
</tr>
<tr>
<td>March 2017</td>
<td>107.1</td>
<td>83.4</td>
</tr>
<tr>
<td>February 2017</td>
<td>107.1</td>
<td>83.4</td>
</tr>
<tr>
<td>January 2017</td>
<td>107.1</td>
<td>82.4</td>
</tr>
<tr>
<td>December 2016</td>
<td>106.3</td>
<td>83.2</td>
</tr>
<tr>
<td>November 2016</td>
<td>105.3</td>
<td>84.2</td>
</tr>
<tr>
<td>October 2016</td>
<td>117.4</td>
<td>91.6</td>
</tr>
<tr>
<td>September 2016</td>
<td>102.1</td>
<td>97.5</td>
</tr>
<tr>
<td>August 2016</td>
<td>102.1</td>
<td>98.7</td>
</tr>
<tr>
<td>July 2016</td>
<td>102.1</td>
<td>100.6</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Staffing levels were planned and the skill mix improved by training advanced nurse practitioners to support the medical staff. There was very low use of agency nurses.

The paediatric emergency department originally based its assessment of nursing establishment on the activity of the department. The unit manager told us that activity has risen steadily over the past thirteen years from 6,000 attendances per year to over 27,000 in 2016/17. The lead consultant told us that nursing management was responsive to spikes in the workload and put on extra staff on a twilight shift when needed.

Managers had recently reviewed the establishment figures for nursing in paediatric urgent care and told us that they needed another 2.7 whole time equivalents (WTE) to meet the needs of the service; a business case was in progress to approve these staff. There were no nursing staff vacancies in the department at the time of inspection.

Staffing included one band 7 unit manager, 10.24WTE band 6 nurses including an advanced nurse practitioner (ANP) and trainee ANP, 8.2WTE band 5 nurses and eight band 3 healthcare assistants.

Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for nursing staff of 22.0% in Urgent and Emergency Care. As at June 2017, the vacancy rate was 20.7%.

Ormskirk and District General Hospital

The vacancy rate for nursing staff at the paediatric emergency department was much lower than at Southport and Formby District General Hospital. As at June 2017, there were no vacancies in the paediatric emergency department at Ormskirk and District General Hospital and the department was over-establishment with 2.8 WTE staff in post compared with one at establishment.

Turnover rates

From July 2016 to June 2017, the trust reported a turnover rate of 16.3% for nursing staff in Urgent and Emergency Care. The turnover rate for nursing staff in urgent care at Ormskirk and District General Hospital was much lower than at Southport and Formby District General Hospital:

- Ormskirk and District General Hospital: 5.1%
Sickness rates

From July 2016 to June 2017, the trust reported a sickness rate of 6.2% for nursing staff in Urgent and Emergency Care. The sickness rate for nursing staff in urgent care at Ormskirk and District General Hospital was higher than the trust rate and included one individual on long-term sick leave:

- Ormskirk and District General Hospital: 7.9%

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. We are aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported overall bank usage for registered nurses of 1,085 shifts in Urgent and Emergency Care and agency usage of 1,704 shifts. The trust reported that 488 shifts were unfilled by bank and agency staff over this time period.

Ormskirk and District General Hospital

As noted below, the paediatric emergency department used bank nurses but very few agency nurses. All contracted nurses rotated around the paediatric department, meaning that all gained urgent care experience. If no bank nurses were available, managers allocated an appropriately experienced agency nurse to the paediatric ward and reallocated a contracted nurse to the emergency department.

One-hundred and forty-six shifts in Urgent and Emergency Care at Ormskirk and District General Hospital were covered by bank staff from April 2016 to March 2017, and one shift by agency staff. Fifteen shifts were unfilled by bank or agency staff over this time period.

Medical staffing

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust has reported the following planned and actual whole time equivalent (WTE) staffing figures for medical and dental staff working in Urgent and Emergency care at Ormskirk and District General Hospital as at November 2017.

<table>
<thead>
<tr>
<th>Month</th>
<th>Planned WTE Staff</th>
<th>WTE in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>36.0</td>
<td>33.0</td>
</tr>
<tr>
<td>May 2017</td>
<td>36.0</td>
<td>35.0</td>
</tr>
<tr>
<td>April 2017</td>
<td>36.0</td>
<td>33.0</td>
</tr>
<tr>
<td>March 2017</td>
<td>36.7</td>
<td>33.0</td>
</tr>
<tr>
<td>February 2017</td>
<td>36.7</td>
<td>32.5</td>
</tr>
<tr>
<td>January 2017</td>
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<td>33.5</td>
</tr>
<tr>
<td>December 2016</td>
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<td>35.5</td>
</tr>
<tr>
<td>November 2016</td>
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<td>October 2016</td>
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<tr>
<td>August 2016</td>
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</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>July 2016</td>
<td>35.7</td>
<td>31.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

At the time of inspection, there were two whole time equivalent (WTE) paediatric urgent care consultants including one locum consultant and four WTE tier two speciality paediatric urgent care doctors. Adult urgent care medical staff from Southport and Formby District General Hospital supported the service from 8am until midnight when needed. Normal staffing on a daily basis included one consultant working 8am to 5pm, with on-call cover out-of-hours until midnight; a senior registrar on duty day and night, an urgent care trainee doctor and a trainee GP. An advanced nurse practitioner and emergency nurse practitioners supported the medical staff. After midnight until 8am, the paediatric medical consultant supported the paediatric emergency department.

**Vacancy rates**

From July 2016 to June 2017, the trust reported an overall vacancy rate for medical and dental staff of 8.3% in Urgent and Emergency Care. As at June 2017, the overall vacancy rate was 8.4%.

**Ormskirk and District General Hospital**

Vacancy rates for medical and dental staff in Urgent and Emergency Care at Ormskirk and District General Hospital were consistently high from July 2016 to June 2017, peaking at 22.0% from December 2016 to March 2017 before decreasing to 13.4% in April and May 2017. The rate rose to 24.4% in the most recent month available, June 2017; this relates to 2.2WTE vacancies out of the establishment of 9 WTE.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

The directorate management continued to recruit to medical vacancies and recognised the vacancies as a risk. The medical staff were supported by one advanced nurse practitioner (ANP), one trainee ANP and two Emergency Nurse Practitioners.

**Turnover rates**

From July 2016 to June 2017, the trust reported an overall turnover rate for medical and dental staff of 33.4% in Urgent and Emergency Care. As noted there was no turnover of medical staff in paediatric urgent care:

- Ormskirk and District General Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From July 2016 to June 2017, the trust reported an overall sickness rate of 2.7% for medical and dental staff in Urgent and Emergency Care. The sickness rate for medical staff in paediatric urgent care was much lower as seen below:

- Ormskirk and District General Hospital: 0.7%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request
spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.
(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Staffing skill mix

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for whole time equivalent medical staff working in Urgent and Emergency Care at Southport and Ormskirk Hospital NHS Trust

![Staffing skill mix chart](image)

(Source: NHS Digital Workforce Statistics)

Records

Staff could access the information they needed to assess, plan and deliver care. Hard copy records were held securely in the administrative office serving the paediatric emergency room and outpatient department. While staff were seeing patients in the emergency room, records were kept in a rack outside the minor injuries area under constant observation by staff. Staff used two electronic systems to manage patient information: an electronic patient administration system on which patients could be tracked through the stages of their attendance in the emergency department and an electronic medical record system on which previous admissions, safeguarding referrals and previous medical history were stored. Staff had access to copies of care plans for patients with complex conditions and who frequently attended the department. Staff told us they could access the information they needed and were able to monitor waiting times easily on the system.

The quality of documentation was inconsistent. We reviewed thirteen sets of case notes in total. Most of the entries were legible, dated, timed, signed and included the designation of the nurse or doctor. One patient complaining of a sore ear had no PEWS or pain score at triage. Another patient complaining of head pain received paracetamol without a pain score recorded but staff recorded pain scores with subsequent observations. Two children were seen with a history of fits, one had observations including PEWS recorded two hourly until discharge. The second child had a set of observations including PEWS at triage, repeated after four hours, changed to two-hourly for two hours then four hourly again. There was no documented reason for the change in frequency. A new protocol to standardise the procedures for observations was being implemented at the time of the inspection and the unit manager continued to audit and monitor the quality of documentation.

Medicines

Medicines were stored and disposed of safely and children received their medicines as prescribed. Staff kept medicines in locked cupboards in a locked treatment room and medications for destruction or return to pharmacy were held securely. We saw that medicines in cold storage were kept in a locked fridge and a daily record kept of the fridge temperature to ensure they were held at the correct temperature. Controlled drugs were kept in an appropriate locked cupboard in the resuscitation room and we saw stock movements were recorded in the controlled drugs register. We reviewed thirteen records and noted staff recorded allergies for each patient and medicine administration records were complete.

There were trust-wide protocols in place for the administration of antimicrobials and paediatric...
dosage tables for a range of medications available for reference in the department. Ketamine was used for sedation in some instances and the trust had a Paediatric Procedural Sedation with Ketamine Guideline. We saw that there was a locked store cupboard containing pre-packed take home medicines of commonly prescribed drugs and staff gave instructions to parents or carers on the administration of discharge medications. Out-of-stock items could be obtained when pharmacy was closed, from an emergency pharmacy store.

Trained nurses had training in adminstering intravenous medicines, medicines management and use of patient group directives (PGDs). PGDs are signed by a doctor, agreed by pharmacy and act as a direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. These directives enabled the nurses to administer analgesia and other medicines to children without waiting for a doctor to prescribe them.

The trust had PGDs in place but these were under a trust-wide review for standardisation by pharmacy. The PGDs covered administration of an antihistamine, oxygen, topical and oral analgesics and entonox, an inhaled gas used as a pain medication. We saw pharmacy had approved extending the PGDs’ review date to the end of 2017; However, all the PGD documents were originally approved in 2009 and none showed evidence of review and approval since that date. The out of date PGDs were recorded as a risk on the paediatric department risk register.

**Incidents**

We saw evidence that the service investigated serious incidents thoroughly and monitored the impact of recommendations for improvement through audit. Staff understood and fulfilled their responsibilities to be open and transparent, raise concerns and report incidents. Lessons were learned and communicated through staff meetings, email, paediatric department and risk management newsletters and daily safety huddles.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2016 to August 2017, the trust reported no incidents classified as never events for Urgent and Emergency Care.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in Urgent and Emergency Care from September 2016 to August 2017 which met the reporting criteria set by NHS England.

Site specific information can be found below:

- Southport and Formby District General Hospital: seven incidents
- Ormskirk and District General Hospital: one incident

*(Source: NHS Improvement - STEIS (01/09/2016 - 31/08/2017))*

One incident in paediatric urgent care at Ormskirk and District Hospital met serious incident reporting criteria and related to sub-optimal care of the deteriorating patient. We reviewed the Serious Incident report and the action plan. Management took a number of actions to improve the
quality of care including a review of the status epilepticus pathway and standardising the procedure for taking observations. At the time of the inspection, the majority of staff had received training on the new procedures and the paediatric department had approved the standard operating procedure for assessing, measuring and monitoring vital signs in infants, children and young people. A revised PEWS chart was expected to be in use by the end of November 2017. Audit outcomes for recording observations had improved from 46% to 79% in the emergency department since standardisation had been introduced.

Safety thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

The paediatric emergency department did not report a separate monthly harm free care audit but did contribute to the paediatric harm free care dashboard. From November 2016 to October 2017, in the paediatric department including urgent care, the assessment bay and the ward, there had been no pressure ulcers, four falls and no urinary tract infections. 
(Source: Dashboard Paeds (01/11/2016 - 31/10/2017)

Is the service effective?

Evidence-based care and treatment

The service participated in national and local audit to benchmark the quality of care and provided care and treatment based on national guidance. We saw that trust policies referred to National Institute for Health and Care Excellence (NICE) guidance and clinical guidelines; for example for the treatment of head injury and diabetes. These policies were accessible to all staff through the trust intranet. Managers also reviewed compliance with clinical standards issued by professional bodies such as the Royal College of Emergency Medicine (RCEM) and Royal College of Paediatrics and Child Health (RCPCH). Local standard operating procedures were in place; for example, for fasting guidelines and criteria for referrals to specialty services such as plastic surgeons and ear, nose and throat services. The service had started to use pre-prepared intranasal diamorphine for treating severe pain in children following approval by the trust Evidence-based Practice Committee.

Nutrition and hydration

There were facilities for parents, carers and children to obtain cold drinks and snacks from a nearby vending machine or from the hospital restaurant which was open seven days a week. No hot drinks were allowed in the department for safety reasons. Staff could obtain snack boxes from the restaurant for children when required. Warm milk and other food stocks for small children were accessible from the children's ward and staff offered meals to breast-feeding mothers. Children who were vomiting went on a trial of fluids; there was no water machine in the department and staff supplied patients with tap water. Staff displayed notices to remind parents to check with nursing staff before giving their child food and drink. On review of nine nursing records, documented evidence of staff offering food and drink to children in the emergency room was inconsistent.

Pain relief
Parents we spoke to were satisfied with the way staff managed their child’s discomfort. Staff assessed each child for level of pain at the point of triage. They used a visual tool which showed a series of faces ranging from a happy face at 0 which represented "no hurt" to a crying face at 10 which represented "hurts worst". Staff asked children to choose the face that best depicted the pain they were experiencing and used a range of pain relief medications that were administered orally, by inhalation or intranasally. Staff could administer basic pain relief in a timely manner by using the patient group directives. We saw that staff omitted to record the pain score at triage in two out of nine records we reviewed. One of these patients received paracetamol at the initial assessment without a pain score recorded but staff recorded pain scores with subsequent observations. We reported these omissions to the unit manager who reminded staff to ensure the pain score was documented.

**Patient outcomes**

The service monitored the effectiveness of care and treatment and used the findings to improve them. They participated in national and local audits and the clinical and directorate management monitored outcomes. One example of improved practice related to the 2014/15 audit: Initial management of the fitting child. There was room for improvement in checking and documenting the blood glucose of a child following a fit or suspected fit. Staff audited this practice and told us it had improved since being actively monitored and reported. The paediatric emergency department contributed to the following national audits:

**RCEM Audit: Moderate and acute severe asthma 2016/17**

**Ormskirk and District General Hospital**

In the 2016/17 RCEM audit of moderate and acute severe asthma, Ormskirk and District General Hospital did not meet the RCEM standard of 100% for any of the seven agreed metrics.

The hospital was in the upper quartile compared to other hospitals for one measure:
- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy (93.1%)

The hospital was between the upper and lower UK quartiles for the remaining six standards.
(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant Sign Off (2016/17)**

The 2016/17 Consultant Sign Off Audit monitors the proportion of patients of various groups who were reviewed by a consultant in emergency medicine prior to discharge from the ED. For each group, the RCEM standard is that 100% of all patients receive a review from senior medical staff on discharge.

**Ormskirk and District General Hospital**

Of all children under 1 year of age admitted with a fever in audited in 2016/17, 31.3% were seen by a consultant, which was in the upper quartile when compared to other hospitals, and 43.8% were seen by an ST4 or above. This failed to meet the RCEM standard of 100% seen by an ST4 or above.

Of all patients making an unscheduled return to the ED in 2016/17 with the same condition within 72 hours of discharge, 34.5% were seen by a consultant, which was in the upper quartile when compared to other hospitals, and 79.3% were seen by an ST4 or above. This failed to meet the RCEM standard of 100%.
(Source: Royal College of Emergency Medicine)

Medical staffing levels in the paediatric unit were on the directorate risk register and recruitment
efforts were underway at the time of the inspection.

**Unplanned re-attendance rate within 7 days**

**Ormskirk and District General Hospital**

From October 2016 to September 2017, the unplanned re-attendance rate for the paediatric A&E department at Ormskirk and District General Hospital within seven days was consistently better than the national standard of 5% with an overall average of 2.5%.

In the latest month, September 2017, performance within the paediatric A&E department was 2.7%.

*Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable paediatric A&E departments nationally.*

**Unplanned re-attendance rate within 7 days – October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital**

(Source: Trust data)

**Competent staff**

All staff in the paediatric emergency department were qualified to carry out their roles effectively. All registered nurses were qualified in child health nursing, trained in paediatric life support, caring for the critically ill child and in level three child safeguarding. All nursing staff, including health care assistants, rotated through the paediatric unit including the ward, assessment bay and emergency department to develop their knowledge base and skills. Healthcare assistants went on a three day paediatric course and received training in venepuncture, applying plaster splints and observations.

Staff were positive about their experience of rotating through the paediatric departments and the support received from peers and senior staff. For example, in triage each nurse completed the competencies and were observed completing the triage assessment for a number of patients before being signed off. We were told about the induction process and how trained nurses were supernumerary for the first two weeks while shadowing a nurse. A practice development nurse was in post to support learning and development in the paediatric department but had been on long-term sick leave. All trained nurses undertook training for mentorship and there were nursing leads for bereavement, safeguarding and wound care.

Managers appraised staff's work performance and supported professional development. Staff confirmed they received one to one meetings from their line manager and all staff we spoke to
had received an appraisal in the previous 12 months. They gave examples of how their personal development plan had led to developing their skills. One healthcare assistant told us that she had been in the department for two years and had expressed interest in paediatric diabetes. She was seconded to the paediatric diabetes team for experience and transferred her skills to the emergency department.

