Care Quality Commission

# Wrightington, Wigan and Leigh NHS Foundation Trust

# Leigh Infirmary

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this hospital | Good |
| Medical care (including older people's care) | Good |
| Surgery | Good |
| Maternity and gynaecology | Good |
| Outpatients and diagnostic imaging | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

The medical care services at the Leigh Infirmary provide neurological rehabilitation care for those with an acquired brain injury or neurological illness and elective diagnostic procedures such as gastroscopy, colonoscopy and flexible sigmoidoscopy. Taylor ward has 20 beds including 3 side rooms. The endoscopy unit was opened in May 2013 with decontamination facilities on the same site. There are two surgical wards, wards two and three, providing day case and short stay services.

At the Hanover Diagnostic Centre, the hospital offers an extensive range of urology services. The urology department is located in the Richmond unit and offers a range of services for patients including rapid access clinics, prostate assessment, vasectomy, haematuria, one stop and out of hours evening clinics.

The main outpatient clinic areas are situated on the ground floor of the infirmary in six 'areas'. These areas house a range of clinics covering colorectal, breast and orthopaedic surgery, diabetes, lipids, renal, urology, neurology, anti-coagulation, cardiology, chest, obstetrics and gynecology. The Hanover Diagnostic and Treatment Centre provide clinics for women's health, urology and endoscopy patients.

Diagnostic imaging and haematology services are also provided at Leigh Infirmary including ultrasound, plain film x-ray, barium enemas, and barium swallows with video-fluoroscopy and video-urodynamics.

We inspected the hospital between the 8 and 11 December 2015 as part of the comprehensive inspection of Wrightington, Wigan and Leigh NHS Foundation Trust.

Overall we found the hospital provided good services across the four domains of effective, responsiveness, caring and of being well led. However they required improvement in safety in medicine and effectiveness in maternity and gynaecology.

Our key findings were as follows:

- Staffing levels were adequate to meet the needs of patients at the time of the inspection.
- Staff received training appropriate to their role however uptake of some training could be improved especially in Mental Capacity Act training.
- Care was provided in clean and tidy surroundings and infection control practice was good. However the environment on Taylor ward did not fully meet the needs of the patients and were not conducive with safe patient care and the storage of waste was not always safe.
- Food and drinks were available and suitable to meet the varied needs of patients.
- Discharges from Taylor ward were not always timely.
- Care was not always supported by robust policies, procedures and guidance and not always adhered to.
- The use of restraining lap belts on one ward had become custom and practice and individual risk assessments had not been completed.

We saw several areas of outstanding practice including:

- Urology staff offered 'one-stop' appointments for haematuria patients which enabled patients to undergo biopsies during initial appointments rather than having to re-attend on another day.
- A trust 'pioneering staff engagement' programme was in place across a multi-disciplinary team with a number of innovating programmes in progress. The service had received several awards over the past two years.

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

# Summary of findings

Importantly, the trust must:

- Ensure safeguarding, mental capacity act (2005) and deprivation of liberty safeguards are in place and followed to ensure patients safety at all times. Processes must be clearly defined, understood and followed by staff.
- Improve mandatory training uptake particularly mental capacity act training.
- Ensure that there is adequate space on the wards for patients to receive safe and effective care.
- Ensure that there are adequate facilities to store clinical waste safely.
- Ensure care is delivered as per evidence based guidance.

In addition the trust should:

- Improve the timeliness of patient discharges from Taylor ward.
- Improve staff annual appraisal rates.
- Keep trolleys containing patients notes locked
- Improve the completeness of records particularly with name and designation always clearly recorded and printed and consent forms available to review.
- Review local rules held in the radiology department and ensure staff can locate them if required.
- Review dosage instructions for adrenaline administration to treat anaphylaxis and ensure they are satisfied instructions are easy to interpret in an emergency.
- Review the benefit of documenting processes for organising staffing for outpatient clinics.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Why have we given this rating? |
|---|---|---|
| **Medical care (including older people's care)** | Good  | There were concerns in relation to staff understanding and processes around the Mental Capacity Act (2005) and the Deprivation of Liberty safeguards (DoLs). Completion of patients assessments on Taylor ward were inconsistent and trust policy was not always followed. Staff who had completed mental capacity act training was within the trust target although it was unclear as to which specific staff this included. The trust target was 95%.<br>There was limited space in some areas of Taylor ward. Clean equipment was stored in an unsecure sluice which increased the risk of cross infection and clinical waste was in an unlocked metal cage on the corridor accessible to members of the public. We found records were left unlocked on the wards we visited, a risk that personal information was accessible to members of the public.<br>There were governance structures in place which included a risk register. However there was no date for completion on the actions identified to lower the risk which meant it was unclear if the risks were being managed effectively. Incidents were reported through effective systems and lessons learnt or improvements made following investigations were shared.<br>Staff followed good hygiene practices and there were good systems for handling and disposing of medicines. The majority of areas on the wards were clean but there was equipment on Taylor ward that wasn't.<br>Staffing levels were good across the ward and multidisciplinary team meetings were held on a regular basis to review patients. Team meetings were held on all wards to ensure that information was passed down to staff to improve patient care.<br>Staff had access to information they required and best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. All staff knew the trust vision and said they felt supported and that morale was good. Patients were observed receiving compassionate care and their privacy and dignity were maintained |
| **Surgery** | Good  | Staff were enthusiastic and proud of the services they provided. Staffing levels were sufficient and a safer |

nursing care staffing tool was utilised to ensure staffing levels were adequate. Medical staff rotas were in place and locum agency staff filled any gaps when the service was short staffed. Staff morale was good and staff felt well supported.
Incidents were reported and lessons learnt shared. Staff knew how to access the incident reporting system and could tell us about incidents they had reported. There were low incidents of pressure ulcers and infections.
Risk assessments were completed and staff implemented measures to reduce risks.
The environment was clean and tidy and staff had access to the equipment they required to do their jobs.
Medicines were managed safely and stored securely.
Referral and discharges worked well and staff shared relevant information. Services were coordinated and patients were appropriately referred to specialist services. Staff treated patients with respect and dignity, offered support and included them in their care planning. Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach. Referral to treatment times for the hospital were similar to or above the national average.
Risk registers were in place and discussed at team meetings. Staff were aware of the trust's values and vison. Staff felt well-supported by managers and colleagues.

## Maternity and gynaecology

**Good**

The maternity and gynaecology services at Leigh Infirmary required improvement in the effective domain but were good in the other domains.
Policies were not always clear or followed current guidelines. Staff knew how to report incidents. Lessons were shared and, however; there was no integrated trust wide learning system. All areas were visibly clean and tidy and staff followed hygiene procedures.
Daily checks of equipment were completed, but systems for monitoring the maintenance of equipment were not robust. Safeguarding processes were in place and under review. Medicines were stored in secure cupboards and daily checks completed. Records for patients receiving surgical care and termination of pregnancy were reviewed and completed appropriately.
Staff had received mandatory training relevant for their role however there was room for improvement in the uptake of Breastfeeding for midwives, basic life support

# Summary of findings

training by medical staff and delirium training by all staff. Medical staffing numbers were adequate for the patient's needs. Any shortfall in staffing levels was supported by bank nurses.

Trust guidelines were in place; however these were not always clear or adhered to. Two guidance documents for the management of termination of pregnancy gave differing guidance. Guideline reviews were not robust in that they did not always include reviewing the references on the document. The trust participated in a number of local and national audits.

Women were assessed for pain relief and supported individually postoperatively. Patients breast feeding was supported in the community, however; the numbers decreased after discharge from postnatal care.

Midwives were annually assessed by their supervisors and other staff had been appraised to be competent although midwives did not rotate.

Services were available on weekdays only. Ward two carried out elective day-case surgery and clinics were at Leigh for routine antenatal and gynaecology appointments. Community staff had limited access to records due to a lack of computers.

We observed positive interactions between patients and staff. We observed staff actively engaging with patients in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed.

The service had been planned across the geographical location. Gynaecology clinic services were based in the women's centre at Leigh Infirmary. The antenatal clinics were being supported by main outpatients as they are in the process of relocating to refurbished premises in the former ward one. Each maternity patient was allocated a named midwife, in the community. Antenatal clinics were available across the Wigan and Leigh areas in GP surgeries.

There were specialist midwives including public health, safeguarding and a mental health nurse. Also diversity and dementia champions were available. Any patient identified with a learning disability or mental health issue were supported on an individual basis as needed.

Midwives were not clear about the trust vision and strategy. There were regular senior meetings that were cascaded to staff but staff felt that meetings with them

needed to be more formal. Staff felt that they were supported by their managers; however hospital midwives felt there were fewer opportunities for them to develop than in the community.
A trust 'pioneering staff engagement' programme was in place across a multi-disciplinary team with a number of innovating programmes in progress. The service had received several awards over the past two years. Policies were not always clear or followed current guidelines.

## Outpatients and diagnostic imaging

Good

Whilst low numbers of incidents were recorded by the departments those that were reported were graded according to risk and shared to promote learning. There was an open and honest culture amongst staff. The environment differed depending upon location. Whilst the outpatient department was dated with little natural light, the Hanover Centre was light and spacious following refurbishment in 2013. The areas we inspected were visibly clean and tidy.
Safeguarding was managed by a central team who advised and supported staff who had been trained according to the level of contact with patients and those close to them. Patient risks were managed with resuscitation trolleys in departments.
Staffing was adequate with few vacancies and little or no use of agency staff. Staff used guidelines, procedures and policies to provide care for patients. Departments undertook audits and presented findings to colleagues to promote learning and improve services.
Staff received appraisals and were given opportunities to enhance learning. Radiology services were provided seven days a week. Outpatient clinics were not routinely provided on a seven day basis but clinics were held in the evenings and occasionally on a Saturday morning to manage waiting lists.
Patient records contained the necessary information. However medical signatures were not always legible and registration numbers and printed names were not always included. Approximately ten patient records per month were unavailable for clinic appointments. Staff accessed the electronic systems or contacted GPs if information was not available.
Staff understood consent and we saw evidence that written or verbal consent was obtained when required.
Outpatient services documented standards to maintain high levels of service and these were displayed for patients and visitors.

# Summary of findings

Patients were happy with the care they received and said staff had a polite and compassionate manner.
Patients felt supported by staff during appointments.
A range of initiatives were in place to meet people's needs.
The hospital met the department of health target of providing appointments for patients within 18 weeks. Ninety seven percent of patients referred for an urgent appointment for suspected cancer were seen within the department of health target time of two weeks. On average patients received appointments within 19 days for non-obstetric ultrasound scans, and two days for x-ray.
Waiting times following arrival in clinic varied depending on the type of appointment. At the time of our inspection there were no visible delays for patients waiting to be seen. Reporting time for scan results was one to two days. However, in September 2015, 1,367 x-rays were waiting for reports to be completed across all sites. Further staff were being recruited to manage this.
Verbal complaints were dealt with at the time through communication if possible, but verbal complaints were not always recorded by staff. Those that were recorded were monitored with results shared monthly to promote learning.
Staff had ideas about how to improve services. Trust values were evident in the areas we inspected.
Governance meetings were held monthly. Risk was managed through a local risk register which documented the issue, mitigation, risk score and review date of each risk.
Staff felt supported by managers and services engaged with the public, through forums and questionnaires.
Urology staff offered 'one-stop' appointments for haematuria patients which enabled patients to undergo biopsies during initial appointments rather than having to re-attend on another day.

# Leigh Infirmary

## Detailed findings

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

# Detailed findings

## Contents



## Background to Leigh Infirmary

The medical care services at the Leigh Infirmary provide neurological rehabilitation care for those with an acquired brain injury or neurological illness and elective diagnostic procedures such as gastroscopy, colonoscopy and flexible sigmoidoscopy. Taylor ward has 20 beds including 3 side rooms. The endoscopy unit was opened in May 2013 with decontamination facilities on the same site. There are two surgical wards, wards two and three, providing day case and short stay services.

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## Our inspection team

Our inspection team was led by:

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

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

The team included a CQC Inspection Manager, four CQC inspectors and a variety of specialists including Junior doctor, Practice Development Matron, Consultant physician, Clinical Nurse Specialist: Infection Prevention & Control, Consultant Haematologist, Vascular Surgeon, Matron for Theatres and a Health Care Assistant.

We did not have any Experts by Experience on the team but held a listening event on 2 December 2015 which was attended by a number of local people who had experienced the services at Wrightington, Wigan and Leigh. It was also attended by the local Healthwatch team who shared information they had received about services.

# Detailed findings

## How we carried out this inspection

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

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

The inspection team inspected the following four core services at Leigh Infirmary:

- Medicine
- Surgery
- Maternity
- Outpatients

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We received feedback through focus groups. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Wrightington, Wigan and Leigh hospitals.

## Facts and data about Leigh Infirmary

In 2014, there were 35,277 surgical stays trust wide serving a population of around 320,000 people in the Wigan and Leigh area. At Leigh Infirmary 99% of surgical stays were day cases and 1% were elective and patients stayed overnight.

At Leigh Infirmary between April 2015 and November 2015, 2470 antenatal appointments were attended and a total of 305 medical terminations of pregnancy (TOP) were carried out and 66 surgical TOP's.

Between January 2014 and December 2014 the service provided 188,707 patient appointments, 21% of which were new appointments and 53% were follow up appointments.

On average radiology staff see 85 patients each weekday and between 30 and 50 patients at the weekend.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

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

## Notes

# Medical care (including older people's care)

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

## Information about the service

The medical care services at the Leigh Infirmary provide neurological rehabilitation care for those with an acquired brain injury or neurological illness and elective diagnostic procedures such as gastroscopy, colonoscopy and flexible sigmoidoscopy.

Taylor ward at Leigh Infirmary has 20 beds including 3 side rooms. The endoscopy unit was opened in May 2013 with decontamination facilities on the same site.

We visited Leigh Infirmary as part of our announced inspection on 10th and 11th December 2015. During inspection we visited Taylor ward and the endoscopy unit. We reviewed the environment, staffing levels and looked at five care records and five medication records. We spoke to three patients and fifteen members of staff of different grades including nurses, doctors, ward managers, ward clerks, allied health professionals along with senior managers who were responsible for medical services. Due to the care being provided at the time of the inspection we were only able to speak to three patients but spoke to relatives at the listening events.

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

## Summary of findings

We rated medical services at Leigh Infirmary as requires improvement in safe and good in the effective, responsive, caring and well led domains.

There were concerns in relation to staff understanding and processes around the Mental Capacity Act (2005) and the Deprivation of Liberty safeguards (DoLs). Completion of patients assessments on Taylor ward were inconsistent and trust policy was not always followed, for example the trust mental capacity assessment form was inconsistently completed. It was unclear if there was any trust defined guidance for staff in the appropriate use of lap straps on wheelchairs in line with the principals of the mental capacity act and consent.

The number of staff who had completed mental capacity act training across the wards was within trust target however it was unclear as to whether these figures included medical staff and allied health professionals.

There was limited space in some areas of Taylor ward including around bed bays and bathrooms. Clean equipment was stored in an unsecure sluice which increased the risk of cross infection and clinical waste was in an unlocked metal cage on the corridor which was accessible to members of the public.

# Medical care (including older people's care)

We found records were left unlocked on the wards we visited and although staff were present in these locations at all times; there was a risk that personal information was accessible to members of the public.

There were governance structures in place which included a risk register. However there was no date for completion on the actions identified to lower the risk which meant it was unclear if the risks were being managed effectively. Incidents were reported through effective systems and lessons learnt or improvements made following investigations were shared.

Staff followed good hygiene practices and there were good systems for handling and disposing of medicines. The majority of areas on the wards were clean but there was equipment on Taylor ward that wasn't.

Staffing levels were good across the ward and multidisciplinary team meetings were held on a regular basis on Taylor ward to review patients this ensured information was passed down. Team meetings were held on all wards to ensure that information was passed down to staff to improve patient care.

Staff had access to information they required, for example diagnostic tests and risk assessments and best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. All staff knew the trust vision and said they felt supported and that morale was good. Patients were observed receiving compassionate care and their privacy and dignity were maintained.

## Are medical care services safe?

**Requires improvement**

We rated the medical services as 'Requires Improvement' for Safe.

Taylor ward was situated on a site which was owned by a neighbouring NHS mental health trust who had been asked to vacate the location. The environment of Taylor ward was on the risk register and a business plan was in place to find alternative accommodation for the ward by November 2016 which included carrying out remedial work. The Trust informed us that the Taylor Unit was part of a GM wide service, where there was a lack of capital funding, and that the Trust was committed to finding a solution to the quality of the building. At the time of the inspection, the future of this service had been under review at a Greater Manchester level, no alternative accommodation had been found and no decision had been made with regard to the future of the Taylor Unit and neuro-rehabilitation service at the Trust. The future of the Taylor Unit was on the Corporate Risk Register discussed, at the Trust's Risk & Environmental Management Committee (REMC) on a monthly basis and had been escalated to the Quality and Safety Committee and Trust Board in accordance with our Governance and Risk Management Processes.