Leadership training was encouraged for the band six sisters, one of whom had completed the NHS leadership programme for frontline staff. Each sister had their own team of nursing staff for whom they did an appraisal, provided management support and monitored performance. They were currently working on each band six sister conducting a peer review of another band sixes team in the department to support improvement.

**Appraisal rates**

**Ormskirk and District General Hospital**

Ormskirk and District General Hospital had an 87.5% appraisal completion rate for staff in Urgent and Emergency Care.. A split by staff group can be seen in the graph below. However, please note that this analysis is based on a small number of staff.

![Appraisal completion graph](image-url)

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff worked collaboratively to understand and meet the complex needs of children in areas such as learning and physical disabilities, mental health and safeguarding. Staff on the paediatric unit including the emergency department, assessment bay and ward worked closely together and gained experience working in each area. Allied health professionals such as physiotherapy and dietetics were included in the safety huddles and worked with staff and patients across the unit. Specialist nurses provided support in areas such as paediatric diabetes and learning disabilities.

Urgent care medical staff were supported by the paediatric medical consultants to cover the emergency department from midnight to 8am and for referrals to the ward. The urgent care medical team at Southport and Formby District General Hospital (most of whom were dual qualified for adult and paediatric urgent care) supported the paediatric urgent care team with rota cover and during episodes of high activity. Orthopaedic consultants from the Southport site worked with the team to manage orthopaedic injuries.
Staff of different professions worked together as a team to benefit patients. Staff worked with local authority child protection professionals, children and young people mental health professionals, school nurses, health visitors and social workers. They also worked in liaison with the two regional children’s hospitals when transferring children for specialist or intensive care.

Seven-day services

Key services were available seven days a week. Consultant cover was available 24 hours a day, seven days a week, and supported by registrars and an advanced nurse practitioner. Pharmacy was open 9am to 5pm Monday to Friday and access to medications out-of-hours was from emergency pharmacy stock held in the department if required. Radiology was available seven days a week from 8:30am to midnight and on-call radiographers came from the Southport site between midnight and 8:30pm. Computed tomography (CT) scanning and magnetic resonance imaging (MRI) could also be accessed seven days a week. Pathology laboratories were open 9am to 5pm and specimens sent by taxi to the Southport site out-of-hours.

Liaison mental health services were available to access 24 hours a day, seven days a week from one of the two child and adolescent mental health services (CAMHS) serving the local population. The trust was working with the second CAMHS service to enable equitable access out-of-hours to all children and young people with mental health care needs attending the emergency department. For these children, staff could ‘spot’ purchase services out-of-hours.

Health promotion

The service worked with children and parents to increase awareness of respiratory inhaler management, diet and weight management and diabetes care. Staff provided patients with supporting information and referral contacts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke to understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff obtained consent to care and treatment was in line with legislation and guidance. Staff received consent training as part of their annual paediatric training days and were aware of ‘Gillick competency’ and legal requirements when obtaining informed consent from a child or young person. Where a child was not Gillick competent or unconscious, staff made decisions through discussions with the parents or in the best interests of the child where this was not possible. Procedures were in place to document these decisions. Staff were trained to manage conflict resolution and knew how to support patients experiencing mental ill health. One consultant trained in solution focused therapy to support children who experienced emotional difficulties following an injury such as persistently refusing to attend school. The consultant told us how this had been used successfully.

Mental Capacity Act and Deprivation of Liberty training completion

The trust reported that, from July 2016 to June 2017, Mental Capacity Act (MCA) level 1 training had been completed by 50.3% of all staff within Urgent and Emergency Care:

- Southport and Formby District General Hospital: 51.9%
- Ormskirk and District General Hospital: 22.2%

The trust has not provided any target for the completion of this training.

(Source: Routine Provider Information Request (RPIR) P14/P49)
Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

**Is the service caring?**

**Compassionate care**

Parents we spoke to were happy with the service and told us they felt that staff were consistently caring and kind. Staff treated children, young people and parents with compassion. Feedback from children and parents to us confirmed that staff treated them well. Parents we spoke to were happy with the service and three told us that they preferred this emergency department to others for their children. Several parents had brought their other children to the department on previous occasions and felt that the staff were consistently caring and kind. Staff were described as “courteous, efficient and helpful”. One parent described the staff as “lovely, friendly and very helpful from the start”.

We saw parents and children being engaged by nursing and medical staff using humour and a calm manner as they examined the child. Staff maintained privacy and dignity for families by keeping curtains drawn while children received treatment or were being examined in the department. We saw the receptionist communicate with new arrivals in a friendly but quiet manner to maintain privacy while the child was being registered.

**Friends and Family test performance**

The Friends and Family Test performance (% recommended) for the paediatric A&E department at Ormskirk and District General Hospital fluctuated from October 2016 to October 2017. In the most recent month, October 2017, 85.4% of patients would recommend the unit.

*Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable paediatric A&E departments nationally.*

A&E Friends and Family Test Performance – October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital

Low response rates are common for A&E friends and family tests; however, the average response rate during the same period of 2.8% was worse than the England average of 12.6% for emergency departments. *(Source: Trust data)*
Emotional support

Staff provided emotional support to children and parents to reduce their stress. We saw nursing and medical staff providing reassurance to concerned parents and to children. Staff could assign a play therapist to work with a child and provide them with emotional support during their visit. Senior staff told us they were experienced in breaking bad news and supporting parents to manage their stress during a visit to the emergency department. The multi-faith chaplaincy was available to provide pastoral and spiritual support to parents and family members. There was a bereavement link nurse on the unit who supported staff and families in the event of a child death and the chaplaincy conducted an annual remembrance service for parents experiencing baby or child loss.

Understanding and involvement of patients and those close to them

Parents told us they felt well-informed by staff and that they could ask questions at any point during the visit to the department. We saw staff involve parents and children where possible in decisions about their care. We saw staff members talking with parents and, where possible, the child to ensure they understood what was planned and the outcome of the medical assessment. If children and parents needed continued support after discharge, the emergency department could refer them to the community children’s outreach team who provided training and support for carers or family members involved in the child’s care. Staff provided parents with information about care, medications and who to call if they were concerned following discharge. Parents we spoke to felt they were well-informed by staff and that they could ask questions at any point during the visit to the department.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of the local people. For example, there was adequate seating and space for parents and children including a large playroom adjoining the waiting area. Parents could be seated at reception and during the triage assessment. There were toilet facilities for physically disabled patients.

There was a relatives’ room furnished with comfortable seating and suitably decorated. Staff could direct parents or families to the room for privacy if distressed or to conduct a difficult conversation.

Since the last inspection, the trust had constructed a room in the department specifically designed for young patients with mental health needs. CAMHS facilitated the input of children and young people to the final decisions about fittings in the room including access to lower lighting and charging points for mobile phones.

As noted in the previous inspection report, the two local clinical commissioning groups commissioned some services differently. There were differing access arrangements for epilepsy specialist nursing and children and young people mental health services, which could be challenging for staff. The position remained the same at the time of this inspection. The trust and paediatric department recognised both these gaps as risks and the trust continued to work with commissioners to resolve these issues.

Meeting people’s individual needs

The service supported patients’ individual care needs by using play therapists and ‘distraction’ boxes. In radiology, there were ‘distraction’ boxes for children that contained small toys and staff encouraged play while they prepared patients for an x-ray. Radiographers provided children with
award stickers at the end of each procedure. Play therapists worked on the pediatric ward but were available to distract and play with children in the emergency room to reduce stress for children and parents when needed.

Staff managed a consistent approach to frequent attenders with complex conditions by maintaining copies of their care plans for reference in the department. This ensured that the child’s treatment was person-centred and aligned with the care plan agreed by specialist consultants and GPs. In addition, the pediatric emergency department staff took part in a regular meeting to discuss frequent attenders with representatives of safeguarding, independent domestic violence advocacy, mental health services and a children and young people community support charity. Staff discussed care plans and possible interventions to sustain the child’s well-being.

The trust learning disability lead nurse provided support to staff in managing the needs of patients with learning disabilities if required. The pediatric diabetes clinic was adjoining the emergency department and specialist advice was available if required. Staff could access face to face or telephone translation services for patients.

Access and flow

The pediatric emergency department performed well against the national urgent care standards.

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The pediatric A&E department at Ormskirk and District General Hospital consistently met this standard from October 2016 to September 2017.

In the most recent month, September 2017, 99.2% of patients were admitted, transferred or discharged within four hours.

*Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable pediatric A&E departments nationally.*

Four hour target performance – October 2016 to September 2017, Pediatric A&E department at Ormskirk and District General Hospital

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<th>Ormskirk pediatric A&amp;E department</th>
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<tbody>
<tr>
<td>Oct-16</td>
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</tr>
<tr>
<td>Nov-16</td>
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<tr>
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</tr>
<tr>
<td>Sep-17</td>
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<td>99%</td>
</tr>
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</table>

*Admitted, transferred or discharged*
(Sources: Trust data)

Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted

From October 2016 to September 2017, two patients waited between four and 12 hours from the decision to admit until being admitted within the paediatric A&E department at Ormskirk and District General Hospital, March and August 2017.

(Source: Trust data)

Number of patients waiting more than 12 hours from the decision to admit until being admitted

Over the 12 months from October 2016 to September 2017, one patient waited more than 12 hours from the decision to admit until being admitted within the paediatric A&E department at Ormskirk and District General Hospital, in May 2017.

(Source: Trust data)

Percentage of patients that left the Paediatric A&E at Ormskirk and District General Hospital before being seen for treatment

From October 2016 to September 2017 the monthly percentage of patients leaving the paediatric A&E department at Ormskirk and District General Hospital before being seen for treatment fluctuated with an overall average of 1.2%.

Performance against this metric peaked in the most recent month, September 2017, when the percentage of patients leaving the paediatric A&E department at Ormskirk and District General Hospital before being seen for treatment was 2.3%.

Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable paediatric A&E departments nationally.

Percentage of patient that left the Paediatric A&E at Ormskirk and District General Hospital without being seen – October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital

(Source: Trust data)

Median total time in paediatric A&E per patient
From October 2016 to August 2017 the paediatric A&E department at Ormskirk and District General Hospital’s monthly median total time in A&E for all patients was between 80 and 105 minutes.

The longest median time was seen in the most recent month, September 2017, when the department’s monthly median total time in paediatric A&E was 105 minutes.

*Please note that this analysis has not been benchmarked against the England average as we do not hold data for comparable paediatric A&E departments nationally.*

**Median total time in A&E per patient – October 2016 to September 2017, Paediatric A&E department at Ormskirk and District General Hospital**

![Graph showing median total time in A&E per patient from October 2016 to September 2017.](image)

(Source: Trust data)

**Learning from complaints and concerns**

**Summary of complaints**

The service took concerns and complaints seriously, investigated them and learned lessons from the results which were shared with staff. Staff were aware of the complaints policy and there was information available in the department for patients and parents about how to submit a complaint. The lead consultant told us that she invited complainants to discuss the complaint in the first instance, to identify and resolve issues in a timely manner. The formal complaint rate was low in the paediatric emergency department and staff told us they referred parents to the trust complaints procedure or the patient advice and liaison service if they were unable to resolve concerns at the time they were raised.

One example of action following complaints about the safeguarding referral process was the production of a patient and carer information leaflet – Attendance at Hospital for a Child with an Unexplained or Concerning Injury. Staff developed this to improve parents’ understanding of the triggers for safeguarding referrals.

From July 2016 to June 2017 there were 94 complaints about the trust-wide Urgent and Emergency Care services. The trust took an average of 80.8 days (58.8 working days) to investigate and close complaints.

Six of the 76 closed complaints (7.9%) about Urgent and Emergency Care services were closed in over 180 days while three of the 18 complaints that remained open at the time of response were received in 2016 and therefore had been open more than six months. This does not meet
the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The most common subjects of the complaints were all aspects of clinical treatment (55); and the attitude of staff (17).

The breakdown of complaints by site was:

- Ormskirk and District General Hospital: There were 15 complaints, the highest number of complaints (eight) were about all aspects of clinical treatment.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

Is the service well-led?

Leadership

Leaders had the experience and capability to understand the challenges to and priorities for sustaining the paediatric emergency service. All levels of management were visible and approachable. The specialist services directorate managed the paediatric emergency department within paediatric services. The lead paediatric emergency care consultant, matron and assistant matron for paediatrics supported the paediatric unit manager and the emergency department staff. All the senior nursing and medical leads were experienced and had worked in the department for a number of years. They were well-known by staff and described as approachable and supportive.

The paediatric emergency care lead consultant and nursing leads were clear about the challenges and risks to the sustainability of the emergency department and the quality of care and we saw these issues were discussed at the paediatric department meetings. Staff were familiar with the chief executive and told us she had visited the department. Her most recent visit was the week prior to the inspection to be shown the new room constructed for children with mental health needs.

Vision and strategy

There was no individual strategy in place for the paediatric emergency department. Staff we spoke to were aware of the trust values known as ‘SCOPE’: supportive, caring, open and honest, professional and efficient, but unaware of future plans for the department other than the increase in use of advanced nurse practitioners to support the medical staff. Managers told us that future plans for the paediatric department included incorporating the community children’s outreach service to enable a smooth transition for children between emergency, inpatient and community services. The leadership team were also involved in promoting equality of access to epilepsy specialist nursing and mental health services for the children and young people served by the emergency department.

Culture

The leadership encouraged staff empowerment to drive improvement and all staff we spoke to had received an appraisal in the twelve months prior to inspection. All levels of management promoted a positive culture that supported and valued staff. Staff told us they enjoyed working in the emergency department and felt well-supported by their colleagues and line managers. All the staff we spoke to had a positive attitude about working on the unit and the experience they were gaining. We saw good working relationships between all grades of nursing, medical and ancillary staff on the unit. Staff told us that professional development within the paediatric unit was encouraged through the rotation programme but we were not aware of nursing staff attending external courses apart from the trainee advanced nurse practitioners.
Staff were aware of the duty of candour and able to describe what this meant. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers. There was a culture of openness, transparency and honesty led by the senior nursing and medical staff and we saw that performance inconsistent with the expected standard was dealt with appropriately and swiftly.

**Governance**

Governance structures, processes and systems of accountability were clearly set out in the paediatric unit and the specialist services directorate. The paediatric unit held monthly ‘harm’ meetings chaired by the assistant matron and attended by a range of staff including the lead paediatric emergency care consultant. The agenda followed a standard template and covered a review of the risk register, complaints, all types of incidents including serious incidents, alerts and concerns to escalate to the paediatric department meeting and/or the specialist services clinical governance meeting. This meeting alternated every two weeks with a meeting to review all the electronic incident reports which was minuted directly onto the system.

The harm meeting reported to the monthly paediatric department meeting, which was attended by paediatrician consultants and a representative from the emergency department, neonatal unit, paediatric ward, children’s community outreach team, safeguarding, risk and governance. This group also reviewed the paediatric risk register, approved policies and reviewed clinical audit outcomes, NICE guideline compliance, patient experience feedback, serious incident reports and safeguarding issues. This group also oversaw the introduction of the paediatric sepsis pathway and the standardisation of observations to the emergency department.

A paediatric mortality review panel had recently completed a mortality review of child deaths over a period of the previous three years to confirm the lessons identified and that these had been implemented. The action plan helped focus the unit audit programme to drive improvement in standards of documentation and elements of practice such as the standardisation of observations.

**Management of risk, issues and performance**

There were effective processes in place to identify, monitor and address current and future risks. We saw the electronic paediatric risk register and discussed the key risks with the management team. These included medical staffing for the paediatric unit overall, the lack of dedicated clinical bed management support on the Ormskirk site and the limited CAMHS cover offered by one of the providers serving the area. We were told that construction of the new room in the emergency department for children with mental health needs mitigated the risk in part when having to wait until the following day for a CAMHS assessment. Bed management duties were being provided by paediatric staff in the interim until sufficient staff across the Ormskirk site had gained the skills required to carry out bed management duties. Band 6 nurses in the paediatric unit including the emergency department had voiced concerns about this arrangement and the unit manager was providing them with support including an interactive session to discuss the concerns. The trust had engaged a head of patient flow to review patient flow and bed management systems across both sites. The department continued to advertise for medical staff but was also developing a cohort of advanced nurse practitioners to support the unit.

In a staffing emergency, staff could be transferred from the special care baby unit to assist. In the event of a major incident, paediatric patients would be taken to Southport and Formby District General Hospital emergency department and paediatric staff from Ormskirk and District General Hospital would attend to assist.

The service had effective systems for monitoring and managing performance. Directorate management reviewed quality, safety and operational performance indicators at the monthly...
directorate governance meeting. The average percentage of patients admitted, transferred or discharged within four hours, October 2016 to September 2017, was 99.5%. The November 2017 paediatric department meeting noted that recent increased activity was having an impact on performance, with a reduction to 95% but still achieving the standard. A clinical audit meeting was held every three months to review the paediatric clinical audit programme and outcomes in more detail. Key outcomes were reported in the monthly directorate quality and safety report. The department did not display performance data for the public to see.

Information management

The service and directorate used information well to support its activities and decision-making. Managers submitted detailed reporting to the directorate quality and safety report that covered the full range of clinical governance, clinical effectiveness and patient experience topics. Monthly safety performance data for the paediatric unit was displayed for staff to view. The paediatric department meeting monitored clinical audit outcomes and these informed their action plans to introduce improvements such as ensuring a blood sugar was checked for all children suspected of or having a fit.