On Taylor ward space was limited around the bed bays and bathrooms. Clean equipment was stored in an unsecured sluice area increasing the risk of cross infection. Clinical waste was accessible to patients and the public in the corridor and an open sharps box containing sharps was on top of the resuscitation trolley which presented a risk to people.

All areas on the wards were generally clean and free from odour however some equipment was not clean on Taylor ward. We observed all staff following good hygiene practice and there was personal protective equipment available on the wards.

Staff attended mandatory training courses and compliance rates for nursing staff was mainly above the trust target however compliance for medical and dental staff were mainly below target (with the exception of

safeguarding and high risk conflict training). All of the equipment had up to date electrical safety certificates other than one which had no evidence of any electrical testing.

Patient's records on both units were not locked away however they were kept securely in an area which staff where in attendance at all times.

Records we looked at were clear and legible with completed risk assessments. Staff had knowledge regarding safeguarding and were aware of how to access the safeguarding team. Incidents were reported by staff through effective systems and lessons learnt and improvements made following investigations were shared.

The endoscopy unit was fit for purpose, clean and spacious. The decontamination unit on site supported efficient service delivery.

**Incidents**

- There were systems for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents.
- Staff we spoke with felt they were well supported throughout the process when they reported incidents.
- From August 2014 to July 2015 medical services trust wide reported 1857 incidents. 11 of those were serious incidents. These were mainly in relation to pressure ulcers, ward closures and infection control issues. The other reported incidents were rated as low or moderate harm. This indicated that the service had a positive culture of reporting incidents.
- Serious incidents were reported and actioned appropriately in a timely manner. Staff felt they were supported throughout the process, lessons were learned and action plans implemented which were shared with the rest of the team.
- There were examples of learning and changes to practice following an incident. For example the blood pressure machine was now charged in a separate area following a member of staff tripping over an electrical lead to the blood pressure machine in the endoscopy unit.
- Minutes of key governance meetings in medical services showed that incidents and learning were discussed and actions identified to improve care provided. For example the inclusion on the incident reporting system of additional categories for neurological observations.
- The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. 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.
- Multidisciplinary mortality and morbidity reviews were held and medical services had identified key themes, for example, poor documentation and access to hospice care. The themes were discussed at key governance meetings to identify learning for each ward. These were disseminated to staff.

**Safety thermometer**

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- From October 2014 to October 2015 there were three falls resulting in harm on Taylor ward and two catheter acquired urinary tract infections.
- The trust had a falls team which undertook a rapid review of the care of all patients who had fallen. Learning from these reviews included the introduction of 14 safety matrons across the trust

**Cleanliness, infection control and hygiene**

- Between June 2014 and April 2015, the trust overall infection rate was sometimes worse and sometimes better than the England average. However between April 2015 and September 2015 there have been no reports of methicillin-resistant staphylococcus aureus (MRSA), methicillin-susceptible staphylococcus aureus (MSSA) or Clostridium Difficile on Taylor ward.

- There were sufficient number of hand washing sinks and hand gel was available. Hand towels and soap dispensers were adequately stocked and personal protective equipment, such as gloves and aprons, was available throughout the ward areas.
- During the inspection we observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.
- The majority of areas were visibly clean and free from odour, however, on Taylor ward we observed a mobility aid and assisted seat in the toilet that were not clean.
- On Taylor ward we observed a toilet which was also being used as a sluice room. The sluice door was unlocked and during our inspection we witnessed a visitor accessing the room. This door was locked once we highlighted it to the manager. We raised this issue with the Trust at the time of the inspection and the trust sent an improvement plan which was put in place on 06/01/2016 to ensure the sluice door be locked at all times and visitors be directed to the appropriate toilet.
- The trust used the national colour coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection. Cleaning storerooms were generally clean and tidy. However on Taylor ward colour coded cleaning buckets were inappropriately stored increasing in the risk of cross contamination.
- On Taylor ward we observed an example of poor practice of clearing clinical waste as there were used surgical gloves in a bag in attached to blood pressure monitoring equipment, this posed an increased infection risk.
- We observed inappropriate storage of patient manual handling equipment on Taylor ward which was stored next to clinical waste this increased the risk of cross contamination.
- Infection, prevention and control (IPC) audits and hand hygiene audits were carried out on a regular basis across the trust. These identified good practice and areas for improvement. Key actions were identified to be implemented by the staff team, for example reminders were sent to staff to ensure they had access to products and were familiar with the trust policy for dealing with spillages such as blood and body fluids.
- Between March 2015 and August 2015 Taylor unit were 100% compliant with infection control spot audits and from April 2015 to November 2015 hand hygiene audits were also 100%. Some of our observations during the inspection do not reflect these results including storage of clean materials in the sluice area.
- Hand hygiene audits performed on the endoscopy unit from April 2015 to November 2015 showed compliance rates of 94.4% to 100%.
- Infection control audits performed on the endoscopy unit showed an overall score in November 2015 of 93.9% and in December 95.7%. The audits identified key areas for improvement however no action plans were in place. In November 24 improvements were identified , of those 12 remained outstanding during the audit in December 2015.

**Environment and equipment**

- In order to maintain security of patients, visitors were required to use the intercom system outside the wards to identify themselves on arrival before they were able to access the ward.
- The endoscopy unit opened in May 2013 and was fit for purpose with same sex changing, waiting and recovery areas. In addition there were also two side rooms with ensuite facilities which were used for patients requiring bowel preparation.
- A decontamination unit was on the same site; this assisted staff in providing an efficient service to patients on the endoscopy unit. The unit was fit for purpose, spacious and clean.
- In February 2015 a Health and Safety Support Visit (HSSV) was undertaken in the Endoscopy Unit. The purpose of the visit was to provide the Manager with advice, guidance, and where necessary, support in the interpretation and implementations of health and safety policies and procedures. Following the visit recommendations were made, for example to ensure

all equipment was on the department inventory register and required inspection, maintenance and servicing was scheduled. All equipment we reviewed had been maintained and serviced.

- The environment on Taylor ward was on the trust risk register and a business case had been drafted as the ward was required to be relocated by November 2016. This also included remedial work to be carried out to bring the facilities in line with service specifications. At the time of inspection it was unclear if any remedial work had been carried out and staff told us that a suitable location to accommodate the unit had not been found. Following trust review 1st November 2015 the risk remained high with a score of 20. The Trust informed us that the Taylor ward was part of a GM wide service, where there was lack of capital funding, and that the Trust was committed to finding a solution to the quality of the building.
- We observed one bed whose bedframe was touching another bed to allow space for a chair. Therefore there was an increased risk of cross infection, falls and space for staff to support patients was limited. Staff we spoke with acknowledged lack of space was a problem on the ward.
- We observed that there was reduced space in bathrooms as doors opened inwards and not outwards. However, the trust informed us that an appropriate larger bathroom was used for patients who required hoisting and other assistance. The Trust is in the process of changing these for sliding doors and two have been completed
- On Taylor ward oxygen cylinders were stored on the corridor. However the trust informed us they were stored in line with trust policy. Cylinders are stored within the unit in readiness for use, they are stored in an appropriate trolley which complies with Trust policy and has been agreed with the Authorising Engineer (MGPS).
- Clinical waste and closed sharps boxes were inappropriately and insecurely stored and accessible to the public on Taylor ward. Department of Health guidance on the safe management of healthcare waste (HTM 07-01) states: "Storage areas at the point of production should be secure and located away from public areas."
- On Taylor ward a store cupboard containing needles, bandages and syringes was not locked and therefore accessible to patients and the public.
- Resuscitation equipment for each ward was readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of equipment had taken place on the units we visited with tamper safe seals intact. However on Taylor ward two of the three ECG electrode packs had expired.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use. However on Taylor ward an open sharps box containing used sharps was placed on top of resuscitation trolley. This was brought to the attention of the ward manager, who closed it immediately.
- There were systems in place to maintain and service equipment. Portable appliance testing (PAT) had been carried out on electrical equipment regularly and electrical safety certificates were in date. Hoists had been serviced appropriately. However a blood pressure machine on Taylor ward had no evidence of ever being PAT tested.
- Patient Led Assessments of the Environment (PLACE) assessments in 2015 at the hospital showed all assessment scores were higher than the England average including cleanliness which was 100%.The England average for cleanliness was 97.6%.

**Medicines**

- Pharmacists were based at Royal Albert Edward Infirmary. A Pharmacy technician visited Taylor ward twice weekly to order medication for patients and undertake medicine reconciliation.
- The current mechanisms for medication stock control lacked robustness and staff told us this sometimes resulted in overstocks of medication.
- On Taylor ward medicines requiring cool storage were appropriately stored in a locked fridge in the clinic room. Daily temperature checklists were completed and recorded as within range.

- Suitable cupboards and cabinets were in place to store medicines. Controlled drugs (medicines which are required to be stored and recorded separately) were stored appropriately. All drugs randomly checked were within date. Daily check records in November and December were reviewed and all but one day over these months was completed.
- We looked at five patient's prescription records which were fully completed, dated and signed and both had the patients allergy status documented.
- We saw that antibiotics, for patients who required them, had all been prescribed in line with guidance.
- Medication errors and risks identified were discussed at medicines clinical quality meeting. The trust completed a report following reviewing incidents of medication errors. There were 1129 incidents reported across the trust including two serious resulting in injury between August 2014 and July 2015.
- There was medicines safety newsletter available on the intranet for staff.

**Records**

- We looked at five care records and saw that entries were legible and complete. They included a range of risk assessment and care plans that were completed on admission and reviewed throughout a patient's stay. Patients had an individualised care plan.
- At the time of the inspection we observed patient records were in sight of staff at all times. They were stored in a records trolley by the nurse's station on the endoscopy unit and in the main office on Taylor ward.
- The trust undertook regular record keeping audits twice a year. The last audit in May 2015 showed that errors were not being crossed out correctly and were not signed and times when entries were written were not always documented. Patient number and the role of clinician making the entry were poorly recorded. Recommendations had been identified which included ensuring that staff crossed out any error with a single line only and were signed and dated separately. The trust plan to re audit records the following year to determine if improvements have been made.

**Safeguarding**

- Training statistics provided by the trust showed that the majority of the staff across the hospital had completed safeguarding adult training. Compliance rate at the hospital was mostly above the overall trust target except for medical and dental staff whose compliance rate was 86%. The Trust target was 95%. Safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- The trust had a designated safeguarding team who were accessible 24 hours a day, seven days a week and there was a system for raising safeguarding concerns. Staff we spoke to were aware how to access the safeguarding team.
- Between April 2014 and March 2015 there had been 526 contacts trust wide with the safeguarding team regarding adult safeguarding referrals across the trust. This resulted in 271 actual safeguarding referrals.

**Mandatory training**

- Staff received mandatory training on a rolling annual programme in areas such as safeguarding, health and safety, fire, manual handling and infection control and prevention.
- All the staff we spoke to said they were up to date and had completed all their mandatory training.
- Information provided by the trust at the time of our inspection showed that mandatory training compliance rates for nursing and midwifery staff at the hospital was mostly above the trust target of 95%. Staff on the endoscopy unit and Taylor ward were compliant with dementia, basic life support and mental capacity act training.
- Compliance rates for medical and dental staff across the hospital were below the trust target of 95% for all mandatory training with the exception of safeguarding children and high risk conflict training.

**Assessing and responding to patient risk**

- A modified early warning score system (MEWS) was used throughout the service to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- We saw evidence in a patient's record of when the MEWS had been used in a deteriorating patient who was transferred to AE at The Royal Albert Edward Infirmary for management of their condition.

# Medical care (including older people's care)

- On the endoscopy unit staff had access, if needed, to an anaesthetist and a senior nurse who covered theatre Monday to Friday for any deteriorating patients.
- We reviewed five patients' records and found that all necessary documentation was completed to ensure that patients risk was assessed and care was managed safely.
- The endoscopy unit at the hospital provided care for patients who were low risk. Patients who were high risk were treated at Royal Albert Edward Infirmary (RAEI). Staff said they had occasionally identified higher risk patients on admission and these had been redirected to have the procedure performed at the RAEI.
- Upon admission the ward staff on Taylor ward carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, pressure ulcer and nutrition (Malnutrition Universal Screening Tool or MUST).
- Therapists we spoke with on Taylor ward said they carried out initial assessments on patients within one day of being admitted for example moving and handling assessments and if required wheelchair assessments.
- We reviewed two patient's records on Taylor ward and saw that each patient had been seen on a daily ward round and had had a senior review.

**Nursing staffing**.

- Each ward had a planned nurse staffing rota and reported to senior managers on a daily basis if vacant shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust. Medical wards undertook the audit every three months. Taylor ward displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- We looked at staffing levels on Taylor ward between June 2015 and October 2015. The average percentage of nursing shifts filled as planned during the day was 89.8% and during the night the average staffing fill rate for both nursing and care staff was over 100%.
- Staff on Taylor ward assured us that additional staff were available through either agency or their own staff to cover patients who required 1:1 nursing care.
- The number of nurse vacancies in medical services across the trust was low. On Taylor ward the vacancy rate was 0.1%. The turnover rate of nursing staff was also low at 3.1%. Staff sickness for April 2014 to April 2015 was 6.9%.
- The number of agency and bank staff used on Taylor ward was between 1.1% and 8.2% from April 2014 to March 2015. Agency staff were given an induction before commencing work.
- Staff on the endoscopy unit said they used their own nurses to cover for sickness or leave. The data provided by the trust showed no agency or bank staff were used between April 2014 and March 2005 on the endoscopy unit.
- We currently have no further figures regarding staffing on the endoscopy unit. This has been requested from the trust but not received; this meant that we were not assured that staffing levels were adequate on the endoscopy unit. Although staff raised no concerns in respect to staffing levels.

**Medical staffing**

- At the time of inspection there were no medical vacancies on Taylor ward. The turnover rate for medical staff on Taylor ward was 40% which equates to one whole time equivalent and 0% staff sickness for the last financial year.
- The use of locum medical staff across medical services trust wide during April 2014 and March 2015 was low. From the data provided by the trust no figures were recorded for medical services at the hospital. This suggested that locum medical staff were not used for Taylor ward or the endoscopy unit.

**Major incident awareness and training**

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff in medical services had been involved in major incident exercises.

## Are medical care services effective?

# Medical care (including older people's care)

Good

We rated the medical services as 'Good' for effective

Most staff had received their annual appraisal. However current annual appraisal figures were not available for Medical and dental staff with only data up to March 2014 provided by the trust.

Care and treatment was provided in line with national and best practice guidelines and medical services participated in the majority of clinical audits where they were eligible to take part.

The endoscopy unit had been formally recognised that it had competence to deliver against the measures in the endoscopy GRS standards and has received JAG accreditation in August 2015. The summary of the JAG accreditation assessment report was in the reception area for staff and the public to see.

The number of staff on the wards who had completed mental capacity act training was within trust target although it was unclear as to which specific staff this included.Staff on Taylor ward were aware of the mental capacity act (2005) and deprivation of liberty safeguards (DOLS) however knowledge and interpretation of this legislation was varied.

Rehabilitation services on Taylor ward and elective diagnostic services were not accessible to patients seven days a week as services were provided Monday to Friday. The average length of stay for rehabilitation services at the hospital was longer than the England average however the risk of readmission was lower than the England average of 100 days.

Patient's assessments were not completed consistently and Trust policy was not always adhered to. The staff did not recognise that a lap strap was a form of restraint or when consent was required. It was uncertain if there was any guidance for staff regarding the inappropriate use of lap straps on wheelchairs in line with the mental capacity act.

**Evidence-based care and treatment**

- Medical services participated in the joint advisory group on GI endoscopy (JAG) and received JAG accreditation for the endoscopy unit in August 2015. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.
- Medical services were using national and best practice guidelines to care for and treat patients. These included diabetes care and MUST screening. The trust monitored compliance with NICE guidance and were taking steps to improve compliance where further actions had been identified.
- The trust reviewed local and regional clinical audits rom 1 April 2014 to 31 March 2015 and actions were identified. For example the catheter care passport was introduced at the trust 18 months ago to provide patient held documentation in relation to on-going management and care of their indwelling catheter. Recommendations stated staff should update documentation with relevant information at each catheter change and access the catheter care e-learning module. Audit actions were monitored at monthly audit meetings as well as Divisional Quality Executive meetings
- We reviewed examples of recent local audits completed on the wards, these included consent. The consent audit concluded that although there was good practice, improvements were required. Recommendation's identified documentation needed to include printing name, job title and to offer patients a copy of the consent form. The name and job titles were printed on the records we reviewed.
- Following a number of medication errors in relation to the wrong patient, a multi-speciality patient identification audit was performed to assess staff compliance to the trust standard operating procedure for administering medication. The audit concluded that compliance was excellent however it highlighted discrepancies. This included access to printed wrist bands, the number of staff on medicine rounds and ensuring patient information corresponds with bed numbers and whiteboard. Heads of Nursing disseminated information and recommendations following audits to staff. The trust have told us they will be re auditing to review the implementation of actions in 2016-2017.