Alerts were placed on the patient administration system for vulnerable children such as those on a protection plan or with learning disabilities. The alerts improved communication of needs and consistency of care. The emergency department had plans to be linked with the national Child Protection Information System (CPiS), which provides a connection between hospitals, social care and urgent care. If a patient comes to the department and is on a child protection plan or is a looked after child from an area where the CPiS system has also been implemented, social care will immediately know they have attended but not why. Management were also considering the use of an electronic mobile clinical system that monitors and analyses patients' observations to identify deteriorating conditions.

Engagement

The service engaged well with staff to plan and manage services. The unit manager was leading a review of the role of the band 6 sister and involving the band 6’s in this process. The sisters’ meeting minutes demonstrated that staff felt able to contribute to decision-making on the unit; however, the meetings were intermittent. The meeting prior to November 2017 was in May 2017. The unit manager told us that various staff in the department had won the trust ‘Pride’ awards and that there were regular staff social events.

There was evidence of a proactive approach to responding to negative feedback from patients and parents. Actions in response to feedback included training to improve communication skills with children to ensure they understood what was being said and felt more involved in the decisions about their care.

Managers told us that the service proactively engaged with external stakeholders such as the clinical commissioning groups, safeguarding boards, regional children’s hospitals, the paediatric emergency transport service, local authorities, mental health services and social services,

Learning, continuous improvement and innovation

There was a focus on continuous learning and improvement. Management led annual training days for all staff in paediatric emergency nursing and staff reported that these were useful for developing their knowledge base. The paediatric department conducted a mortality review in 2017 for child deaths that had occurred in all areas of the service including those who had attended the emergency department. This was a proactive review of each death to identify any themes for improvement. The initiative to standardise the approach to taking observations was supported by this review and was being implemented at the time of the inspection.
At each sisters’ meeting, they discussed topics around service improvement. They contributed to finding solutions to improve communication across the unit and drive the focus of the education programme. Each sister led a team of staff and was responsible for monitoring, managing and reporting the quality of care provided by their team.

The team were working with the child and adolescent mental health service providers to ensure equitable access to mental health services across the geographical areas served by the trust.

**Surgery**

**Facts and data about this service**

The hospital has the following surgical wards and departments:

**Ormskirk and District General Hospital**

- Ward G – Urology (19 inpatient beds)
- Ward H – Orthopaedics (12 inpatient beds)
- Ward F – Ophthalmology (five inpatient beds)

*(Source: Routine Provider Information Return (RPIR) – “Sites-Acute” tab)*

The trust had 17,095 surgical admissions from July 2016 to June 2017. Emergency admissions accounted for 3,657 (21.4 %), 11,010 (64.4%) were day cases, and the remaining 2,428 (14.2 %) were elective.

*(Source: Hospital Episode Statistics)*

**Is the service safe?**

**Mandatory training.**

Approximately one third of staff members had not completed mandatory training. Dashboards used to monitor performance were not up to date and therefore did not reflect current completion rates. However, mandatory training completion levels had improved since the last inspection.

**Mandatory training completion rates**

The trust has not provided any targets for the completion of mandatory training.

**Ormskirk and District General Hospital**

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Surgery at Ormskirk and District General Hospital is shown below:
### Name of course

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 and 5 (Prevent Awareness) - 3 Years</td>
<td>38</td>
<td>51</td>
<td>74.5%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>36</td>
<td>51</td>
<td>70.6%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>36</td>
<td>51</td>
<td>70.6%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>35</td>
<td>51</td>
<td>68.6%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>35</td>
<td>51</td>
<td>68.6%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>34</td>
<td>51</td>
<td>66.7%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>32</td>
<td>51</td>
<td>62.7%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>32</td>
<td>51</td>
<td>62.7%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>30</td>
<td>51</td>
<td>58.8%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>27</td>
<td>51</td>
<td>52.9%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>24</td>
<td>51</td>
<td>47.1%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>7</td>
<td>90</td>
<td>7.8%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at Ormskirk and District General Hospital was 56.1% from July 2016 to June 2017.

Only seven of the 90 eligible staff (7.8%) completed the resuscitation module over this time period. This module was completed by 11.0% and 5.7% of medical staff in 2015/16 and 2016/17, respectively.

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for nursing staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>24</td>
<td>27</td>
<td>88.9%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>24</td>
<td>27</td>
<td>88.9%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>22</td>
<td>27</td>
<td>81.5%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 and 5 (Prevent Awareness) - 3 Years</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>21</td>
<td>27</td>
<td>77.8%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>18</td>
<td>27</td>
<td>66.7%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>18</td>
<td>27</td>
<td>66.7%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>16</td>
<td>27</td>
<td>59.3%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>2</td>
<td>42</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

The overall completion rate for nursing staff at Ormskirk and District General Hospital was 68.2%
from July 2016 to June 2017. Only two of the 42 eligible staff (4.8%) completed the resuscitation module over this time period. This module was completed by 15.4% and 1.5% of medical staff in 2015/16 and 2016/17, respectively.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

The trust provided mandatory training annually face-to-face learning and via e-learning. Mandatory training completion rates were low on some wards and further training dates had been arranged by the trust to address this.

Staff told us that the performance dashboards did not reflect the correct ward information in relation to training compliance following recent ward moves. Data from October 2017 showed that 100% of staff on ward H had completed mandatory training. However, ward G had no data recorded between August - October 2017. Senior managers were aware of the issue and stated this had been addressed.

Information provided by the trust at the time of inspection showed an improving compliance rate.

Senior managers told us the trust were providing human factors training, commencing in December 2017.

Acute Illness Management Course (AIMS) was also provided by the trust and this included sepsis 6 training. The trust had a policy for sepsis that staff were aware of.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. This has significantly improved since the last inspection.

Safeguarding training completion rates

The trust did not provide a target for the completion of safeguarding training or any data for the number of medical/dental or nursing staff within surgery who were trained on the safeguarding adults and children level one modules.

Ormskirk and District General Hospital

Ormskirk and District General Hospital had an overall safeguarding training completion rate for all medical/dental and nursing staff in Surgery of 92.9%.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental and nursing/midwifery staff in Surgery at Ormskirk and District General Hospital is shown below:
Staff knew where to access the safeguarding policy and told us how they raised an alert.

On inspection trust staff provided data that showed training figures above the trust’s target of 90%.

The trust had policies that included information about rapid tranquilisation.

Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one: 93.9%
- Safeguarding adults level two: 92.8%
- Safeguarding adults level three: 94.2%
- Safeguarding children level one: 94.7%
- Safeguarding children level two: 90.9%
However, this information was not broken down into the core services we inspected.

**Cleanliness, infection control and hygiene**

All areas we inspected appeared visibly clean and tidy. Wards displayed environmental audit results which were visible to staff, patients and visitors.

Equipment was routinely maintained and serviced. Some displayed green ‘I am clean’ stickers, however, this was not consistent.

Ward curtains were disposable and had due dates of change visible. All of those inspected were in date and visibly clean.

Personal protective equipment (PPE) including gloves and aprons were available in all areas. Hand sanitiser gels were present at entrances and throughout the wards, and we observed staff using them. Hand hygiene audits completed showed that 98% staff were compliant.

Sinks in ward areas had hand hygiene posters visible and had wall mounted soap dispensers, hand towels and hand sanitiser available. Staff followed ‘arms bare below the elbows’ guidance and we observed them following hand washing guidance. Waste bins had foot pedals and bags were readily available. Waste was segregated and disposed of appropriately.

Sharps bins were available in all areas and the trust had a system in place to ensure weekly changes.

The infection prevention and control team monitored infection rates and produced monthly reports. The data showed that between August 2017 and October 2017 there was no incidence of Clostridium difficile (C. diff) or Methicillin resistant staphylococcus aureus (MRSA) for surgery at Ormskirk.

The service completed monthly hand hygiene audits. There was an average compliance of 98% for surgical wards and theatres for the three months prior to inspection.

Weekly checks of commode cleanliness were carried out and data for September 2017 showed weekly checks were completed and passed each time.

Records were provided by the trust to demonstrate that tests were carried out to identify any legionella in the water systems in theatres in accordance with recognised standards.

We requested information about infections. The trust told us that the orthopaedic specialist nurse reported yearly to the clinical business unit all infected joint replacements whether originally operated at this trust or other trusts. An in depth report was provided by the orthopaedic specialist nurse and also reported to the surgical site surveillance. The orthopaedic specialist
nurse also presented twice a year to the orthopaedic audit team how the trust was performing with end of year statistics and comparison to previous years. The nurse also reported all post-operative fractured neck of femurs to the clinical business unit and to the end of year orthopaedic audit. From 2016 to 2017 the post-operative fractured neck of femur infection rates had increased from 1.38% to 2.04%. Total hip replacement infection rates had improved from 0.54% to 1.4% to 0.54%. Total knee replacements had increased from 0.4% to 1.03%. There had been a further 18 joint replacements treated in the trust with deep infection where surgery took place in this trust over 12 months ago.

Environment and equipment.

All wards and theatres were accessible via swipe card or by staff responding to a door buzzer. People leaving wards pressed a green exit button.

All rooms that stored medication or intravenous fluids were locked with keypad entrances, except one on ward H.

We found dirty utility room doors left open and unlocked. We noted toilet cleaner and hand sanitiser accessible on the sinks.

Oxygen cylinders were stored on corridors in designated carriers.

Resuscitation trolleys had checks daily with a tamper-proof label attached. The trolleys were checked fully on a weekly basis. However, we found a number of out-of-date or damaged items on each ward. The theatre resuscitation trolleys had all been checked appropriately.

Monitoring equipment was well maintained with stickers indicating that checks had been carried out within the last 12 months. However, we noted two pieces of equipment that needed calibrating on ward H. We highlighted this to ward staff and they took immediate action.

Theatre equipment was noted as requiring upgrading during the last inspection. We spoke to senior staff regarding this as the equipment had been included on the divisional risk register, which noted that new equipment was on order. Senior staff reported that the equipment functioned well, was well maintained and with no reported incidents.

One ward had a fire door propped open on three consecutive days. Staff rectified this when highlighted by inspection staff.

Assessing and responding to patient risk

Staff completed risk assessment for patients on admission including venous thrombo embolism (VTE), Falls, Malnutrition Universal Screening Tool (MUST) and Waterlow.

The trust completed an audit of completion of VTE assessments in July 2017. This noted that assessments were being completed on admission. However, they were not repeated 24 hours later in line with National Institute of Clinical Excellence guidance. Records we reviewed
confirmed this.

Staff documented patient allergies in nursing records and on prescription documentation. Coloured wristbands identified patients with allergies or assessed as at risk of falls.

Patients vital signs were recorded by staff via an electronic system and these could be monitored at the nurses’ station. Early warning scores were also recorded and the system noted when the next review was due and what score each patient had.

Patients attended preoperative assessment clinic prior to surgery. Any patient identified as American Society of Anaesthesiologists (ASA) level three (high risk) were admitted for surgery at Southport rather than Ormskirk.

We observed the World Health Organisation five steps to safer surgery checklist process and found it was completed well.

Sepsis trolleys were present on wards that included equipment to manage acute infections. We were told that sepsis 6 training was part of the Acute Illness Management Course (AIMS).

The trust has a monthly programme for auditing the use of the WHO checklist in surgery and the results were reported to the planned care governance committee. The audit was based on the WHO checklist and compliance levels with all areas were high. There had also been an audit of the compliance with the trust’s theatre pathway.

**Nurse staffing**

Nursing staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for nursing staff working in Surgery for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>153.0</td>
<td>135.3</td>
</tr>
<tr>
<td>May 2017</td>
<td>157.8</td>
<td>135.8</td>
</tr>
<tr>
<td>April 2017</td>
<td>157.8</td>
<td>135.4</td>
</tr>
<tr>
<td>March 2017</td>
<td>167.6</td>
<td>135.9</td>
</tr>
<tr>
<td>February 2017</td>
<td>167.6</td>
<td>134.5</td>
</tr>
<tr>
<td>January 2017</td>
<td>167.6</td>
<td>137.8</td>
</tr>
<tr>
<td>December 2016</td>
<td>169.6</td>
<td>141.1</td>
</tr>
<tr>
<td>November 2016</td>
<td>179.0</td>
<td>151.9</td>
</tr>
<tr>
<td>October 2016</td>
<td>178.7</td>
<td>149.9</td>
</tr>
<tr>
<td>September 2016</td>
<td>178.7</td>
<td>155.1</td>
</tr>
<tr>
<td>August 2016</td>
<td>178.7</td>
<td>151.2</td>
</tr>
<tr>
<td>July 2016</td>
<td>178.7</td>
<td>154.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual)
Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for nursing staff in surgery of 13.3%. As at June 2017, the vacancy rate was 9.9%.

Ormskirk and District General Hospital

Ormskirk and District General Hospital reported an overall vacancy rate in surgery of 17.3% from July 2016 to June 2017, with rates consistently over 12%. The highest rates were reported in August and September 2016 (18.3%).

In the most recent month, June 2017, Ormskirk and District General Hospital reported a vacancy rate of 16.9%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2016 to June 2017, the trust reported a turnover rate for nursing staff in Surgery of 15.1%:

- Southport and Formby District General Hospital: 14.2%
- Ormskirk and District General Hospital: 17.5%

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2016 to June 2017, the trust reported a sickness rate of 8.0% for nursing staff in Surgery:

- Southport and Formby District General Hospital: 8.8%
- Ormskirk and District General Hospital: 5.2%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

We routinely request this information within a universal provider information request. We are aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported bank usage for registered nurses in surgery of 1,312 shifts and agency usage of 650 shifts. There were 658 shifts that were unfilled by bank and agency staff.

Ormskirk and District General Hospital

There were 192 shifts within surgery at Ormskirk and District General Hospital that were filled by bank staff from April 2016 to March 2017. One hundred and seventeen of these shifts were in the
elective orthopaedic surgery ward (Ward G).
Ninety-two shifts were filled by agency staff, 80 of which were in the elective orthopaedic surgery ward (Ward G).
The hospital had 119 shifts unfilled over this time period. Ninety-five of these were in the Elective Orthopaedic Surgery Ward (Ward G).

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Whilst there were high vacancy and turnover rates, during our inspection the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

The trust used an acuity tool to match the number of staff to the needs of patients. Numbers of registered nurses and health care assistants were displayed on boards when entering wards for staff, patients and visitors to view.

The trust had implemented an electronic ‘safe staffing’ system. This enabled senior staff to review staffing three times a day.

Nurse staffing was managed at site level and also both hospitals, when required, to ensure safe numbers of staff.

Bank staff, many of who were trust employees, supplemented gaps in rotas.

Senior managers told us there were approximately 13 vacancies across the division and this had been stable on the wards. The trust held recruitment events for nurses and included interview and recruitment on the day.

Gaps in rotas were being supplemented by bank staff, although many of these were nurses formerly employed by the trust. Regular staff were offered overtime, although many nurses worked long – day shift patterns.

Medical staffing

Medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported the following planned and actual whole time equivalent (WTE) staffing figures for medical and dental staff working in surgery for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>131.5</td>
<td>106.9</td>
</tr>
<tr>
<td>May 2017</td>
<td>131.5</td>
<td>104.9</td>
</tr>
<tr>
<td>April 2017</td>
<td>131.5</td>
<td>105.0</td>
</tr>
<tr>
<td>Month</td>
<td>Planned</td>
<td>Actual</td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>March 2017</td>
<td>131.5</td>
<td>110.0</td>
</tr>
<tr>
<td>February 2017</td>
<td>131.5</td>
<td>110.8</td>
</tr>
<tr>
<td>January 2017</td>
<td>131.5</td>
<td>112.7</td>
</tr>
<tr>
<td>December 2016</td>
<td>131.5</td>
<td>111.7</td>
</tr>
<tr>
<td>November 2016</td>
<td>134.5</td>
<td>114.7</td>
</tr>
<tr>
<td>October 2016</td>
<td>134.5</td>
<td>114.7</td>
</tr>
<tr>
<td>September 2016</td>
<td>134.5</td>
<td>115.7</td>
</tr>
<tr>
<td>August 2016</td>
<td>134.5</td>
<td>122.4</td>
</tr>
<tr>
<td>July 2016</td>
<td>134.5</td>
<td>113.9</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for medical and dental staff in Surgery of 17.4%. As at June 2017, the vacancy rate was 18.5%.

Ormskirk and District General Hospital

Ormskirk and District General Hospital reported an overall vacancy rate for medical and dental staff in Surgery of 16.6% from July 2016 to June 2017, with rates consistently over 13%. The highest rates were reported in April and May 2017 (18.6%).

In the most recent month, June 2017, Ormskirk and District General Hospital reported a vacancy rate of 15.8%.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2016 to June 2017, the trust reported a turnover rate for medical and dental staff in Surgery of 17.3%:

- Southport and Formby District General Hospital: 32.3%
- Ormskirk and District General Hospital: 6.0%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2016 to June 2017, the trust reported a sickness rate for medical and dental staff in Surgery of 0.3%:

- Southport and Formby District General Hospital: 0.2%
- Ormskirk and District General Hospital: 0.5%

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and locum staff usage
This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

**Staffing skill mix**

As of June 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at Southport and Ormskirk Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>48%</td>
</tr>
<tr>
<td>Middle career</td>
<td>41%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>5%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior</td>
<td>14%</td>
<td>11%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

Senior managers told us that there were consultant vacancies for a chronic pain specialist and dermatologists. The trust had appointed 10 physician’s assistants that included allocations to general and orthopaedic surgery. There were plans to develop a medical bank. At the time of our inspection there were two locum staff (FY2 level) in post.