- Staff said they received the results of the audits and any learning was shared with them in team meetings. We observed this on the minutes of a meeting.

**Pain relief**

- The trust used a recognised pain tool to assess pain for those patients who had a cognitive impairment such as dementia or a learning disability.
- Patients having a procedure on the endoscopy unit were provided with pain relief which was managed on an individual basis. Staff told us patients were offered entonox during their procedure if required.

**Nutrition and hydration**

- A coloured tray and jug system was in place across the trust to highlight which patients needed assistance with eating and drinking.
- Patients' nutritional status was assessed using MUST assessments and fluid balance charts were completed on patients whose intake and output required monitoring.
- Specific dietary requirements including coeliac and diabetic food were available if required. If patients missed a meal for example they were not on the ward at the time, staff ordered a snack for them. Patients on Taylor ward could also have their breakfast when it suited them and could eat their meals in the communal dining area or by their beds.
- In the endoscopy unit there was a patient's kitchen in which staff had facilities to make drinks and store sandwiches for those who had missed their meal.
- During our inspection we observed patients being offered and provided with drinks and food. No negative feedback regarding the food was given during the inspection.

**Patient outcomes**

- The rehabilitation service at Leigh Infirmary had a longer than average initial stay of 58 days compared to national length of stay of 30 days, however this had a positive effect in that the risk of readmission to the hospital was better than the England average.
- Staff told us they input data into UKROC which evaluates development of services by looking at patient's needs. UK specialist rehab outcomes collaborative (UKROC) is a national data base for collating case episodes for inpatient rehab.
- The trust took part in the National Diabetes Inpatient Audit in 2013. The trust scored above the England average in 14 of the 21 measures. The Trust scored 100% on the questions about staff knowledge regarding Diabetes. This is the most recent data available.

**Competent staff**

- According to trust figures at the end of September 2015, 95% of allied health professionals and 96% of nursing staff at the hospital had received their annual appraisal. Data was only provided up to March 2014 for medical and dental staff where 90% had received their annual appraisal. The trust target was 85%.
- Consultants said that the trust had fully embraced the appraisal system and it was a supportive and constructive process.
- Staff said they were supported to access any relevant training to support their personal and professional development. For example, two nurses on the endoscopy unit were trained endoscopist and a further three were currently undertaking this training.
- All new nurses on the endoscopy unit were supernumerary for the first 3 months. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- There was a preceptorship programme which supported junior nursing staff. Competency in care procedures were assessed by higher level qualified staff.
- Some staff said that there were developmental opportunities which were emailed to them on a regular basis and they were supported to access these.

- The trust also participated in the pre-employment programme with the skills for health academy which gave local unemployed people the opportunity for work experience and to undertake training at the hospital to increase skills and experience. This had resulted in a member becoming permanently employed in medical services at the trust.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications. Trust data showed that three members of staff had completed NVQ level 2 with one member of staff completing level 3. The trust told us that staff on Taylor unit had been offered the opportunity but had not undertaken any vocational training.
- Medical services ensured that the appropriate staff undertook the care certificate. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants. Between April 2015 and May 2015, 11 health care workers across the trust had been supported to complete the care certificate. Staff confirmed they had an adequate induction. Newly appointed staff said their inductions had been planned and delivered well.

**Multidisciplinary working**

- Multidisciplinary team (MDT) was well established on both wards. All staff we spoke to described good collaborative working practices.
- On Taylor ward patients were having daily input from a range of allied healthcare professionals (AHP) including Occupational, physiotherapy and speech and language therapists, clinical psychologist, psychiatrist and social worker.
- On the endoscopy unit patients had access to trained nurses, nurse endoscopist, doctors and gastroenterology specialist.

**Seven-day services**

- The endoscopy unit is a five day service which provided endoscopy procedures to low risk patients. Any patients identified as higher risk went to Royal Albert Edward Infirmary for the procedure as there was full medical /acute cover.
- Allied health professional services were not accessible to patients on Taylor ward at weekends.
- A medical registrar was available for advice on Taylor ward after 5pm and at weekends. Staff told us there was a transfer policy in place and they called 999 for assistance in emergencies.

**Access to information**

- Staff had access to information they needed to deliver effective care and treatment to patients. On the endoscopy unit staff had access to the electronic patient record if written records were not available All staff we spoke to could easily access Trust information including policies, procedures and patient information leaflets on the ward computers.
- On the wards, files which included minutes to team meetings and previous audits were available to staff.

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

- Consent forms were sent out in the post for patients to read prior to attending the endoscopy unit for a procedure. Staff we spoke with said that patients were given the opportunity to discuss any concerns or ask questions in private prior to completing the consent form on the day.
- Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity.
- Staff knowledge about the key principles of the Mental Capacity Act (2005) and the Deprivation of Liberty safeguards (DoLs) and how these applied to patient care was variable.
- Information provided by the trust showed that 97.3% of staff on Taylor ward and 94.7% of staff on the endoscopy suite had completed mental capacity act training. However there was no clarity to confirm whether these figures included medical staff and allied health professionals. Trust data provided across

the hospital showed 25% of medical staff, 54% and 48% of allied health professionals had completed the training. The ward manager on Taylor ward said they had only recently completed the training.

- Staff on Taylor Ward told us that it was doctors and staff from the mental health trust who carried out more formal capacity assessments but they carried out informal capacity assessments on a regular basis. The Trust policy included a capacity assessment form to be completed by staff. Two of the four records of the patients who lacked capacity and had a deprivation of liberty safeguard in place were available to review and we could not see any completed.

- All wheelchairs on Taylor unit had lap straps fitted. Key principles were not clearly defined as to when to use the lap straps on wheelchairs. Nursing staff we spoke to did not know that the use of lap straps could be seen as a form of restrain and said they used the lap straps on all patients in wheelchairs to keep people safe and that patients never complained. They said they would not ask for consent from the patient prior to putting the lap strap on. This was discussed with the ward manager who said they would address the issue.
- Only one patient on the unit had a DoLs application in place for the use of lap straps on a wheelchair and five patients were observed having a lap strap in place whilst in their room or in the main activity room.
- The trust policy clearly states that a copy of a DoLs application must be submitted to the trust safeguarding lead. However there was no evidence of this taking place.
- The staff on Taylor ward said they had access to psychologists who would come in as required and review patients and provided advice and support to staff when carrying out capacity assessments.

## Are medical care services caring?

Good

We rated the medical services as 'Good' for caring.

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with patients were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained.

Patients were involved in their care, and were provided with appropriate emotional support.

The patient-led assessments of the care environment (PLACE) and CQC inpatient survey results supported our observations.

**Compassionate care**

- Medical services were delivered by caring and compassionate staff. We observed patients being treated with dignity, respect and kindness.
- On the endoscopy unit we spoke with three patients. They were positive about their care and treatment for example one patient was having their blood pressure monitored and they felt well informed and the staff explained what was happening.
- Patients were booked into the endoscopy unit by the receptionist separately. If more than one patient was waiting to be booked in at the endoscopy unit reception area, confidentiality was maintained as they were directed to the waiting area and provided with a buzzer which notified them when the receptionist was available to book them in.
- The Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. Between April 2015 and June 2015 the endoscopy unit scored above 98% although the response rate was only 17%. At the time of the inspection rehabilitation services scored 63% with the number of responses being eight. The very low response rates mean the scores are less reliable.
- Patients also had opportunity to complete comment cards on the endoscopy unit and a comments box was available at the entrance to Taylor ward. These were captured and discussed at team meetings.
- We saw the majority of patients who were at their bedside or in bed had access to call bells and staff responded promptly. On Taylor ward patients in wheelchairs in the communal areas did not have access to call bells however staff were visible and within the same area as the patient.

# Medical care (including older people's care)

- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities. They scored 100% for cleanliness.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

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

- We observed patients arriving at the endoscopy unit being orientated to the unit by staff. There were clear written signs on walls as to what to expect including waiting times.
- Patients we spoke to said they felt safe and had received ongoing clear information of what was happening prior and after the procedure.
- Dementia leads were undertaking a project looking at implementing an electronic menu with live pictures of the meals available for patients. Patient experience was then going to be captured to inform the future of the project.
- There were clear and visible information boards specifically for those accessing the service. For example on the endoscopy unit there was an information board explaining procedures carried out along with diagrams. On Taylor ward there was an information board for carers which included information and contact numbers regarding people living with dementia and acquired brain injury.

**Emotional support**

- Staff felt they had time to spend with patients if they needed support throughout their stay on the endoscopy unit.
- On the endoscopy unit family and friends could wait in the separate waiting area if they wished however staff were very aware of the positive impact of having carers present for those with additional needs. Carers were allowed to stay with the patient throughout the process if this was the patient's choice.
- Friends and family including children visited patients on Taylor ward. This was at set times but staff told us they were flexible to the needs of the patient.
- Chaplaincy services were available for patients 24 hours a day, seven days a week. There was a multi faith prayer room with ablution facilities at the hospital.

## Are medical care services responsive?

Good

We rated the medical services as 'Good' for Responsive

Services provided had been developed to meet the needs of the local population.

Specialist rehabilitation therapy was provided to patients on Taylor ward by a range of professionals including allied health professionals and neuropsychologist. Patients were given an estimated day of discharge on admission.

There was a clear focus on discharge planning supported by ward discharge coordinators. Medical services trust wide data showed that delayed discharges due to equipment not being in place was worse than the England average however it was better than the England average for those awaiting a care package to be put in place. At the time of our inspection there were 26 patients in medical services across the trust whose discharge was delayed.

The trust implemented a red label applied above the patient's bed to identify those who were at risk of falls. However, this scheme was not being fully used in rehabilitation services. Those staff did discuss and highlight those patients at risk during each staff handover meetings.

The booking system currently used for patients could be improved to improve access and flow on the endoscopy unit.

Patients on Taylor ward were supported to participate in structured activities with the assistance of an activities coordinator and volunteers.

People were encouraged to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made. Across the two wards there was one formal complaint from September 2014 to August 2015.

# Medical care (including older people's care)

Staff and patient's had access to nurses and doctors from different specialities including diabetes, gastroenterology and psychiatry.

There was access to interpreter and translation services and leaflets available for patients about the services and the care they were receiving. There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient living with dementia or a learning disability.

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

- Taylor ward offered specialist rehabilitation to patients from the Wigan and Bolton area. The ward provided assessment and rehabilitation from a range of professionals, including speech and language therapist, neuropsychologist and AHP's.
- Following assessment by the MDT patients on Taylor ward were given an estimated day of discharge.
- On Taylor ward there was a therapy gym area for therapy staff to rehabilitate patients, a meeting room and large communal area which was bright, well decorated and easily accessible from both corridors via double doors. This room was used for patients to have their meals and participate in activities, watch television and listen to music. Patients were observed listening to music, playing games, socialising with each other and sitting with their families/friends during visiting times.
- The premises and facilities on the endoscopy unit and decontamination unit were appropriate for the services that were planned and delivered.

**Access and flow**

- Patients were admitted to the endoscopy unit as a day case. If patients became unwell or required admission they were transferred via ambulance to RAEI Accident and Emergency department.
- From April 2015 to July 2015 planned day case admissions for gastroenterology and endoscopy across the trust were 1153, however the actual number of patients attended was 2339.
- The current booking system, including appointment timings and appointment letters not being sent out in a timely manner was affecting the efficiency of service deliver on the endoscopy unit. Staff told us the previous day 6 patients did not attend as the letters had only been sent out two days earlier. When patients were contacted they said they couldn't attend the appointment as this was too short notice to arrange work or family commitments. Staff had raised their concerns at the endoscopy user group meetings.
- There was a clear focus on effective discharge planning for patients from wards. Staff discussed discharges at the bed management meeting. There were discharge managers allocated to medical wards to support the process.
- There was a discharge team who supported patient discharges which were complex or required rapid discharge. Discharges were often delayed due to waiting for care packages, 3.2% which was better than the England average of 12% or for equipment that was needed in the home, 4.8% which was worse than the England average of 2.7%. The discharge team met daily and this included, senior management staff, discharge co-ordinators, social services representatives and a member of the local clinical commission group.
- At the time of the inspection on 11 December 2015, there were 26 delayed discharges across medical services trust wide including Taylor ward. This meant that there were 26 people in hospital that didn't need to be. These were discussed at the discharge meeting and actions put in place by the multidisciplinary team to ensure the patient was discharged as soon as possible. The discharge meeting was effective and well-coordinated.
- The therapy staff on Taylor ward were implementing a pilot rehabilitation services for patients who were discharged within the Wrightington, Wigan and Leigh area. This was to be evaluated to inform future plans.
- Therapy staff told us they were still providing therapy in patient's homes that lived out of area until the local authority had arranged domiciliary therapy.

**Meeting people's individual needs**

- Patients with complex learning needs along with their carers (if required) were invited to attend the

endoscopy unit a week prior to their procedure. During this visit they met the staff who showed them around the unit and explained their proposed procedure to help alleviate any anxieties or concerns.

- Staff ensured diabetic patients on the endoscopy unit who needed to be nil by mouth for their procedure were seen in the morning.
- After 5 pm and at weekends there was a medical registrar available for advice. In an emergency staff told us they dial 999 as outlined in the trust transfer policy. We observed documentation in a patient's record which showed staff were following this process. This has been requested from the trust.
- The trust used a red label above beds to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure reasonable adjustments were made. We observed two patients on Taylor ward who were high risk and one did not have an indicator on the patient's board. Staff told us those patients identified as being at risk were discussed and highlighted during each staff handover.
- On Taylor ward there was an activity coordinator who provided structured activities to patients including art and games. We observed patients listening to music and a member of staff, together with a volunteer and patients playing bingo and dominoes together.
- Translation services and interpreters were available to support patients whose first language was not English. Whilst on inspection we observed an interpreter on Taylor ward.
- The majority of leaflets for patients about services and care they received were accessed via the trust intranet and printed off by staff. There was a limited accessible format for those people living with learning disabilities, dementia and those whose first language was not English.
- There was a clinical lead for dementia who provided support for staff and acted as a central point of contact for queries. The service had a dementia strategy. There were core groups looking at what was required for the implementation of the strategy, for example improving the patient journey and caring for carers.
- There were dementia champions on Taylor ward. The role of the champion was to act as a resource for staff, patients and carers. All staff compliance with dementia training at the hospital was above the 95% trust target however only 76 % of medical and dental staff had completed the training.
- There was a range of specialist nurses for example gastroenterology, dementia and diabetes who offered specialist advice to staff. Staff told us they knew how to access these specialists and felt supported by them.
- There was access to psychiatric services from the Five Borough Partnership NHS Foundation trust to see and assess patients with a cognitive impairment. Staff told us they had access to this service as required.

**Learning from complaints and concerns**

- The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- The trust recorded complaints on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Data showed there had been one formal complaint raised on Taylor ward between September 2014 and August 2015. The complaint was regarding damage to a wheel chair.
- From the data provided by the trust there were no complaints on the endoscopy unit however staff said that some patients had verbally complained regarding the waiting time. Staff said they had actively explained to patients that there may be a wait until seen and this information was also visible on walls in waiting areas for patients.
- Complaints were discussed at key governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers shared information about complaints and lessons learnt during staff meetings.

## Are medical care services well-led?

Good

We rated the medical services as 'Good' for Well Led.

# Medical care (including older people's care)

Medical care services were well led with evidence of effective communication within staff teams. The visibility of senior management was good and there was a clear strategy and actions for implementation. Staff knew how their ward performance was monitored.

Risk registers were in place and had actions identified. The risks were reviewed regularly however, there were no targets for expected date of completion of the actions. The risk register was monitored at the medical division governance and risk panel meetings.

According to the NHS staff survey staff stated felt supported and able to speak up if they had concerns although the number of staff who felt valued was lower than the England average. Medical services captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative. There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

**Vision and strategy for this service**

- The trust's vision, which included providing the best quality healthcare for all patients, being in the top 10% for everything they do and to be safe, effective and caring. This was reinforced by values of compassion, respect and dignity, patients first, team work, accountability and forward thinking. To demonstrate how the strategic elements link together the trust developed a visual aid called The 'WWL' wheel.
- Staff at all levels within medical services at the hospital referred to this behavioural framework.
- Trust strategic objectives were based on this vision and these objectives were cascaded down to individual objectives for staff.
- Medical services had a quality strategy in place which identified challenges and objectives. For example reducing medication incidents and achieving the expected date of discharge for all patients. The plans also identified actions to meet the objectives.
- The trust values were clearly presented in the reception area of the endoscopy unit for staff and patients to see.