**Records**

Staff kept records of patients’ care and treatment. However, they were difficult to navigate and not stored securely. Staff completed notes, dated and signed them. However, they did not consistently include time, printed name or designation.

There were whiteboards on each ward that included initials or names of patients on the wards. Staff told us that patients had to complete a consent form to enable them to display their name. We observed these forms in patients’ records.

Nurses recorded care and treatment in paper records and also bedside such as fluid charts and two hourly intentional rounding. Eight out of twelve records we reviewed did not have staff names printed or designations noted.

Patients’ vital signs were recorded via an electronic system. Patients medical care records were stored in trolleys with locks; However, they were not locked during the inspection. This included the records trolley in pre-operative clinic in the outpatients department.
Medicines

The wards had medicine trolleys which were kept secure. However, one ward out of three had an unlocked and unattended medicine trolley, which was accessible by anyone on the ward.

Medicines were stored in trolleys that were locked and secured to walls when not in use, except one on ward H. Staff rectified this when we highlighted this to them.

Pharmacists provided support on the wards and pharmacy technicians reviewed stock levels of medicines.

We reviewed storage and records of controlled drugs and these had been checked daily. Stock levels were correct.

Staff recorded fridge and room temperatures daily, all of which were within ranges.

The division completed a monthly antibiotic prescribing audit which reported that patient’s allergy status was recorded in 98% of records. Prescriber details documentation However, showed an average compliance of 67%. All records we reviewed had allergy status recorded.

Incidents

Staff understood their responsibility to report incidents and how to access the policy. Staff told us that they received feedback regarding incidents and lessons learned posters were displayed at the time of our inspection.

Never Events

During the inspection period, the trust reported a never event that was classified as wrong-site surgery. The incident occurred in July 2017 but was not initially identified as a never event.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2016 to August 2017, the trust reported no incidents classified as never events for Surgery.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported nine serious incidents (Sis) in Surgery which met the reporting criteria set by NHS England from September
2016 to August 2017.

Of these, the most common type of incident reported was

- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with three (33.3% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with two (22.2% of total incidents).
- HCAI/Infection control incident meeting SI criteria with one (11.1% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (11.1% of total incidents).
- Slips/trips/falls meeting SI criteria with one (11.1% of total incidents).
- Pressure ulcer meeting SI criteria with one (11.1% of total incidents).

Site specific information can be found below:

- Ormskirk and District General Hospital: five incidents

(Source: Strategic Executive Information System (STEIS))

Staff understood their responsibility to report incidents and how to access the policy.

The trust had an electronic reporting system. Staff could describe the process for reporting incidents and felt confident in doing so. Incidents were reviewed at ward and divisional level.

Staff told us that they received feedback regarding incidents and lessons learned posters were displayed.

Staff were not clear about duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person).

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

Each ward displayed a colour-coded ‘safety cross’ each month. This included falls, pressure...
ulcers and care of any deteriorating patient. It was displayed for staff, patients and visitors to view.

Wards collected data on dashboards, about performance, although the accuracy needed to be conformed due to ward changes.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported six new pressure ulcers, eight falls with harm and five new catheter urinary tract infections from September 2016 to September 2017 for Surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Southport and Ormskirk Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>Pressure ulcers</th>
<th>Falls</th>
<th>Catheter urinary tract infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Safety thermometer – Safety Thermometer)

**Major Incident Planning**

There was a major incident plan and staff could explain the process. Staff told us that ‘prompt cards’ for individual responsibilities in a major incident could be found on the intranet.
Staff told us there had been a practice drill prior to inspection.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance. Managers checked to make sure staff followed guidance.

Staff utilised national guidelines by the National Institute for Health and Care Excellence (NICE). This included prevention of pressure ulcers and prevention of surgical site infection.

Staff could access local policies and procedures via the intranet.

Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines were utilised in theatre for checking anaesthetic equipment (2012).

Best practice was shared and reflective practice was carried out at monthly departmental meetings.

Staff handovers included any concerns and additional needs of patients, which included any onward referrals made including social services.

Nutrition and hydration

Dietetic support was available to ward staff to ensure patient needs were met.

Staff completed a malnutrition universal screening tool (MUST) to assess patient’s nutrition and hydration status via an electronic system.

Ward staff ensured water jugs were available to all patients who were not nil by mouth for theatre. We observed these being refreshed when patients had finished their jug.

Patients reported plenty of choice at each meal and that food was good.

We inspected fluid balance charts and all reviewed were up to date and fully completed.

Pain relief

Records we reviewed showed that pain relief had been prescribed pre-operatively and also that pain relief had been administered as required.

Patients had their pain scores recorded and staff asked if they required pain relief.
Patients we spoke to told us that they had their pain needs met.

**Patient outcomes**

**Relative risk of readmission**

*Please note that this analysis includes the Spinal Unit.*

**Trust level**

From June 2016 to May 2017, patients at the trust had lower than expected risks of readmission for both elective and non-elective admissions when compared to the England average.

Elective admissions

- Patients in general surgery and urology had lower than expected risks of readmission for elective admissions when compared to the England averages
- Trauma and orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average

Non-Elective admissions

- General surgery and urology patients at the trust had lower than expected risks of readmission for non-elective admissions when compared to the England averages
- Trauma and orthopaedics patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average

**Elective Admissions – Trust Level**

**Non-Elective Admissions – Trust Level**

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity*

(Source: HES – Readmissions (01/06/2016 – 31/05/2017))
**Ormskirk and District General Hospital**

From June 2016 to May 2017, all patients at Ormskirk and District General Hospital had lower expected risks of readmission for elective and non-elective admissions when compared to the England average.

**Elective admissions**

- Patients in General Surgery had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Ophthalmology patients had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Trauma and Orthopaedics patients at the trust had a higher than expected risk of readmission for elective admissions when compared to the England average.

**Non-Elective admissions**

- Trauma and Orthopaedics patients at the trust had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

**Elective Admissions – Ormskirk and District General Hospital**

![Elective Admissions Chart](image1)

**Non-Elective Admissions – Ormskirk and District General Hospital**

![Non-Elective Admissions Chart](image2)

*Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.*
Hip Fracture Audit

In the 2017 Hip Fracture Audit, which covers the period from January to December 2016, the risk-adjusted 30-day mortality rate was 8.3% which was within the expected range. The 2016 figure was 9.1%.

The proportion of patients having surgery on the day of or day after admission was 77.5%, which was worse than the national standard of 85%. The 2016 figure was 73.8%.

The perioperative medical assessment rate was 51.3%, which failed to meet the national standard of 100%. The 2016 figure was 51.5%.

The proportion of patients not developing pressure ulcers was 98.7%, which falls in the top 25% of trusts. The 2016 figure was 100%.

The length of stay was 20.9 days, which falls in the middle 50% of trusts. The 2016 figure was 19.4 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 75.8% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was higher than the national aggregate of 69%. The 2015 figure was 75.3%.

The risk-adjusted 90-day post-operative mortality rate was 0% which was within the expected range. The 2015 figure was also 0%.

The risk-adjusted 2-year post-operative mortality rate was 23.7% which was within the expected range. The 2015 figure was 18.6%.

The risk-adjusted 30-day unplanned readmission rate was 10.1% which was within the expected range. The 2015 figure was not reported.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 39.2% which was within the expected range. The 2015 figure was 48.8%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not submit any data to the 2016 National Vascular Registry (NVR) audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0%. This placed the trust within the top 25% of all trusts for this measure. The 2015 figure was 1.3%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 45.0% which was higher than the national aggregate of 37.6%. The 2015 figure was 44.9%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)
National Emergency Laparotomy Audit

Southport and Formby District General Hospital

In the 2016 National Emergency Laparotomy Audit (NELA), which covered the period from December 2014 to November 2015, Southport and Formby District General Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 102 cases.

The hospital achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 88 cases.

The hospital achieved a red rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 55 cases.

The hospital achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 34 cases.

The risk-adjusted 30-day mortality for the hospital was within expectations, based on 195 cases.

Ormskirk and District General Hospital

Ormskirk and District General Hospital did not participate in this audit.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

From April 2016 to March 2017, the trust had higher proportions of patients who reported they felt worse after a procedure than the England average for all of the four procedures.
The trust had experienced some issues with discharges due to the community services provision being relocated to another provider. This was discussed at the board meeting in October 2017. The trust liaised with their stakeholders to try to improve this issue and this was ongoing.

At the time of our inspection the trust had a decreased return rate for three of the national patient reported outcome measures. There were for varicose veins, hips and knees. These areas were being reviewed at the time of our inspection.

**Competent staff**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff reported having access to development within their roles and were given time to access courses.

All new staff attended a trust induction and had their competencies assessed before working unsupervised. Staff felt supported to develop and had no issues accessing training.

Managers told us that appraisal rates had been below the trust’s target. However, staff on the wards said they had had one within the last 12 months. Data provided by the trust showed the appraisal rate was 52%.

Staff had access to training relevant to their working environment. This included multi-disciplinary training, support and some ward based refresher sessions.

Medical staff had lunchtime learning twice weekly. However, they could only attend if workload permitted.

**Appraisal rates**

From June 2016 to June 2017, 65.6% of staff within surgery at the trust had received an appraisal compared to a trust’s target of 90%.

**Ormskirk and District General Hospital**

Ormskirk and District General Hospital had an 89.1% appraisal completion rate. A split by staff group can be seen in the graph below:
The medical and dental and the support to doctors and nursing staff groups met the trust completion rate target of 90%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

Multidisciplinary working

The multidisciplinary team (MDT) included physiotherapists, occupational therapists, dieticians, speech and language, and pharmacists.

Physiotherapy and occupational therapy staff were based on ward H, and provided to support to all the surgical wards. We observed therapy staff being involved in the morning ‘huddle’ and they reported that they did attend some ward meetings also.

Therapy staff also provided an outreach service and completed home visits when required to ensure safety of patients on discharge.

Records had a MDT record sheet which staff completed when undertaken any assessments or treatment with patients. Therapy staff told us they also kept and stored their own records and would document in the electronic patient record if they had any concerns.

Staff had access to information on patients’ care and treatment. However, new staff would need to navigate multiple systems to be able to holistically understand a patient’s need. All staff had access to an electronic records system that they could all update.

Seven-day services

The service provided elective surgery Monday to Friday. Therapy support covered Saturday as well.

Consultants provided on-call cover However, there was no consultant onsite at weekends or overnight. However, there was support provided by Advanced Nurse Practitioners (ANP).

Health promotion
The trust had a no smoking campaign and offered to support to patients.

The trust provided a wide range of healthy foods and water was readily available.

Staff encouraged patients to self-help where appropriate and to mobilise as soon as possible to aid recovery and facilitate earlier discharge.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that Mental Capacity Act (MCA) level 1 training had been completed by 40.5% of all staff within surgery from July 2016 to June 2017. No target was provided for the completion of this training.

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

No information was provided by the trust on the completion of Deprivation of Liberty training within Surgery.

*(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)*

The trust completed an audit of consent to treatment in May 2017. The results showed compliance to policy of 94%, which was noted as full assurance for the board.

Staff told us consent was completed in pre-operative assessment and re-addressed on admission. We reviewed documentation on the wards that confirmed this. No patients on the wards required Deprivation of Liberty Safeguards (DoLS) during the inspection. Staff told us that patients who had additional needs were identified in outpatients and attended Southport service.

**Is the service caring?**

**Compassionate care**

We observed staff providing compassionate care in wards and theatre areas.

We spoke to nine patients and two relatives during the inspection. Patients described staff as great and very respectful.

One patient told us that their hospital stay had been a “positive experience” and another stated “I’m treated beautifully”.

We received no negative feedback from patients or relatives during the inspection.

Due to staff shortages, urology and gynaecology patients were sometimes moved between the urology and gynaecology wards at short notice. As a result patients recovering from gynaecology
surgery could be moved to the urology ward shortly after surgery and vice versa. This compromised patient privacy and dignity as it often led to mixed sex breaches.
Friends and Family test performance

The Friends and Family Test response rate for Surgery at Southport and Ormskirk Hospital NHS Trust was 8.5% which was worse than the England average of 29% from September 2016 to August 2017.

The percentage of patients recommending the service as a place to receive treatment was quite variable across the different wards. The lowest annual recommendation rate was found in Ward 14A – Surgical Trauma and Orthopaedics (72%).

A breakdown of response rate by site can be viewed below:

Friends and family test response rate at Southport and Ormskirk Hospital NHS Trust, by site

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Sept-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Annual performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT / Eye Unit</td>
<td>1</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
<tr>
<td>Ward C</td>
<td>2</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not available</td>
</tr>
<tr>
<td>Ward H</td>
<td>71</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99%</td>
</tr>
<tr>
<td>14A</td>
<td>102</td>
<td>13%</td>
<td>56%</td>
<td>65%</td>
<td>71%</td>
<td>75%</td>
<td>83%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td>15B</td>
<td>137</td>
<td>11%</td>
<td>90%</td>
<td>80%</td>
<td>100%</td>
<td>65%</td>
<td>67%</td>
<td>60%</td>
<td>83%</td>
<td>63%</td>
<td>89%</td>
<td>100%</td>
<td>80%</td>
<td>99%</td>
</tr>
<tr>
<td>PIU</td>
<td>205</td>
<td>10%</td>
<td>90%</td>
<td>85%</td>
<td>91%</td>
<td>63%</td>
<td>83%</td>
<td>83%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
<td>92%</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>Ward F</td>
<td>241</td>
<td>12%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>Ward G</td>
<td>251</td>
<td>14%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>100%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>88%</td>
<td>100%</td>
<td>99%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Key: Highest score to Lowest score

Note: The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

Friends and family test results for those who would recommend the service ranged between 97-99%.
Response rates ranged from 0 - 50.5% between August – December 2017. Staff told us that a matron collected responses previously and collated the results. Staff did not know how responses had been collated since the matron had left.

**Emotional support**

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We observed staff treating patients with respect and compassion. Patients gave us consistently positive feedback and confirmed staff treated them with dignity.

Staff involved patients and their relatives in decisions about their care and treatment. We observed staff discussing care and treatment options with patients and relatives.

The service had access to specialist nurses including urology, stoma and vascular who provided advice and support to staff and patients. Understanding and involvement of patients and those close to them.

**Understanding and involvement of patients and those close to them**

Staff respected patient choices and delivered and promoted person-centred care. Patients’ care records were individualised to take into account personal wishes.

Patients and relatives told us they received information in a manner they understood.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

Surgical services were planned to meet the needs of local people. There were service level agreements in place with neighbouring independent health providers to meet the demands of the local population.

Arrangements were in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital.

A range of elective surgical procedures were available, some of which were able to be done as day case procedures (meaning that patients could be discharged on the same day as the procedure).

Patients who were booked for planned surgery attended health checks prior to the operation to assess their fitness for surgery and screen for infections. These pre-operative assessments took place in a dedicated area. Any patient assesses as high risk according to the American Society of Anaesthesiologists (ASA grade three or higher), was assigned to Southport District General Hospital, rather than Ormskirk, in order to provide safe monitoring following surgery.
Average length of stay

Trust Level – elective patients

From July 2016 to June 2017, the average length of stay for all elective patients in surgery at the trust was 2.8 days, which is lower compared to the England average of 3.3 days.

The average length of stay for trauma and orthopaedics elective patients at the trust was 3.0 days, which is lower compared to the England average of 3.4 days.

The average length of stay for general surgery elective patients at the trust was 3.4 days, which is as expected compared to the England average of 3.3 days.

The average length of stay for urology elective patients at the trust was 1.6 days, which is lower compared to the England average of 2.0 days.

Elective Average Length of Stay – Trust Level

(Source: Hospital Episode Statistics)

Trust Level – non-elective patients

The average length of stay for all non-elective patients in Surgery at the trust was 6.4 days, which is higher compared to the England average of 5.1 days.

The average length of stay for general surgery non-elective patients at the trust was 4.9 days, which is higher compared to the England average of 4.0 days.

The average length of stay for trauma and orthopaedics non-elective patients at the trust was 10.6 days, which is higher compared to the England average of 8.9 days.

The average length of stay for urology non-elective patients at the trust was 3.8 days, which is higher compared to the England average of 3.0 days.

Ormskirk and District General Hospital - elective patients

From July 2016 to June 2017 the average length of stay for all elective patients in Surgery at Ormskirk and District General Hospital was 2.2 days, which is lower compared to the England average of 3.3 days.

The average length of stay for trauma and orthopaedics elective patients at Ormskirk and District General Hospital was 2.7 days, which is lower compared to the England average of 3.4 days.

The average length of stay for general surgery elective patients at Ormskirk and District General Hospital was 1.5 days, which is lower compared to the England average of 3.3 days.

The average length of stay for urology elective patients at Ormskirk and District General Hospital was 1.3 days, which is lower compared to the England average of 2.0 days.
**Elective Average Length of Stay - Ormskirk and District General Hospital**

![Graph showing elective average length of stay](image)

*(Source: Hospital Episode Statistics)*

**Ormskirk and District General Hospital - non-elective patients**

The average length of stay for all non-elective patients in Surgery at Ormskirk and District General Hospital was 9.7 days, which is higher compared to the England average of 5.1 days.

The average length of stay for trauma and orthopaedics non-elective patients at Ormskirk and District General Hospital was 6.1 days, which is lower compared to the England average of 8.9 days.