**Governance, risk management and quality measurement**

- There was a divisional risk register in place which recorded risks for each specialism. The register included a description of the risk, a risk score, current and additional mitigation action, a named person responsible for dealing with the risk and a review date. Risks corresponded with the issues senior staff highlighted to us and their action plan for addressing those risks.
- The biggest risk to the service on Taylor ward was the environment which was owned by another trust and required actions to ensure it was fit for purpose. The service would be required to vacate the building by November 2016 but at the time of the inspection no firm plans were in place and it was unclear if any remedial work required had been carried out.
- Risks were reviewed including unable to identify a long term solution for Taylor ward; this was documented in the medical divisional quality executive committee minutes June and July 2015 as no change. It was unclear from the minutes whether any further actions were being taken.
- Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services. The medical divisional quality executive meeting was held on a monthly basis. During the meeting there was a review of items to celebrate, good practice and items of concern. There was also feedback from other key meetings, for example senior nurse update and update from the governance and risk panel.
- The medical division governance and risk panel was held on a monthly basis and risks were discussed in detail and some had further actions and target dates for completion identified.
- It was clear from the minutes we reviewed that review and discussion had taken place of the risk register, incidents and complaints. It was also apparent that learning had taken place to be shared with staff. Actions from the meeting were identified in the

minutes along with the person responsible but there was no target dates for the actions to be completed making it difficult to track progress against agreed actions.

- The trust had a quality champion project in place and staff were awarded either a bronze, silver or gold award for undertaking projects which improved the quality of care provided for patients. Examples of projects included reducing the number of pressure ulcers and preventing respiratory admissions. There was a number of staff in medical services who were quality champions including a physiotherapist on Taylor ward who was currently working towards a silver award.

**Leadership of service**

- Staff reported there was clear visibility of the trust's board throughout the service. Staff could explain the leadership structure within the trust and within medical services. The executive team were accessible to staff.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within the teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

**Culture within the service**

- Staff said they felt supported and able to speak up if they had concerns. They said that morale and team working was good and they felt respected and valued.
- On Taylor ward therapy and nursing staff both felt that improvements could be made in collaborative working for example all staff to attend in service training together and practices identified also be shared.
- All staff on the endoscopy unit felt they worked collaboratively together as a team at all times.
- In the 2014 staff survey, 96% of staff at the trust said they were enthusiastic about their job and 92% looked forward to going to work.

**Public engagement**

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The medical divisional quality executive meeting highlighted patients' experiences of using the hospital's services.
- The trust had in place comments cards for patients and relatives to complete. From January 1st 2015 to 31st December 2015 Taylor ward received 67 comment cards, 61 of those were positive feedback. For the same period the endoscopy unit received 42 comment cards and of those 37 were positive in their feedback.
- In July 2015 the endoscopy unit carried out a telephone survey to 50 patients selected randomly. Data collected concluded that the majority of patients had a positive experience and recommendations were highlighted including improvements to the booking line, information on appointment letters and waiting times on the day of the procedure.
- In 2015 200 patients were randomly selected and sent a JAG patient survey to complete. Of those 97 were returned. The survey concluded that a very good service was provided overall with many patients commenting on how caring the staff were and that they put patients at ease before the procedure. Recommendations were identified.
- Feedback from the comments cards along with the results of the audits were discussed and shared at staff meetings.
- In the May 2015 trust patient survey, medical services achieved the trust target except for two questions which were being involved in decisions about their discharge and knowing which consultant was currently treating them.

**Staff engagement**

- The trust celebrated the achievements of staff at an annual event. At the last event medical services had had a number of staff nominated for their work at the trust.
- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development. 73% off staff in the trust felt the training and development they had undertaken had helped them to deliver a better

patient experience and 74% felt it had helped them to do the job more effectively. 52% felt they were valued by the organisation. This was better (higher) than the national average of 42%.

- In July 2015 the trust quality pulse check received 40.3 % completed surveys from staff, of those 26% were from medical services. 47 questions were asked and an example of the results are 87.1% of staff likely to recommend WWL to friends and family if they needed care or treatment was 87.1% and 79.7 % of staff likely to recommend WWL to friends and family as a place to work.
- In April 2015 a staff satisfaction survey was sent on the sent to staff on the endoscopy unit. Twelve surveys were completed. However the report did not state how many were sent therefore it is difficult to clarify the significance of the findings. The report concluded that staff felt valued in their job, had support in their training needs and the unit worked well as a team. Recommendation regarding improving in house training was highlighted. The results were discussed at the staff meeting.
- A staff engagement survey and report was completed in August 2015 and actions identified.

**Innovation, improvement and sustainability**

- Trust wide medical services had implemented an acute kidney injury specialist service which had seen the development of and education programme and ward champions. This had been successful in reducing the average length of stay for patients form eight days to three days.
- Services had undertaken a trust wide pilot project looking at reducing aspiration pneumonia. This had resulted in a pathway and guidance for staff and had successfully reduced the mortality rate for patients. This was being evaluated to inform future plans.
- An analysis of the 2014 staff survey results showed 74% of staff in the trust, who responded, felt they were able to make suggestions to improve the work of their team/department. This was the same as the national average of 74%.

# Surgery

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

## Information about the service

Leigh Infirmary offers elective, diagnostic and rehabilitation services as part of Wrightington, Wigan and Leigh NHS Foundation trust. There are two surgical wards, wards two and three, providing day case and short stay services. The service is offered Monday to Friday.

At the Hanover Diagnostic Centre at Leigh Infirmary, the trust offers an extensive range of urology services. The urology department is located in the Richmond unit and offers a range of services for patients including rapid access clinics, prostate assessment, vasectomy, haematuria, one stop and out of hours evening clinics

In 2014, there were 35,277 surgical stays trust wide serving a population of around 320,000 people in the Wigan and Leigh area. At Leigh Infirmary 99% of surgical stays were day cases and 1% were elective and patients stayed overnight.

## Summary of findings

Overall, we found that Leigh Infirmary delivered good surgical services.

Staff were enthusiastic and proud of the services they provided. Staffing levels were sufficient and a safer nursing care staffing tool was utilised to ensure staffing levels were adequate. Medical staff rotas were in place and locum agency staff filled any gaps when the service was short staffed. Staff morale was good and staff felt well supported.

Incidents were reported and lessons learnt shared amongst staff. Staff knew how to access the incident reporting system and could tell us about incidents they had reported. There were low incidents of pressure ulcers and infections. Risk assessments were completed and staff implemented measures to reduce risks.

The environment was clean and tidy and staff had access to the equipment they required to do their jobs. Medicines were managed safely and stored securely.

Referral and discharges worked well and staff shared relevant information. Services worked in coordination and patients were appropriately referred to specialist services. Staff treated patients with respect and dignity, offered support and included them in their care planning. Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach. Referral to treatment times for the hospital were similar to or above the national average.

# Surgery

Risk registers were in place and discussed at team meetings. Staff were aware of the trust's values and vison. Staff felt well-supported by managers and colleagues.

## Are surgery services safe?

Good

We rated the surgical services as 'Good' for being Safe.

Staff knew how to report incidents and could give us examples of incidents reported such as pressure ulcers and falls. Staff were aware of 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided was in practice) and felt confident to practice this.

Staff had infection control training and were aware of trust polices. Audits were completed and hand washing techniques and the use of personal protective equipment (PPE) was observed.

The environment was clean and tidy. Equipment was available and routinely serviced. Medicines storage was secure and records were well maintained.

There was sufficient staffing levels and staff felt confident to raise issues with management. Mandatory training was provided annually, both face to face or via e-learning.

**Incidents**

- Staff were aware of the electronic incident reporting system and could access it.
- Staff could tell us about the types of incidents reported, these included pressure ulcers, staffing issues and falls.
- The trust commissioned its solicitors to deliver Duty of Candour training in 2014, and is being rolled out again. An e-learning training module for Duty of Candour was under development.
- The incident reporting system prompted staff to indicate if Duty of Candour had taken place when reported harms classed as moderate or above.
- Mortality and morbidity were audited weekly trust wide and a report was produced which was distributed to over 1000 staff. The trust aimed to audit 400 deaths per year. The division also conducted mortality and morbidity meetings.

**Safety thermometer**

# Surgery

- NHS Safety Thermometer data between July 2014 and July 2015 showed three falls that resulted in harm were reported, one in July 2014 and two in May 2015. The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care.
- Safety thermometer results were displayed on each ward and theatre area.