The average length of stay for urology non-elective patients at Ormskirk and District General Hospital was 4.0 days, which is higher compared to the England average of 3.0 days.

The average length of stay for general surgery non-elective patients at Ormskirk and District General Hospital was 47.2 days, which is higher compared to the England average of 4.0 days.

**Non-Elective Average Length of Stay - Ormskirk and District General Hospital**

![Graph showing non-elective average length of stay](image)

*(Source: Hospital Episode Statistics)*

**Meeting people’s individual needs**

The service assessed patients’ and took account of their individual needs, planning and delivering care in-line with those needs. The service coordinated care and treatment with other services and providers.

Patients had access to their individual nurse call bells and we observed these being answered in a timely fashion.

The wards promoted protected mealtimes and the details were displayed outside ward areas.

Staff told us they had access to an interpreter and translation service and that they had no incidents when this was requested.
We observed a number of leaflets on the wards which were all in English. Staff did not know how to access these in other languages or formats.

Staff had access to equipment to enable them to do their job. We did not observe any issues with accessibility during the inspection.

The electronic record system flagged any individual need such as a safeguarding concern, learning disability, mental health need or end of life programme.

Staff told us told that patients with a learning disability would have their individualised needs assessed prior to admission. We did not observe this during the inspection.

**Access and flow**

Patients attended the hospital for day case, elective and some minor trauma surgery.

The surgeon and anaesthetist reviewed patients on the day of surgery to ensure medically fit for the procedure and to consent.

Staff and senior managers told us about planned ward re-configurations to improve ward utilisation and create more capacity.

During inspection there were some orthopaedic patients on the gynaecology ward classed as outliers. Therapy staff supported patients on all wards.

Ward G managed day case and care of patients who required an overnight stay. Overnight patients from this ward and the gynaecology ward ‘pooled’ patients cared for by two trained members of staff. The service had a standing operating procedure in place to manage this. However, at the time of our inspection due to staff shortages and challenges with access and flow, urology and gynaecology patients were moved between the urology and gynaecology wards each evening. This meant that patients recovering from gynaecology surgery could be moved to the urology ward shortly after surgery and vice versa. This led to mixed sex breaches and patients being cared for on a ward less suited to meet their needs.

Theatre utilisation data showed that the average usage was on average 82% between August and October 2017.

Bed occupancy at for the service was on average 83% between August – October 2017.

From 1 July 2016 to 30 June 2017 there were 52 moves at night (between 22:00 and 08:00).

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From September 2016 to August 2017 the trust’s referral to treatment time (RTT) for admitted pathways for surgery remained fairly consistent and was in line with or better than the England
average in all 12 months.
As of August 2017, 76% of patients were treated within 18 weeks compared to the England average of 70%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for Surgery broken down by specialty is below. Of these, three of specialties were above the England average and three specialties were below the England average.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>91.9%</td>
<td>77.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>87.1%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>77.7%</td>
<td>62.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>69.1%</td>
<td>72.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>63.9%</td>
<td>65.0%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>46.8%</td>
<td>65.8%</td>
</tr>
</tbody>
</table>

Cardiothoracic Surgery, Neurosurgery and Plastic Surgery had no activity during the time period.

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the trust performed consistently better than the England average for treating cancelled patients within 28 days and was generally better than the England average for cancellations as a percentage of elective admissions. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

All of the cancellations were treated within 28 days over this time period.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Southport and Ormskirk Hospital NHS Trust
Cancelled Operations as a percentage of elective admissions - Southport and Ormskirk Hospital NHS Trust

(Source: NHS England)

Learning from complaints and concerns

The service managers told us they were committed to improving services by learning from when things go wrong. However, the service did not identify causative factors well and ensure learning from complaints became embedded.

Summary of complaints

From July 2016 to June 2017 there were 79 complaints about Surgery. The trust took an average of 59.1 days (43.3 working days) to investigate and close complaints.

One of the 79 closed complaints (1.3%) about Surgery was closed in over 180 days while one of the 12 complaints that remained open at the time of response were received in 2016 and therefore had been open more than six months. This meets the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The most common subjects of the complaints were all aspects of clinical treatment (41); and attitudes of staff (11).

The breakdown of complaints by site was:

- Southport and Formby District General Hospital: There were 53 complaints; the highest number of complaints (28) was about all aspects of clinical treatment.
- Ormskirk and District General Hospital: There were 26 complaints; the highest number of complaints (13) was about all aspects of clinical treatment.
Complaints were reviewed and investigated as per trust policy. Staff were aware of the policy and could access it via the trust intranet. Senior staff told us there had been some delays in responding to complaints and that they were working on improving this.

Complaints were discussed at team level and at clinical effectiveness meetings. The service learnt from complaints, and shared this information with staff. Where possible staff tried to resolve complaints locally.

**Is the service well-led?**

**Leadership**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

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

Matrons attended the wards at least daily and staff knew how to contact them if required. Staff told us that the Head of Nursing was visible and approachable.

Matrons participated in briefings two or three times daily, ‘safe at all times’, to discuss staffing and capacity.

**Vision and strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff.

The service did not have a strategy at the time of our inspection. Following the inspection, a presentation of the surgical strategy was forwarded that highlighted plans for surgery on both sites including clear aims dates for completion.

Staff within the service expressed concern about the absence of a clear direction for the trust.

**Culture**

Staff told us their managers were approachable and promoted a positive culture. Staff felt supported and confident to raise any concerns. They told us that this had improved since the last inspection.

We spoke to allied health professionals who felt they worked well within the ward teams and that their input was welcomed by the wider multi-disciplinary team.
Staff described having good working relationships within their teams.

Managers complimented their team's professionalism, work ethic and flexibility to meet the needs of the service.

**Governance**

The service governance and performance management system did not operate effectively. Ward specific performance dashboards did not reflect correct information following several service moves. Senior managers stated that this had been addressed. However, dashboards we reviewed did not reflect this.

Staff attended monthly governance meetings and monthly clinical effectiveness meetings.

We reviewed the trust Quality & Safety Governance Structure which highlighted how the board received assurance from clinical business units.

An associate medical director worked across the trust and was the lead for sepsis.

**Management of risk, issues and performance**

The service had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. These systems were new and had recently enabled the identification in November 2017 of a never event from July 2017.

The planned care division had a risk register and there was also a corporate risk register. Items on the risk register were discussed in governance meetings.

We reviewed the risk register and found some risks had been on the register for several years. However, most risks had recently been reviewed prior to inspection. Risks included control measures and assurances. We found that not all ward managers were aware of risks identified.

Any serious incidents were discussed weekly to review the level of harm.

**Information management**

The trust collected, analysed, managed but did not use information well to support all its activities, using secure electronic systems with security safeguards.

Each ward monitored performance on electronic dashboards. However, due to changes in wards data needed checking with information technology staff. Senior managers told us the issues with performance dashboards had been raised with the relevant teams and this was being addressed.
Work was being undertaken across the trust to improve consistency in reporting across all clinical business units.

**Engagement**

The trust did not always engage well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Senior managers cascaded information from meetings to the operational teams, who then cascaded the information down to the clinical teams.

Staff told us that their matrons had changed recently. However, they knew who their matron was and had seen them on the wards.

Ward meetings were planned monthly and meeting minutes recorded and logged with the governance team.

Staff we spoke to told us they received information from senior managers via emails, as well as via the intranet and monthly staff bulletins.

The service recorded friends and family test results (FFT) on their dashboards. However, this showed poor response rates in all areas. Staff we spoke with were unaware of plans to improve this.

We spoke to two student nurses who felt supported by staff and had a designated mentor.

**Learning, continuous improvement and innovation**

The trust planned to review ward configuration to improve services for patients and to increase capacity to transfer more non-emergency care to Ormskirk.

**Maternity**

**Facts and data about this service**

Maternity services at the trust are provided at Ormskirk and District General Hospital. There are 42 Maternity beds at:

- Maternity Ward (22 beds)
- Maternity Assessment Unit (12 beds)
- Delivery Suite (eight beds)

(Source: Trust Provider Information Return – Acute sites)

In the most recent four quarters, April 2016 to March 2017, 2,237 women delivered their babies at the trust. Trends by quarter for the last two years can be seen in the graph below.
Number of babies delivered at Southport and Ormskirk Hospital NHS Trust by quarter

(Source: HES - Deliveries (01/04/2016 - 31/03/2017))

A comparison between the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at Southport and Ormskirk Hospital NHS Trust – Comparison with other trusts in England.

A profile of the births can be viewed below:
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and the majority had completed this. A practice development midwife had been appointed to ensure the training needs of staff were being met.

The mandatory training figures submitted prior to the inspection as part of the provider information request are detailed below. These figures did not match compliance rates which were monitored at a local level. On inspection, we found that training compliance rates were above 75% in each module and that all midwives were up to date with emergency skills and drills training.

A local database was maintained by the practice development midwife that contained up to date information on compliance with mandatory training for midwifery staff. This did not match the data provided to us as part of the universal provider information request. Senior staff told us that work was being done to improve the accuracy of the trust wide database.

Manual Handling, Conflict Resolution and High Dependency Care were significantly below the trust’s target of 90% However, there was an action plan in place to address this.

The practice development midwife had developed an annual mandatory training package which took place over four days and included opportunities to assimilate theoretical knowledge into practical skills training. This training package had been well received by the midwives and had improved compliance rates with mandatory training.

Mandatory training completion rates

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust’s target for mandatory training was 90%. In addition, the trust did not differentiate between medical and dental staff in maternity and gynaecology so the following mental/dental staff analysis includes gynaecology staff.

<table>
<thead>
<tr>
<th>Single or multiple births</th>
<th>Southport and Ormskirk Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>2,215</td>
<td>98.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.5%</td>
</tr>
<tr>
<td>Multiple</td>
<td>24</td>
<td>1.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s age</th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>65</td>
<td>2.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>20-34</td>
<td>1,745</td>
<td>77.9%</td>
<td>75.0%</td>
</tr>
<tr>
<td>35-39</td>
<td>350</td>
<td>15.6%</td>
<td>17.8%</td>
</tr>
<tr>
<td>40+</td>
<td>79</td>
<td>3.5%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total number of deliveries</th>
<th>Deliveries (n)</th>
<th>Deliveries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2,239</td>
<td>608,950</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)
A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for medical/dental staff in Maternity and Gynaecology at Ormskirk and District General Hospital is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>12</td>
<td>14</td>
<td>85.7%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>11</td>
<td>14</td>
<td>78.6%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>9</td>
<td>14</td>
<td>64.3%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>5</td>
<td>14</td>
<td>35.7%</td>
</tr>
<tr>
<td>Local Fire Training - Core</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>4</td>
<td>14</td>
<td>28.6%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 &amp; 5 (Prevent Awareness) - 3 Years</td>
<td>3</td>
<td>13</td>
<td>23.1%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>3</td>
<td>14</td>
<td>21.4%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>3</td>
<td>14</td>
<td>21.4%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>2</td>
<td>14</td>
<td>14.3%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>0</td>
<td>26</td>
<td>0.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The overall completion rate for medical and dental staff at Ormskirk and District General Hospital was 38.3% from July 2016 to June 2017.

None of the 26 eligible staff completed the resuscitation module over this time period. This module was not completed by any medical staff in either 2015/16 or 2016/17.

A breakdown of completion rates for mandatory courses from July 2016 to June 2017 for nursing/midwifery staff is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Induction</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>105</td>
<td>121</td>
<td>86.8%</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>102</td>
<td>120</td>
<td>85.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>11</td>
<td>13</td>
<td>84.6%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>101</td>
<td>121</td>
<td>83.5%</td>
</tr>
<tr>
<td>Fire Safety - 2 Years</td>
<td>99</td>
<td>120</td>
<td>82.5%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>92</td>
<td>121</td>
<td>76.0%</td>
</tr>
<tr>
<td>Preventing Radicalisation - Levels 3, 4 &amp; 5 (Prevent Awareness) - 3 Years</td>
<td>78</td>
<td>120</td>
<td>65.0%</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>75</td>
<td>120</td>
<td>62.5%</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>74</td>
<td>122</td>
<td>60.7%</td>
</tr>
<tr>
<td>Local Fire Training Core</td>
<td>72</td>
<td>120</td>
<td>60.0%</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>70</td>
<td>121</td>
<td>57.9%</td>
</tr>
<tr>
<td>Prevent WRAP - 3 Years</td>
<td>65</td>
<td>120</td>
<td>54.2%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>5</td>
<td>122</td>
<td>4.1%</td>
</tr>
</tbody>
</table>
The overall completion rate for nursing/midwifery staff at Ormskirk and District General Hospital was 64.8% from July 2016 to June 2017.

Only five of the 122 eligible staff (4.1%) completed the resuscitation module over this time period. This module was completed by 0.8% and 3.3% of medical staff in 2015/16 and 2016/17, respectively.

(Source: Routine Provider Information Request (RPIR) P40 – Statutory and Mandatory Training)

Following our inspection, the trust provided additional information which showed that 92% of obstetricians were up to date with basic life support training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Safeguarding supervision had been made part of mandatory training for all midwives and staff reported receiving good support from the safeguarding midwife.

The trust’s target for safeguarding training had been met by all staff groups in the service. The staff we spoke to were able to give examples of what scenarios would cause concern with regards to safeguarding. Awareness of Female Genital Mutilation and Child Sexual Exploitation formed part of the mandatory safeguarding training for all staff.

Staff told us that they had received good support from the safeguarding midwife when they had needed to make a safeguarding referral in the past.

**Safeguarding training completion rates**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust did not provide a target for the completion of safeguarding training or any data for the number of medical/dental or nursing staff within maternity who were trained on the safeguarding adults and children level 1 modules.

The trust has not provided any targets for the completion of mandatory training. In addition, the trust did not differentiate between medical and dental staff in maternity and gynaecology so the following mental/dental staff analysis includes gynaecology staff.

Ormskirk and District General Hospital had an overall safeguarding training completion rate for all medical/dental and nursing staff of 99.6%.

A breakdown of completion rates for safeguarding courses from July 2016 to June 2017 for medical/dental in Maternity and Gynaecology and nursing/midwifery staff in maternity at Ormskirk and District General Hospital is shown below:
Following the inspection the trust submitted data which indicated that across the trust at the time of our inspection training compliance was:

- Safeguarding adults level one: 93.9%
- Safeguarding adults level two: 92.8%
- Safeguarding adults level three: 94.2%
- Safeguarding children level one: 94.7%
- Safeguarding children level two: 90.9%
- Safeguarding children level three: 92.7%

However, this information was not broken down into the core services we inspected.
Cleanliness, infection control and hygiene

During our inspection we found clinical areas to be clean and observed staff following infection control guidelines such as bare below elbow.

Disposable aprons and gloves were readily available and easily accessible in clinical areas for use during birth or in the incidence of infection. Women we spoke to told us the clinical areas were always clean and they had observed staff washing their hands frequently.

We observed during our inspection that the doors to dirty utility cupboards on the maternity ward and delivery suite were kept closed.

Hand hygiene audits were carried out regularly and compliance rates were consistently high across maternity with a result of 100% for October 17. Hand hygiene gel was readily available on entry to wards, in clinical areas and at bedsides and we observed that wall mounted gel dispensers were full.

We saw evidence of the use of green “I am Clean” stickers which were dated and put onto equipment to show when it had last been cleaned. The stickers we saw were all up to date.

Inflatable birthing pools were available for use on the delivery suite, these were used with single-use disposable pool liners and the pools themselves were cleaned after each use.

Women were offered a pertussis (whooping cough) vaccine after 16 weeks gestation in line with national guidelines. During our inspection we saw evidence of women being offered a flu vaccine and there were public health posters displayed in waiting areas to encourage women to ask for this. However, some staff we spoke to were not offering the flu vaccine to women postnatally which is important as the immune system is suppressed in women throughout their pregnancy and following delivery.

Environment and equipment

The service had suitable premises and equipment and looked after them well. There had been improvements since the last inspection.

There was a lack of storage on the maternity ward which had been noted on our last inspection. Neonatal resuscitation equipment had since been moved from the corridor into a room where it was accessible and ready for use. The resuscitation equipment was checked daily, the consumables were all in date and there were records to demonstrate this. Some equipment remained in the corridors but this did not pose a safety issue as there was still adequate room along the corridors and none of the fire doors were blocked.

There was access to specialist equipment when needed such as a neonatal resuscitaire, fetal blood sampling machine, cardiotocographs and adult resuscitation equipment in line with Safer Childbirth requirements. There was access to blood products on delivery suite for use in an emergency.

The obstetric theatre and main theatres were easily accessible from delivery suite. The maternal assessment unit, maternity ward and neonatal unit were situated on another floor meaning that women accessing theatres from the maternity ward or assessment unit and babies requiring transfer to the neonatal unit from delivery suite would need to use the lift in order to do so. Staff told us that a key was needed to operate the lift and that there had been no delays in access to theatre using the lifts.

We observed that portable appliance testing had been carried out on electrical equipment and this was within the review date.
A ROTEM machine was being used by the anaesthetists to aid management of postpartum haemorrhage. The machine analyses levels of clotting factors in a blood sample which can help to better identify which blood products are most appropriate in the management of the individual case.

The anaesthetic machine in the obstetric theatre was not consistently recorded as being checked that it was safe to use. We found 12 days in October 17 when the record had not been completed to confirm that the anaesthetic machine had been checked and was safe to use.

The bereavement room which is located on the maternal assessment unit had recently been refurbished following input from the bereavement midwife. There were tea making facilities and a sofa bed which partners could use. An order had been placed for a wider hospital bed.

On the delivery suite, room eight which had previously been used as a second obstetric theatre was no longer in use which mitigated concerns over the suitability of the room for that purpose.

**Assessing and responding to patient risk**

Staff did not consistently complete Modified Early Warning Scores assessments in accordance with trust policy in order to detect deterioration in a woman’s condition. Women did not always receive a medical review when their assessment identified this was required.

We reviewed five perioperative pathways which included the monitoring of Modified Early Warning Scores following caesarean section. One out of the five we looked at was completed correctly in accordance with trust policy. We found an example where one woman had a Modified Early Warning Score of three yellow indicators which should have prompted escalation for review by an obstetrician but this was not done. A subsequent 13 consecutive sets of observations relating to the same woman which should have prompted a medical review resulted in no action being taken. We reported this to the shift leader at the time in order to ensure a review was carried out.

In an ongoing audit of postoperative Modified Early Warning Score assessments the service had reviewed 40 sets of notes dating from as far back as April 17. None of the 40 had been completed in accordance with trust policy. This meant that women were not sufficiently monitored for signs of deterioration in their condition following surgical procedures.

We also found two occasions when Modified Early Warning Score assessments had been referred for obstetric review but these were not in relation to postoperative women.

Some midwives we spoke with told us that they were unsure what the policy was in relation to Modified Early Warning Score assessments. There was no prompt on the online records system to highlight the need for a referral for review or instruction to repeat observations if necessary. When we reviewed the trust policy in relation to Modified Early Warning Score this stated in terms of a numeric score and not a red/amber/green score which was used in the perioperative pathway. The policy was that a score greater than or equal to three required review by an obstetrician. There was no mention of what action to take if a woman scored between one and three.

We found two records out of five where the World Health Organisation (WHO) surgical checklists were not fully completed. The World Health Organisation surgical checklist was introduced in 2009 as a tool to reduce deaths and complications arising from surgical errors. The surgical checklist prompts clinicians to check that the relevant safety checks have taken place prior to the procedure.
However, we found that comprehensive risk assessments were carried out at booking appointments including; social, medical assessments and maternal mental health and wellbeing. Women were referred to consultant led care appropriately. Women identified as being at increased risk of haemorrhage were advised to transfer care to a unit where there was 24 hour access to transfusion services on site.

For women who chose to give birth at Ormskirk the risks posed by there not being a 24 hour transfusion lab on site were mitigated by the availability of eight units of ‘O’ negative blood on the delivery suite. All women were assessed for eligibility for electronic prescribing to speed up the process of getting blood products if required. The unit had worked closely with transfusion services to ensure risks were mitigated and had tested out procedures in the instance of a massive obstetric haemorrhage.

There was a robust triage pathway in use on the maternal assessment unit to ensure that women were given correct advice and treatment when they called with concerns. We observed on the unit that calls were answered in a timely way and that women’s concerns were addressed in a sensible manner.

**Midwifery and nurse staffing**

The staffing figures below in relation to midwifery staffing show an over establishment meaning that there were more staff in post than the establishment levels. Conversely, 724 shifts were filled by bank staff between June 16 and July 17. This was partly due to demand on the maternity ward as one midwife was allocated per shift to undertake the Newborn Infant Physical Examination (NIPE) and was not able to take an allocation of women to care for. During our inspection we found that staff working on the maternity ward were often pulled to cover a shift on the delivery suite and that there were gaps on the maternity ward rota which were filled by bank staff.

Staffing levels were audited by the service and any incidences of women not receiving one to one care in labour were identified.

The midwife to birth ratio was consistently below 1:28 between June 16 and July 17.

Recommendations set out in Safer Childbirth were met including provision of a consultant midwife, student midwives were supernumerary and an experienced shift coordinator was available on each shift.

Establishment levels had recently been reviewed across the unit and due to the additional roles of midwives such as sonography and completing the Newborn Infant Physical Examination (NIPE) additional midwifery staff were needed. A business case had been put forward for an additional 4.5 Whole Time Equivalent midwives although senior staff told us that there were concerns whether these posts could be filled through recruitment.

We observed two midwifery handovers and one obstetric handover as part of our inspection. Midwives on the maternity ward had protected time for handovers at the beginning of each shift meaning that they were not required to accept admissions onto the ward during this time. This enabled the midwives to handover care without interruption. The handovers we observed were thorough and included a “safety huddle” which highlighted any incidents and women with complex needs.

Nursing staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template.

The trust reported the following planned and actual whole time equivalent staffing figures for
nursing and midwifery staff working in maternity for the period from July 2016 to June 2017. These figures were not provided at site level.

<table>
<thead>
<tr>
<th>Month</th>
<th>WTE Staff</th>
<th>Number in post</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2017</td>
<td>102.2</td>
<td>102.7</td>
</tr>
<tr>
<td>May 2017</td>
<td>102.2</td>
<td>102.9</td>
</tr>
<tr>
<td>April 2017</td>
<td>100.5</td>
<td>103.8</td>
</tr>
<tr>
<td>March 2017</td>
<td>100.4</td>
<td>103.6</td>
</tr>
<tr>
<td>February 2017</td>
<td>100.4</td>
<td>104.2</td>
</tr>
<tr>
<td>January 2017</td>
<td>99.2</td>
<td>104.8</td>
</tr>
<tr>
<td>December 2016</td>
<td>99.2</td>
<td>104.7</td>
</tr>
<tr>
<td>November 2016</td>
<td>99.2</td>
<td>104.9</td>
</tr>
<tr>
<td>October 2016</td>
<td>99.2</td>
<td>104.9</td>
</tr>
<tr>
<td>September 2016</td>
<td>99.2</td>
<td>101.9</td>
</tr>
<tr>
<td>August 2016</td>
<td>99.2</td>
<td>99.3</td>
</tr>
<tr>
<td>July 2016</td>
<td>99.2</td>
<td>98.5</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

Vacancy rates

From July 2016 to June 2017, the trust reported an overall vacancy rate for nursing staff in Maternity at Ormskirk and District General Hospital of -2.9%, indicating they were over-establishment.

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

Turnover rates

From July 2016 to June 2017, the trust reported a turnover rate for nursing and midwifery staff in maternity at Ormskirk and District General Hospital of 6.6%.

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

Sickness rates

From July 2016 to June 2017, the trust reported a sickness rate of 4.5% for nursing and midwifery staff in maternity at Ormskirk and District General Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

Bank and agency staff usage

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. We were aware that the data provided by the trust may not be full or complete as the data for all wards was not included in their new rostering system. Analysis has been carried out on the information that has been provided.

From April 2016 to March 2017, the trust reported bank usage for registered nurses in maternity at Ormskirk and District General Hospital of 724 shifts.

Over the same time period, the hospital reported no agency usage and 233 shifts that were unfilled by bank and agency staff.

(Source: Routine Provider Information Request (RPIR) P20 Nursing – Bank and Agency)

Medical staffing
There was a shortage in middle grade medical staffing; however, the medical rota had been covered up to February 2018 through use of locum doctors and by consultants. A shortage of middle grade medical staffing is not uncommon in maternity services across England as reflected in the figures below. However, we found that the service had taken steps to mitigate this risk to women and their babies.

The trust had taken steps to fill vacancies in middle grade medical staff. A temporary measure had been taken in using consultants to fill shifts in place of registrars and to hire locum staff over longer periods than usual. Plans were in place to trainee medical staff from overseas and provide training for them to progress to registrar level. The recommended consultant presence of 40 hours on delivery suite was met by the service and a consultant was available on call out of hours. Medical staffing information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust did not report their planned and actual whole time equivalent staffing figures for medical and dental staff working in maternity for the period from July 2016 to June 2017.

(Source: Routine Provider Information Request (RPIR) – P16 Total numbers – Planned vs actual tab)

The trust has not differentiated between medical and dental staff in maternity and gynaecology so the following mental/dental staff analysis includes gynaecology staff.

**Vacancy rates**

From July 2016 at Ormskirk and District General Hospital of 7.7%. The highest rates were reported in November 2016 (14.5%) and the most recent month, June 2017 (14.5%).

(Source: Routine Provider Information Request (RPIR) P17 Vacancies)

**Turnover rates**

From July 2016 to June 2017, the trust reported a turnover rate for medical and dental staff in maternity and gynaecology at Ormskirk and District General Hospital of 14.0%:

(Source: Routine Provider Information Request (RPIR) P18 Turnover)

**Sickness rates**

From July 2016 to June 2017, the trust reported a sickness rate of 0.3% for medical and dental staff in maternity and gynaecology at Ormskirk and District General Hospital.

(Source: Routine Provider Information Request (RPIR) P19 Sickness)

**Bank and locum staff usage**

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. However, the trust was unable to provide the appropriate data.

(Source: Routine Provider Information Request (RPIR) P21 Medical Locums)

Following our inspection, the trust provided information that 46 shifts were filled by six locum
middle grade medical staff throughout November 17. The majority of these were night shifts and long shifts.

**Staffing skill mix**

As at July 2017, the proportion of consultant staff reported to be working at the trust were higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 23.4 whole time equivalent staff working in Urgent and Emergency Care at Southport and Ormskirk Hospital NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>44%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Junior</td>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

(Source: NHS Digital Workforce Statistics)

**Records**

Records were not always up to date. We saw examples of delay in scanning records onto the online system meaning there were gaps in women’s care records. Only one member of staff could open a particular record at a time which meant that records around caesarean sections were not always entered onto the system in a timely manner.

The majority of records were electronic with the exception of the perioperative pathway and medicine administration records. Prior to discharge from the delivery suite, perioperative records were to be scanned into the electronic system so that they can be viewed by ward staff. We saw one example out of 16 where this process had not been followed and the woman’s postoperative assessments were not available on the system. Staff informed us that the process was not always reliable for scanning records in a timely manner.

We looked at eight sets of labour records and found two examples where the fresh eyes approach had not been completed. The Fresh Eyes approach relates to interpretation of cardiotocography (CTG) readings which monitor fetal heart rate and contractions during labour. Cardiotocography can also be used antenatally to assess fetal wellbeing but during labour this needs to be reviewed by two midwives each hour as the computer analysis is not valid. The aim of this is to assist midwives in detecting signs of fetal distress during labour.

The midwives we spoke to told us that Fresh Eyes was not always recorded on the online system because only one midwife could access each record at a time. This meant that the midwife providing labour care would have to close down the record so that it could be opened by another midwife in order for them to confirm that the Fresh Eyes review had occurred. However, we looked at the paper print out of the CTG reading which is printed as it is recorded and this had not been signed which is common practice when completing a Fresh Eyes review and could be done without access to the electronic record.
As a person’s medical record could only be viewed by one clinician at a time this caused delays in adding information to the records. For example, staff told us that information relating to surgical interventions was often left until hours after the event before it was added to the online system as the records were often opened by the midwife providing on going care to that woman. This meant that records were not always contemporaneous and there was a risk that staff did not have access to all of the information they needed in order to provide good quality care to women and their babies.

The community midwives reported ongoing issues surrounding access to records away from the hospital setting. At the time of our inspection the midwives had the necessary computer equipment to be able to access online records while at clinic or and during visits but this was not always reliable. This meant that the midwives could not look at a woman’s clinical history during their appointment, view test results or access safeguarding information. This was noted on the maternity risk register but had been an issue raised at our last inspection; the action plan was due for review 31 December 2017.

**Medicines**

The service did not always store medicines well. There was no record of fridge temperatures being escalated when out of range and room temperatures were not consistently recorded where medicines were stored.

We reviewed ten medicines records and all included any known allergies as well as the frequency, route and dose of medicines prescribed. We saw that the administration of medicines was recorded correctly and did not find any errors in the records we reviewed.

We checked the medicines storage on the delivery suite, maternity ward and maternal assessment unit. We found that room temperatures were being recorded inconsistently on Delivery Suit and the Maternal Assessment unit and were not recorded at all on the Maternity Ward. This meant that the temperature at which ward stock medicines and intravenous fluids were kept was not monitored in line with manufacturers’ recommendations.

Fridge temperatures were not consistently recorded. On the maternity ward we found four incidents in November 17 where the fridge temperature had been recorded as out of range (13 degrees Celsius) and there was no record of this being escalated. On the maternal assessment unit there were repeated incidences where the temperature had not been recorded and one example where the temperature had been recorded as out of range (9 degrees) and not escalated.

In theatre, we found that medicines such as phenylephrine which would be used in the case of emergency were being drawn up at the start of each shift and left in the fridge ready for use. Printed labels were available to be added to syringes so that it was clear what had been drawn up. However, we found one instance during our inspection where the labels had been hand written and were illegible. This posed a risk to patients as staff would be unable to determine what was in each syringe if needed. We spoke to an anaesthetist who told us that they would not draw up a fresh syringe at the start of their shift if the label was legible and in date. When we reviewed the trust Medicines Optimisation policy there was no guidance on the drawing up of such medicines in advance of them being needed.

We found that diamorphine was being prescribed to women who attended for induction of labour while they were on the induction suite within the maternal assessment unit. Diamorphine should
be given to women if they request it once they are in established labour. We could not find a trust policy which supported the prescription of diamorphine for women on the induction suite or prior to it being requested.

However, controlled drugs were securely stored and the use and disposal of such medicines recorded in line with trust policy. We reviewed the controlled drugs records on each of the wards we visited and completed a random stock check; we did not find any discrepancies.

**Incidents**

The service managed patient safety incidents well. Most staff recognised incidents and reported them appropriately however, learning was not always shared effectively.

Staff we spoke to knew how to report an incident and could provide examples of reportable incidents. However, recent changes to service provision meant that there was a shortage of diabetic specialist nurses to cover the joint medical clinic and there were times when a specialist nurse was not present. These had not been reported as incidents which meant there was a risk that this issue had not been escalated.

Multidisciplinary meetings were held weekly to review any incidents of moderate or severe harm. There was a planned process of escalation to the head of risk or executive team within 72 hours if a serious incident occurred.

There were systems in place to ensure that all births between 22 and 23+6 weeks gestation who do not survive the neonatal period were reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries UK.

Every incident of postpartum haemorrhage (PPH) above 1000mls was reported as an incident and reviewed. This was part of an action plan developed following a Royal College of Obstetrics and Gynaecology review which took place in 2015 due to a rise in the number of hysterectomies performed which is a last resort in incidences of postpartum haemorrhage. As a result of reviewing each incident of postpartum haemorrhage there had been learning and improvement in the management of PPH at the trust. However, the trust continued to review every incident and staff we spoke to told us that there was little value in doing this and that it was very time consuming.

Ward managers along with a consultant reviewed each incident of PPH between 1000-1500mls and each incident above 1500mls was escalated for a full multidisciplinary review. Staff told us that this impacted the time managers and medical staff had to carry out their day to day tasks.

Learning from incidents was disseminated to staff through discussion at team meetings although attendance had been poor recently. Lessons were also emailed to staff, discussed at the daily safety huddle and a Lesson of the Week letter was put on the notice board on each ward. Senior staff recognised that there had been difficulty in ensuring staff took note of the lessons learned and a recent audit had been completed which showed most staff were not aware what the lesson of the week was. At the time of our inspection there was no action plan in place relating to this audit.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From September 2016 to August 2017, the trust reported zero incidents which were classified as
never events for maternity.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from September 2016 to August 2017.

Of these, the most common types of incident reported were:

- Maternity/obstetric incident meeting SI criteria: mother only with eight (66.7% of total incidents).
- Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with four (33.3% of total incidents).

All of the incidents occurred at Ormskirk and District General Hospital.
(Source: Strategic Executive Information System (STEIS))

Safety thermometer

Safety thermometer results were not displayed within the unit However, the service reported information to the NHS safety thermometer database regularly. The results showed improvement to the number of women left alone at a time that worried them and the proportion of women with concerns which were not taken seriously around labour and birth. There had been a significant decline in harm free care relating to physical harm for the most recent month, November 17.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The unit had implemented Gestation Related Optimal Weight (GROW) guidelines. Gestation Related Optimal Weight is a package of care recommended by the Perinatal institute aimed at reducing the rate of stillbirths by using customised growth charts to identify babies who may be
suffering from growth restriction prior to being born. Outcomes were monitored and reviewed in relation to Gestation Related Optimal Weight.

Arrangements were made to ensure that women who were identified as small for dates received a growth scan within 72 hours in accordance with Royal College of Obstetrics and Gynaecology Green Top Guideline 13.

The service monitored the percentage of women who had seen a midwife by 12 weeks and six days of pregnancy and the service had recently improved the rate of women seen by this gestation. This meant that the service was compliant with the National Institute for Clinical Excellence guideline (CG62) 2016 which recommends that women should ideally be booked for care around 10 weeks of pregnancy.

We found evidence in records that midwives and obstetricians emphasised the importance of fetal movements to women at each antenatal contact in line with the current Royal College of Obstetrics and Gynaecology Green Top Guideline 57. Details of this discussion were documented and we found that written information around normal patterns of fetal movements were available in women’s’ handheld notes.

Staff told us that any changes to national guidelines or best practice were disseminated via email by the consultant midwife.

Staff knew how to access up to date versions of policies and guidelines using the trust intranet service. Policies were created in accordance with national guidelines and evidence based practice. However, of the five policies we reviewed there were two which had passed their review date. The policy around fetal monitoring was due for review in November 15 and had not been reviewed at the time of our inspection.

We saw that women admitted to hospital or undergoing surgical procedures had a venous thromboembolism (blood clot) risk assessment completed. Women identified as high risk were prescribed prophylactic anticoagulants in accordance with national guidelines.

The risk management team identified where the service was not compliant with national guidelines and prompted the relevant risk leads to complete a gap analysis. Staff told us that the service was not compliant with National Institute for Clinical Excellence (NICE) guidance (NG3) Diabetes in Pregnancy as women with a BMI of 35 and over were referred for a glucose tolerance test as opposed to those of a BMI of 30 and over as per guidelines. This had not been identified by the risk management team.

**Nutrition and hydration**

Women were encouraged to maintain a light diet during labour and were offered one to one support if they had chosen to breastfeed.

Women we spoke to reported being encouraged to eat a light diet and keep hydrated throughout their labour and were satisfied with the range of meals on offer at the hospital. We saw evidence of refreshments being offered promptly following delivery and women were able to request a meal out of hours.

Electronic breast pumps were available for use on the maternity ward and there was a stock of formula milk for women who were unable to provide their own.

Women were supported to breastfeed if they chose to. Antenatal classes were open to women who wanted to learn more about breastfeeding. During their stay on the maternity ward, the infant feeding team were available to assist women with positioning, attachment and expression of
breastmilk. A member of the infant feeding team would visit the ward daily to offer support and advice.

Expressed breastmilk was labelled with the date expressed and name of the woman it belonged to and stored in a fridge in Neonatal unit. Women had to ask a staff member to take their expressed breastmilk from the fridge as this was secured in a locked room but staff and the women we spoke to did not report any issues with this system.

Initiation of breastfeeding rates had improved at the trust and was 65% in October 2017. The unit was working towards level three accreditation from the Baby friendly Initiative.

There was no provision for support from the infant feeding team once women were discharged home although staff told us that they would carry out home visits in exceptional circumstances.

The unit did not provide a tongue-tie (frenulotomy) service; parents who opted for this were referred to a local specialist children’s Hospital. Tongue-tie is an abnormality where there is a membrane connecting the underside of the tongue to the hard palate which can negatively impact breastfeeding. Frenulotomy is the process of making an incision in the membrane to free the tongue.

Pain relief

Pain relief was provided to women on request although pain scores were not consistently recorded postoperatively.

There was an anaesthetist on call for Delivery Suite at all times. Of the 16 records we reviewed, we found once instance where the anaesthetist was not available to site an epidural when requested and in this case the baby was born shortly after the request was made.

The median time between request for an epidural and an anaesthetist being in attendance did not exceed 30 minutes as per national guidelines.

We found that pain scores were inconsistently recorded following surgical delivery as part of the perioperative pathway However, the women we spoke to reported receiving adequate pain relief.

For a home birth Entonox (gas and air) and pethidine could be provided by the midwife in attendance.

The unit had recently started providing a hypnobirthing course for women antenatally which can help women to cope with pain during labour. This had been well received by the women and midwives.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

A dashboard was used to monitor outcomes for women and babies and was reviewed regularly by managers. We saw that the results were displayed on notice boards throughout the unit. Staff we spoke to were able to identify outliers on the dashboard but were often unclear as to what had been put in place to improve results.

The dashboard had identified an increase in the incidence of induction of labour within the unit. Senior managers told us this was a result of implementing Gestational Related Optimum Weight (standards. Women who measure below the 10th centile or whose growth stalls or reduces are referred for an ultrasound scan which took fetal measurements and looked at the flow of blood from the placenta. Induction of labour is frequently advised for women with babies identified as being growth restricted. To meet the additional demand for ultrasound scanning, the unit had
funded two midwives to attend a third trimester scanning course and women could be referred to maternal assessment unit for growth scans rather than having to find a free slot in clinic.

An increase in the incidence of third and fourth degree perineal tears had been identified on the dashboard. No trends had been found through reviewing the incidents but additional training on carrying out episiotomies had been rolled out to midwives with the aim of reducing the incidence of third and fourth degree tears. The unit was also trialling epi-scissors which are specially designed to guide where the cut should be made and improve the effectiveness of episiotomies.

Local audits were carried out regularly and were often prompted by issues identified in practice. One example is that a recent audit into the use of syntocinon had been carried out. Syntocinon and Syntometrine are drugs used to cause the uterus to contract following delivery of the placenta in order to reduce blood loss. The unit had recently switch to syntocinon from syntometrine in accordance with national guidelines but the delivery suite midwives had reported an increased blood loss with syntocinon compared with syntometrine. An audit was carried out to identify any differences between the use of either drug and found that the amount of blood loss was actually reduced through the use of Syntocinon. These findings were shared with the midwives.

**National Neonatal Audit Programme**

In the 2016 National Neonatal Audit performance at Ormskirk and District General Hospital was as follows:

**Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?**

There were 14 babies born at less than 32 weeks included in this audit measure for the unit and 93% of these babies had their temperature measured within an hour of birth. This was below the national average, where 96% of eligible babies had their temperature measured within an hour of birth.

**Are all mothers who deliver babies between 24 and 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 49 eligible mothers identified for inclusion in this audit measure for this unit and 86% of these mothers were given a complete or incomplete course of antenatal steroids. This was equal to the national average, where 86% of eligible mothers were given at least one dose of antenatal steroids.

**What proportion of babies less than 33 weeks gestation at birth were receiving any of their own mother’s milk at discharge to home from a neonatal unit?**

There were 11 babies born at less than 33 weeks who met the criteria for inclusion at this unit and 36% of these babies were receiving mother’s milk exclusively, or as part of their feeding at the time of their discharge from the neonatal unit; this was below the national average, where 59% of eligible babies were receiving any mother’s milk at the time of their discharge from neonatal care.

*(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)*

**Standardised Caesarean section rates and modes of delivery**

From April 2016 to March 2017 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective and emergency sections were also as expected.
In relation to other modes of delivery over this time period, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

### Proportions of deliveries by recorded delivery method

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>Southport and Ormskirk Hospital NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections&lt;sup&gt;1&lt;/sup&gt;</td>
<td>601</td>
<td>26.9%</td>
</tr>
<tr>
<td>Instrumental deliveries&lt;sup&gt;2&lt;/sup&gt;</td>
<td>281</td>
<td>12.6%</td>
</tr>
<tr>
<td>Non-interventional deliveries&lt;sup&gt;3&lt;/sup&gt;</td>
<td>1,348</td>
<td>60.3%</td>
</tr>
<tr>
<td>Other/unrecorded method of delivery</td>
<td>7</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,237</td>
<td>100%</td>
</tr>
</tbody>
</table>

<sup>1</sup>Includes elective and emergency caesareans
<sup>2</sup>Includes forceps and ventouse (vacuum) deliveries
<sup>3</sup>Includes breech and normal (non assisted) deliveries

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

### Maternity active outlier alerts

As of 1 November 2017 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

### Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.57 which was in the yellow banding, indicating it was up to 10% lower than the comparator group average of 4.73.

(Source: MBRRACE-UK)

### Competent staff
The service made sure staff were competent for their roles. Midwives who assisted in theatre had the necessary training to undertake this role.

The preceptorship package for newly qualified midwives had been reviewed so that they received sufficient time as a supernumerary member of staff and gained skills and experience in each part of the service through rotation to different areas.

The Head of Midwifery held regular one to one sessions with student midwives and newly qualified midwives undertaking a preceptorship to gain feedback and provide additional support.

There were 32 midwives trained to assist in theatre and rotated in this role regularly in order to maintain their competencies. 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”. Theatre induction training packs were given to newly trained scrub midwives. Scrub midwives rotated to ensure they had enough clinical experience to maintain their scrubbing competencies.

The Newborn Infant Physical Examination (NIPE) was undertaken by suitably trained midwives on the maternity ward prior to discharge for babies following an uncomplicated birth with no additional risk factors. Any babies identified with additional risk factors had their examination completed by a paediatrician.

Some training was multidisciplinary such as skills and drills training. However, staff told us there had been poor engagement from medical staff due to workloads.

Midwives had their competencies assessed face to face for use of specialist equipment such as the blood gas machine for analysing fetal blood samples. The practice development midwife was in the process of developing a comprehensive competency package for midwives to complete. A record was kept of midwives who had completed competency assessments in transfusion. At the time of our inspection the rate of compliance with transfusion competencies fell below the trust’s target (compliance rate 77%) but there was a plan in place to address this.

The service had secured additional funding to provide training for staff around human factors, resilience and external CTG interpretation training. This had been well received by the midwives involved. However, the practice development midwife had not been involved in meetings to determine how this funding was best spent.

**Appraisal rates**

Please note that the trust did not differentiate between medical and dental staff in maternity and gynaecology so the following analysis includes mental/dental staff analysis in gynaecology.

From June 2016 to June 2017, 92.1% of staff within maternity (and gynaecology) at Ormskirk and District General Hospital had received an appraisal compared to a trust’s target of 90%.

A split by staff group can be seen in the graph below:
The qualified nursing midwifery staff and the support to doctors and nursing staff group met the trust completion rate target of 90%.

(Source: Routine Provider Information Request (RPIR) P43 Appraisals)

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff we spoke to told us that there was a good working relationship between medical and midwifery staff. There had been a drive within the unit to promote normal birth and staff said that there had been no resistance from medical staff with regards to this and they had been supportive in enabling midwives to be lead carer for low risk women.

A diabetes clinic was held weekly and led by a diabetic specialist with input from the diabetic specialist midwife and a diabetic specialist nurse.

During our inspection we reviewed records of women with complex needs both social and medical and found good evidence of multidisciplinary working. Women were referred appropriately for specialist care when needed and there was effective communication between care professionals.

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 introduction of a number of specialist midwives within the unit had improved inter professional working as these midwives had worked to establish links and liaise with other services and organisations. For example, the safeguarding midwife had set up a link between herself and a contact at each of the local authorities the trust worked with frequently and held regular meetings to discuss ongoing cases.
Communication with the community midwives was not always effective. Staff told us that when a woman and baby were discharged from the maternity ward to community care there was a box which needed to be checked on the online system to send the referral to the community midwives. Community staff told us that this box was sometimes mistakenly left unchecked and there was no prompt on the system to ensure the discharging midwife completed this.

**Seven-day services**

There was 24 hour access to the psychiatric liaison service meaning that advice was out of hours and when the perinatal mental health midwife was unavailable. The unit operated a triage service which was open 24 hours a day so that women could attend at any time for a prompt assessment. There was access to diagnostics and consultant reviews seven days a week.

An anaesthetist was available on call seven days a week.

A critical care outreach team was available on call at all times for women whose condition deteriorated and needed specialist intervention.

**Health promotion**

Since our last inspection, the trust had appointed a specialist perinatal mental health midwife who ran two clinics a week for women identified as needing this service. Staff told us that they received good support from the perinatal mental health midwife in meeting the needs of women with mental health concerns.

Smoking cessation and alcohol dependency services and support groups were advertised in waiting areas throughout the unit and public health leaflets were readily available.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

We saw evidence of consent being gained prior to interventions. Women we spoke to told us that they felt they had enough information to make informed decisions about their care.

We reviewed five consent forms completed prior to caesarean section. One of these had been completed without specifying whether a general or local anaesthetic would be used and the physician’s signature and printed name was illegible.

Consent for antenatal screening was obtained at the booking appointment and women were sent a copy of the Public Health England booklet “Screening Tests for you and your Baby” which was available in different languages. They were advised to read the booklet prior to their booking appointment for further discussion with their midwife.

Where possible, women were given 24 hours or more between their booking appointment and dating scan so that they could consider the information given to them regarding testing for Down’s, Edwards’ and Patau’s Syndrome. The sonographer would then confirm consent prior to completing the measurements needed for the test at the dating scan. For women who booked late it was not always possible to allow this time as they would then fall beyond the gestational age range for screening.

Midwives completed perinatal mental health training as part of the four day mandatory training course. At the time of our inspection, the compliance rate was 97% for this training module. Information submitted in the provider information request was incorrect as this had not been sourced from the local database maintained by the service. Training included learning around the Mental Capacity Act and consent.
Mental Capacity Act and Deprivation of Liberty training completion

Please note that the trust did not differentiate between medical and dental staff in maternity and gynaecology so the following analysis includes mental/dental staff analysis in gynaecology.

The trust reported that Mental Capacity Act (MCA) level 1 training had been completed by 35.7% of all staff within maternity (and gynaecology) from July 2016 to June 2017. The trust did not provide a target for the completion of this training prior to our inspection.

No information was provided by the trust on the completion of Deprivation of Liberty training within Urgent and Emergency Care.

(Source: Routine Provider Information Request (RPIR) P14/P49)

Following the inspection the trust submitted trust-wide data which indicated that mental capacity training compliance levels had improved to 90.3%.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

There was a quiet room in antenatal clinics which could be used as a private space to discuss care with women and their families if needed.

We witnessed staff interacting with women and families in a sensitive and caring manner. Women were asked about their emotional wellbeing by staff and this aspect of care was discussed at handover between staff members to ensure women received the support needed.

Curtains were used around beds in bays on the maternity ward and maternal assessment unit to maintain privacy and dignity of women and babies. Partners were able to stay overnight on the maternity ward and recliner armchairs had been purchased for partners to sleep in. We noticed that when the recliners were in use this limited space in the bays and staff tried to limit this by filling the side rooms first and leaving the bays for women who required closer observation meaning beds were often free in the bays.

As we carried out our inspection we were stopped on the corridors by a few relatives who wanted to express their satisfaction with the care provided and to tell us how kind staff had been to them. Women we interviewed were all happy with the care provided and one woman had been cared for at Ormskirk in a previous pregnancy and had noticed a real improvement in the quality of care.

The unit took part in the Picker Institute patient survey which had demonstrated a marked improvement in the experiences of women and their families. The results were on display throughout the unit.

Friends and Family test performance

From September to December 2016 the trust’s Maternity Friends and Family Test (antenatal) performance (% recommended) was generally worse than the England average. However, from January to August 2017, the trust did not provide any data.
From September 2016 to August 2017 the trust’s Maternity Friends and Family Test (birth) performance (% recommended) was generally similar to or worse than the England average. In the most recent month, August 2017, performance for antenatal was 96% which was the same as the England average. **Friends and family test performance (birth), Southport and Ormskirk Hospital NHS Trust**

From September 2016 to August 2017 the trust’s Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average. **Friends and family test performance (postnatal ward), Southport and Ormskirk Hospital NHS Trust**

The trust only submitted data for the Maternity Friends and Family Test (postnatal community) performance (% recommended) in October and November 2016. In these two months, the trust’s performance was similar to the England average. **Friends and family test performance (postnatal community), Southport and Ormskirk Hospital NHS Trust**
(Source: NHS England Friends and Family Test)

CQC Survey of women’s experiences of Maternity services 2015

The trust performed worse than other trusts for three out of 16 questions in the CQC Maternity survey 2015 and about the same for the remaining 13 questions.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>RAG</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>About the same</td>
<td>7.97</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>About the same</td>
<td>7.81</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>Worst performing trusts</td>
<td>8.62</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>About the same</td>
<td>9.05</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>About the same</td>
<td>9.04</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>Worst performing trusts</td>
<td>6.01</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>Worst performing trusts</td>
<td>6.83</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>About the same</td>
<td>9.28</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>About the same</td>
<td>7.91</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>About the same</td>
<td>8.94</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>About the same</td>
<td>8.30</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>About the same</td>
<td>7.38</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>About the same</td>
<td>6.83</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>About the same</td>
<td>7.85</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>About the same</td>
<td>7.00</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
<td>About the same</td>
<td>4.00</td>
<td></td>
</tr>
</tbody>
</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2015)

**Emotional support**

Staff provided emotional support to patients to minimise their distress. This included counselling regarding antenatal screening and input from the bereavement midwife when required.

The trust employed a full time screening midwife whose role included counselling women whose screening results showed abnormalities.

The ward manager for the maternal assessment unit had also undertaken the role of bereavement midwife which involved developing guidance and a pathway for staff to use when caring for women suffering fetal loss and stillbirth.

A chaplaincy service was available at Ormskirk for anyone who wished to use this.

The perinatal mental health midwife was available throughout the week to provide advice and care for women who required additional emotional support. Staff told us that if needed the perinatal mental health midwife would complete postnatal visits.

**Understanding and involvement of patients and those close to them**

Staff involved women and those close to them in decisions about their care and treatment.

Staff we spoke to could give examples of a time when they had tailored care to meet a person’s individual needs including cultural and spiritual preferences.

The trust had a higher than average home birth rate (2.6%) and were proactive in supporting women’s preferences over place of birth. Midwives gave a recent example of a couple who chose to birth at home against advice. The woman had previously undergone caesarean section and this was a contraindication for homebirth according to trust policy and guidelines. The consultant midwife was involved in conversations with the couple about how they could best be supported and a thorough plan of care was put in place. They went on to have a successful birth at home without complications.

The service ran a homebirth class where women and their partners could attend to find out more information about homebirth and hear of experiences from women who had previously opted for a homebirth. Women who had chosen a homebirth but then been transferred into hospital for care were also invited to share their experiences as well.

Information sharing was discussed as part of the booking appointment so that women were aware of how their personal information was stored and shared with other agencies where appropriate.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The trust planned and provided services in a way that met the needs of local people.
The service recognised that a large portion of the population served were from out of area. This meant that a lot of women had to travel a significant way to get to antenatal appointments and services. This caused a number of women to opt to receive care with another provider even though this may not have been their preferred choice.

To improve services for women who were out of area, the trust had recently set up a separate team of community midwives who would run clinics in other areas. The team midwives would also work a mixture of shifts on the delivery suite so that they could care for any out of area women who came to the hospital in labour. The aim of this system was to provide better continuity of care for women.

At the time of our inspection, the out of area team was not fully implemented due to issues in sourcing equipment and clinical space for antenatal clinics to be held in the community. Plans were in place to resolve these issues and the midwives we spoke to were positive that once up and running the team would have a positive impact on women’s experiences.

A hypnobirthing course had recently been introduced at the trust for women and their partners and was free of charge. Hypnobirthing involves the teaching of techniques such as light touch and deep relaxation as ways of coping with pain in labour and partners are heavily involved in this. The course was oversubscribed at the time of our inspection and more midwives were scheduled to attend training.

We found that the facilities and premises were appropriate for service delivery needs. At our previous inspection we found that a room on the delivery suite was being used as a second obstetric theatre which was not fit for purpose. This room was no longer in use and the service was working with theatre staff to determine how a main theatre could most effectively be used. Plans were in place to refurbish room eight which had previously been used as a theatre and make this into another delivery room.

**Bed Occupancy**

From 2015/16 quarter 4 to 2017/18 quarter 1 (January 2016 to June 2017), the bed occupancy levels for Maternity at the trust were consistently lower than the England average. The trust had 34.3% occupancy in 2017/18 quarter 1 compared to the England average of 58.9%.

The chart below shows the occupancy levels compared to the England average over the period.
Meeting people’s individual needs

The service took account of women’s’ individual needs.

Any language barriers were identified when women rang to arrange their booking appointment and information could then be sent to them in their own language. The service had access to interpretation services and staff told us they would use face to face translation for appointments and when explaining screening results. However, we observed during a medical that staff had not used a translation service and said that this was due to financial restraints and that they would use a telephone application instead.

The unit was accessible by lift for women and relatives who could not use the stairs. There were accessible toilets on each ward and in the clinic area.

For women with complex social needs there was a safeguarding specialist midwife and a midwife specialising in adults in vulnerable circumstances who had both been proactive in liaising with local authorities to ensure effective information sharing.

Since our last inspection a specialist perinatal mental health midwife had been recruited and a specialist bereavement midwife role had been developed. This meant that women requiring input from mental health services could access this more readily and that midwives could gain advice and support from the perinatal mental health midwife.

Midwives could access advice and information from a specialist disabilities nurse from within the trust.

Women with multiple pregnancies received care and treatment in accordance with national guidelines. They were referred for shared care and reviewed regularly by the obstetric team. Discussions around timing and mode of delivery were recorded and reflected best practice determinate of the complexity of the pregnancy.
On discharge from the unit, a copy of the discharge summary was always sent to the woman’s GP and the community team. A summary could also be sent to other relevant services such as mental health teams, health visitors and local authorities so that women would receive the care and support they needed.

An alert could be placed on the online system to notify midwives and medics of any ongoing concerns or complex needs. The staff we spoke to were aware of this system and could demonstrate how to access alerts.

**Access and flow**

People could access the service when they needed it. Processes were in place to ensure that women had timely access to multidisciplinary input when needed.

The unit operated a 24 hour triage service located on the maternal assessment unit where women could ring for advice and attend for assessment if needed. There was a small waiting area on the maternal assessment unit and during our inspection we did not find this area to be crowded.

The midwives used a rating system on the maternal assessment unit in order to prioritise women depending on their clinical presentation. A rating would be given on the phone and again on arrival at the unit. Those rated red were seen immediately, amber within half an hour and there was no time limit for women rated green. These ratings were audited by the ward manager to ensure women were assessed in a timely manner and the audits demonstrated a positive outcome.

The service monitored any delays of two hours or more between women attending for induction of labour and treatment being commenced and any delays to time critical treatment. The maternity dashboard which displayed these results indicated that delays were not common.

Staff told us that there was a four to six week waiting list for an appointment in the diabetes clinic. This clinic added newly referred women to the end to ensure they were reviewed in accordance with guidelines and standards. This meant that the clinic often overran.

The unit had recently increased the number of scan clinics and had staff trained in ultrasound available on the maternal assessment unit which meant that women could access scan appointments easily when needed.

However, test results were not always reviewed and followed up in a timely manner. Community staff told us that it was their responsibility to chase results when they had obtained the sample or ordered the test. The midwives we spoke with told us that they were not allocated time outside of their usual workload in order to complete this which resulted in delays. There was no system in place for results to be chased in another midwife’s absence.

Midwives could give examples of occasions where results such as low iron levels had been missed and women had not received timely treatment as a result. This was a real concern for the midwives and had been escalated to their managers. Staff told us that managers had advised them there was nothing that could be done and they would have to find time to chase up results. At the time of our inspection no action had been taken to mitigate this risk and it was not indicated on the maternity risk register.

During our inspection we found that during one antenatal clinic at a GP surgery more than one woman had been booked onto the same appointment slot. This caused the clinic to run behind schedule and impacted the length of time the midwife could spend with each woman. The community midwives were not able to manage their own clinics by booking women in themselves; this was done by the GP receptionists. This was reported as an incident and escalated to managers at the time of our inspection.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
Not all the women we spoke with were sure of how they could raise a formal complaint but all felt that they would be comfortable to raise any concerns with a member of staff. Information on how women and relatives could make a complaint or provide feedback was displayed on notice boards in clinical areas.

Ward managers reviewed any complaints which were made and managers told us that they would often meet with women and their relatives to discuss their concerns. Managers recognised that it was common for women to wait a significant length of time before making a complaint and these complaints were taken seriously and handled in the same way as those relating to recent events.

Managers told us that the main theme identified from complaints was lack of communication from midwives. Learning from such complaints was addressed individually with midwives and shared via email and at team meetings which was evidenced in minutes from the meetings. However, when reviewing the information provided around the reasons for formal complaints, this was due to all aspects of clinical treatment.

Staff could give examples of learning from complaints such as improved communication with women and their families. A common example given was that partners were now permitted to stay with women on the maternity ward following feedback from women and families.

The service had recently implemented Talk to the Midwife sessions in which women and relatives were invited to attend and provide feedback to midwives on positive and negative aspects of care.

**Summary of complaints**

From July 2016 to June 2017 there were 18 complaints about Maternity. The trust took an average of 71.4 days (52.0 working days) to investigate and close complaints.

None of the 18 closed complaints about Maternity was closed in over 180 days and none of the three complaints that remained open at the time of response had been open more than six months. This meets the trust’s complaints policy which states that 95% of complaints should be closed within six months.

The most common subject of the complaints was all aspects of clinical treatment (12).

All the complaints related to Ormskirk and District General Hospital.

(Source: Routine Provider Information Request (RPIR) P61 Complaints)

**Is the service well-led?**

**Leadership**

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

Supervision of midwives ended earlier in 2017 meaning that midwives are no longer required to have a named supervisor of midwives and attend regular supervision. Senior staff were able to discuss the plans in place to provide support to midwives during this transition. Changes to staffing rota had been made to ensure that a senior member of staff was available until 8pm on weekdays and staff could contact a senior manager out of hours if needed. Staff who had expressed an interest had been allocated a place on the A-EQUIP training which is a continuous improvement process and was currently piloting a new model of midwifery supervision.

A consultant midwife was in post and was involved in collaborative working with other providers and could provide additional support to midwives caring for women with complex needs.
Staff found leaders to be visible and approachable. The maternity matron completed walk rounds in clinical areas such as clinics and wards but was less visible to the community midwives. Staff told us that they did not see the head of midwifery often but were aware of who she was. Staff generally felt comfortable raising concerns and escalating these to senior staff such as the head of midwifery. Most staff agreed that while they were able to raise concerns little was done in response to concerns raised.

The community midwives had raised a number of concerns including the storage of clinical equipment and medical gases in their own homes but were frustrated that their concerns had not been escalated by their managers. At the time of our inspection, the head of midwifery informed us that a meeting was being arranged with the community midwives to troubleshoot issues raised.

There was little evidence of succession planning in order to sustain effective leadership. Two of the midwives we spoke to were in developmental roles as managers which had been extended indefinitely from a six month position. They did not have set competencies to meet as part of their development and did not have regular meetings scheduled with other managers or more senior staff in order to develop their skills further. They had received no additional training specific to their development role.

The management structure within the organisation meant that the head of midwifery sat above the clinical directors. However, the clinical directors and head of midwifery told us that this was not evident in practice. The head of midwifery maintained a close working relationship with the clinical directors in order to have good oversight of the unit in spite of a demanding workload.

For example, the head of midwifery was also responsible for oversight of some nursing services, radiology and pathology as well as being encouraged to undertake bed manager responsibilities. This meant that she often had to spend time at the site in Southport which reduced her visibility at Ormskirk. The head of midwifery told us that while she was coping well under the strain of her workload her ability to lead and drive improvement within the service was impacted.

There was no board level lead for maternity services. However, the head of midwifery told us that she had access to the board when maternity services were being considered.

**Vision and strategy**

The service did not have a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

There was a quality improvement strategy in place at trust level and a corporate strategy which included the aim of eliminating preventable morbidity in maternity care within four years. Staff we spoke to were not aware of this and the action plan had not been implemented at business unit level at the time of our inspection.

At the time of our inspection, the service was facing uncertainty around sustainability and the future of service provision. Managers from ward level to the head of midwifery were awaiting the outcome from the Cheshire and Mersey Vanguard which was consulting on the provision of services in the area. This uncertainty had a significant impact in the morale, drive and motivation of staff at all levels and there was no clear message to staff about what direction should be taken in the interim.

Many staff described the strategy as “business as usual” with no impetus to improve services or encourage innovation within the service. Staff could not describe a clear vision for the service although most felt the unit would face closure or potentially be transformed into a standalone birth unit in the future. The head of midwifery was looking at the feasibility of a standalone birth unit but was uncertain of the demand for such a service in the area.
The head of midwifery was proactive in gaining access to the trust board when maternity services were under consideration but told us that information was not always feedback once escalated.

Senior managers were aware of the outcomes of the Maternity Review and standards set out in Better Births but at the time of our inspection there was no clear action plan for how these standards would be achieved.

**Culture**

Managers across the service did not always promote a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There had been improvements to culture within the service from our last inspection with the majority of staff reporting a more open and honest culture and better working relationships. However, managers were concerned that there were no effective measures in place to prevent things from “slipping back”.

Overall staff felt able to raise concerns and there were good working relationships between midwifery and medical staff. Conversely, some staff expressed concerns that there was a culture of bullying from some ward managers and midwives. A high workload and staff shortages caused tension between the community midwives which led to a stressful working environment.

There had been some effort to combat this through meetings and mediation with staff involved but this did not have a lasting effect or get to the root cause of the issues. Since our last inspection, most staff had attended resilience training to better cope with challenges and maintain their mental wellbeing.

Staff we spoke to about these issues either couldn’t or did not wish to share specific examples of bullying making it difficult to determine what the cause was of these issues.

Some staff felt valued and respected whereas others did not. Midwives working outside of the delivery suite generally expressed a perceived lack of understanding from other midwives and managers as to their workload and strains.

Some staff told us that there was a blame culture within the unit and that managers did not always look at the available information before reprimanding staff in reference to complaints handling. This impacted the morale of some staff members and affected their confidence in raising concerns.

The safety and wellbeing of staff was not always taken into consideration. Some staff felt well supported and their work schedule had been altered to better suit their needs but this was not consistent. Some staff were working long shifts where others were not and some staff had not rotated to other areas on request where other midwives felt they had no choice. Some staff commented that those who could “shout louder” got what they wanted.

Some midwives told us that due to shift patterns and the staffing rota they had sometimes had to work more than seven days in a row, had been on call three days in a week and time on call or working a night shift had encroached on their days off meaning they had less time to recover between shifts.

Staff at all levels had an awareness of Duty of Candour and could give an example of when this would be implemented. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.
Governance

Systems in place to assess, monitor and improve the quality of services were not always effective. There were governance structures in place and staff at all levels were aware of their roles and who they were accountable to and responsible for overseeing. However, some staff reported that their roles were expanding and sometimes the scope of their role prevented them from having the level of oversight they would ideally like to have.

The clinical lead for risk management was also responsible for reviewing and updating policies as well as being a consultant and carrying out this role. Staff told us that this reduced the amount of time that could be spent on each and as a result there were policies which were out of date and risks which had not been escalated and managed effectively. We found two out of five policies which had passed their review date. The risk to women around non-compliance with national guidelines relating to diabetes care had not been escalated and neither had the absence of a specialist diabetes nurse at clinic.

Attendance at weekly harm meetings was quorate and the trust had appointed a lead for sepsis and the deteriorating patient. Any stillbirths, intrauterine deaths or maternal deaths would be discussed at the harm meeting and escalated for review. Mortality review reports fed into the trust mortality surveillance committee.

All stillbirths were reported to the Each Baby Counts programme for learning at a regional level and discussed at the joint perinatal mortality meeting.

Management of risk, issues and performance

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Performance was monitored and reviewed by the use of a maternity dashboard which displayed outcomes such as delay in treatment, mode of delivery rates, incidents and staffing. The dashboard was updated monthly and we saw that the results were displayed on each ward we visited. Staff were able to identify areas for improvement from the dashboard and managers told us of action plans which had been implemented in order to improve performance.

There was a risk register for maternity services. At the time of our inspection there were 15 risks identified on the risk register. High risks listed included concerns around culture, access to information and medical staffing. There was a review date in place for each risk and all risks were within the review date. A clinical lead was assigned responsibility for each risk.

Incident reports were reviewed daily by a band six midwife and assigned a level of harm which was agreed at the weekly harm meeting. These risks were then escalated to the director of governance when necessary to do so. All severe or moderate incidents were subject to a full multidisciplinary review attended by clinicians, a member of the risk team and any relevant parties including the maternity matron.

A maternity care forum was held monthly. This received information from the harm committee and the meeting reviewed all action plans and followed up outstanding actions from incidents.

Any risks and performance issues could be escalated via the quality and safety report which was updated on a monthly basis. However, we found omissions in the Quality and Safety report dated November 17. In this policies had not been identified as past their review date, non-compliance with National Institute for Clinical Excellence (NICE) guidance in relation to diabetes in pregnancy and there was no evidence of the escalation of risks we had identified such as provision of a diabetic specialist nurse at the joint medical clinic.
Policies were developed using national guidelines and current best practice evidence. However, staff were unaware whether policies were reviewed by a panel prior to implementation. We found evidence of policies which had not been reviewed within the defined timescale. The policy around fetal monitoring was due for review in November 15 and had not been reviewed at the time of our inspection.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

There were systems in place to ensure the confidentiality of identifiable data, records and data management systems in line with data security standards.

The online records system was effective for use in information gathering for audit and reporting purposes. However, there were connectivity issues for community midwives meaning that information was not always accessible.

Staff did not always have access to the information they needed. For example, community midwives told us that they could not always access the online system during clinics which prevented them from viewing any alerts such as safeguarding alerts which would inform the care provided. This was detailed on the risk register and for review at the end of December 17.

Performance measures were monitored by the use of a maternity dashboard; the results of this were updated monthly and displayed on notice boards throughout the unit. The dashboard included indicators such as perineal trauma, delays in care and treatment and staffing. The information included was timely and accurate and used to improve the quality of care.

**Engagement**

The service engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborate with partner organisations effectively.

The views of women and their families were taken into account in order to shape and improve maternity services. They were invited to provide feedback at events such as Talk to the Midwife and the results of the Picker Institute patient experience survey were used to inform decisions around improvement. Feedback was also provided via the maternity Facebook page which was reviewed by managers and used to improve services.

Staff were less well engaged to shape and improve services. As an example, the workloads of the community midwives had recently been reviewed based on clinic sizes and the number of bookings and as a result clinic allocations were altered. The community midwives had not been consulted prior to this change and told us that managers had not taken into account mergers of certain primary healthcare services which affected the numbers of bookings. The transition of different midwives to different clinics had not included a handover of care from one midwife to the next and so the midwives expressed concern that they were not aware of ongoing safeguarding concerns.

The head of midwifery and consultant midwife attended meetings of the Cheshire and Mersey Vanguard aimed at standardising guidelines across the area and improving standards of care. The service was also represented at the maternity services liaison committee for Sefton which met quarterly and had a patient group attached to it.

**Learning, continuous improvement and innovation**

The service was not always committed to improving services by learning from when things go well and when they go wrong.
Improvement and innovation within the service was not driven by leaders and senior managers, instead staff were encouraged to take ideas forwards themselves. Some good work had come as a result of this including fundraising to refurbish the bereavement room for which staff won a trust Pride Award. This meant that change was limited to what was within the limits of the midwives themselves.

The service had taken steps to make improvements following an external review by the Royal College of Obstetrics and Gynaecology. Women were reviewed for electronic prescribing of blood products prior to surgical procedures and the service had invested in a blood dispensing machine which would mitigate the risk of not having transfusion services on site.

Consultant staff expressed to us that it would have been ideal for room eight which had previously been used as a second obstetric theatre to have been renovated into a theatre which was fit for purpose. At the time of our inspection this had not been put to the board for consideration as staff told us that it would not be approved due to financial constraints.

Staff expressed to us that due to the uncertainty around what the outcome of the Vanguard would be they felt any proposals or initiatives to improve services would not be taken forward when the service might be decommissioned.