**Cleanliness, infection control and hygiene**

- All areas we inspected were visibly clean and tidy.
- Hand gel and personal protective equipment was accessible on each ward and was utilised by staff and visitors. Staff washed their hands effectively during and between interventions and tasks.
- Cleaning records were completed efficiently in theatre areas.
- Staff were aware of the current infection control procedures and guidelines. Arrangements were in place for the safe handling, storage and disposal of clinical waste and sharps.
- Sharps bins were signed and dated, and partially closed when not in use.
- Staff completed effective hand decontamination in the operating theatre, and utilised personal protective equipment appropriately.
- Hand hygiene audits were completed and results between March and August 2015 and showed good compliance of between 99.7% and 100%.
- All patients had pre-operative screening for Methicillin-resistant Staphylococcus aureus (MRSA).

**Environment and equipment**

- Wards and theatres were clean and tidy and staff had access to the equipment they required.
- A trust wide equipment service stored, serviced and loaned equipment as required. Staff reported that this was a good and responsive service.
- The trust scored consistency above the England average for Patient-led assessments of the Care Environment (PLACE) assessments.
- Equipment was routinely maintained and serviced. Some displayed green 'I am clean' stickers, however this was not consistent.
- Daily checks of resuscitation trolleys and logs were completed and up to date. Equipment was serviced and in date.
- We observed domestics mopping floors during our inspection and wet floor signs were utilised to alert patients, staff and visitors.

**Medicines**

- Controlled drugs were stored in a locked cupboard and checked daily. Pharmacy staff also reviewed stock levels.
- Recording of daily drug fridge temperatures showed they were within optimum range of between two and eight degrees.
- There was recording of allergies on prescription and nursing assessment documents.
- Medicine charts were in booklet form and included nil by mouth guidance and a prescribing chart for patients with a Parkinson's disease diagnosis.
- Wards had hypoglycaemia boxes available for the treatment of patients with a low blood sugar level.
- Staff had access to medicine management training.

**Records**

- The trust utilised electronic and paper based records. These were in the form of nursing notes and medical case notes. The record trolleys inspected were unlocked meaning records were not always private and secure.
- Records were legible, signed and dated, however name and designation of those completing the record was not always clear or printed.
- There were seven inpatients on the wards during the inspection and five sets of records were inspected. These were of a good standard.

**Safeguarding**

- The trust had safeguarding policies and procedures in place and had allocated leads for safeguarding adults and safeguarding children.

- Online training was available for safeguarding training level one and two.
- Staff knew how to refer to the safeguarding policy and how to raise an alert. Staff showed us how they accessed the policy.
- Trust data showed that 86% of staff at Leigh Infirmary had completed their mandatory training, which included safeguarding adults.

**Mandatory training**

- Staff confirmed they had a trust induction on commencing work and this included temporary staff.
- Mandatory training was provided annually and included training such as infection control, fire safety, health and safety and safeguarding. The trust target for completion was 95% and staff completion rates were between 95-100% at Leigh Infirmary.
- Staff told us they were reminded to attend training and were given the time to complete all elements required.

**Assessing and responding to patient risk**

- Staff told us how they escalated identified risks to the patient safety to manger and matron, examples given included staffing issues and bed capacity issues.
- A Venous thromboembolism (VTE) assessment was completed on each admission. There was appropriate prescribing of medication and days of administration noted. VTE is an international patient safety issue and a clinical priority for the NHS in England
- Risk assessments completed for each patient included falls assessment, bed rail assessment, moving and handling, **Malnutrition Universal Screening Tool** (MUST) and Waterlow (the Waterlow score gives an estimated risk for the development of a pressure sore in a given patient).
- We observed electronic World Health Organisation (WHO) checklist completion in theatre. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors during and after surgery. These were fully completed.
- The trust undertook audits for the completion of the WHO checklists and highlights any areas for improvement. Audit results between January and August 2015 showed compliance at Leigh Infirmary of 94%.

**Nursing staffing**

- Trust data showed eight whole time equivalent staff vacancies at Leigh Infirmary in nursing services.
- Staff moved between wards two and three as required to ensure sufficient cover on the units.
- Wards displayed their expected and actual staffing levels at the entrance to the ward. Ward three had a full establishment of staff on duty on the day of inspection; however ward two had no support workers on duty on the day of inspection when the establishment should have been two. This did not appear to have an impact on care.
- Theatres at Leigh Infirmary had one band six vacancy and ward three had a whole time equivalent Band five vacancy.
- Trust data showed sickness levels on ward two of 6.35% and 7.81% in theatres.
- Use of bank staff was 9.7% in August 2015.
- The trust utilised a safer staffing acuity tool every three months to assess the requirements for each ward and clinical area.Daily staffing levels were reported to Matrons and displayed on boards at ward entrances.

**Medical staffing**

- Medical staff skill mix showed the proportion of consultants was 38% which was lower than the England average of 41%. Junior level grades were higher at 23% against the England average of 12%. Staff reported feeling supported by senior staff.

**Major incident awareness and training**

- Staff told us that they could access the major incident policy via the intranet. Those asked were not aware if a copy was kept on the ward or unit and we did not see one.
- Major incident training was incorporated in mandatory training annually.

# Surgery

## Are surgery services effective?

Good

We rated the surgical services as 'Good' for being Effective.

Staff utilised national and local guidelines and policies. The division participated in local and national audits, such as the hip fracture audit. Action plans were then formulated and shared.

Patients were assessed for pain relief and pain link nurses were available on the wards. Staff had appraisals and access to training and development.

Multi-disciplinary team working worked well across theatres and wards, working collaboratively to plan and provide care. Staff obtained consent to treatment and discussed care planning. Trust policies for mental capacity and deprivation of liberty safeguards were in place.

**Evidence-based care and treatment**

- Staff utilised national guidelines by National Institute for Health and Care Excellence (NICE), as well as local policies and procedures when planning and delivering care.
- 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).

**Pain relief**

- Staff assessed pain for patients with dementia utilising the Abbey pain score (this tool is used for measurement of pain in people with dementia who cannot verbalise**).**
- Patients had their pain scores recorded and staff asked if they required pain relief.
- Wards allocated pain link nurses to offer support and training to ward staff.

**Nutrition and hydration**

- Staff offered patients refreshments and assessed their nutritional needs.
- Patients had a choice of meals, where appropriate.

**Patient outcomes:**

- The trust's patient reported outcomes' were the similar to national results.

**Competent staff**

- Staff reported receiving annual appraisals and felt supported to address any development needs identified following their review.
- Access to training and role specific development was available. Staff felt they had opportunities to develop within their roles.
- Staff had access to role specific training and had annual appraisals.
- The trust scored similar to the England average for the NHS staff survey. An example being the percentage of staff appraised in last 12 months of 89% against England average of 84%.

**Multidisciplinary working**

- Staff worked well together and referred patients to specialist services according to their individual needs.
- Bed availability meetings are held three times a day to determine capacity across the trust sites and any identified issues were escalated appropriately.
- There were regular 'Comm Cells' meetings for all staff to attend where they were encouraged to raise their concerns.

**Seven-day services**

- Five day services were provided for day case and short stay patients. Staff covered across wards, as required, which ensured safe staffing levels.
- The urology service also provided five day clinic services per week. Evening clinic appointments were also available.

**Access to information**

- Information boards were visible in staff areas these displayed audit information, link nurse details and trust wide correspondence.
- Staff had access to the trust intranet and could access policies and procedures when required.

# Surgery

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

- Mental Capacity Act assessments were completed by staff and doctors where appropriate
- Assessment prior to surgery included completion of a consent form. This was not always completed prior to theatre. This was also noted in a consent audit undertaken in September 2015.
- The trust had a safeguarding lead in post and a policy in place for staff to access for information and support.
- Staff knew how to make a safeguarding referral and felt confident to do so.
- Flow charts were displayed in staff areas and resource folders for the Mental Capacity Act and Deprivation of Liberty Safeguards were available for staff to refer to.
- In two sets of notes the consent form was not available to review.

## Are surgery services caring?

Good

We rated the surgical services as 'Good' for being Caring.

Staff engaged with patients and offered kind and considerate care to patients and those close to them. We saw that privacy and dignity was maintained and their needs were met.

Patient feedback from the NHS Friends and Family test showed that most patients felt positive about recommending the surgical services at Leigh Infirmary to friends and family.

**Compassionate care**

- The NHS Friends and Family Test (FFT) overall response rate for this trust was lower than the England average from June 2014 to July 2015; however the response rate for Leigh Infirmary (71%) was 35% higher than the England average of 36%. Post boxes were available on wards to allow submission of FFT forms.
- At the Leigh Infirmary, Ward three scored particularly well in the FFT with a 100% of patients recommending the ward.
- Staff we observed gave compassionate care and communicated well with patients.
- Staff maintained patient's privacy and dignity.

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

- Patients spoken to during our inspection reported good communication with staff and that they were involved in their care planning.
- We observed good interactions between staff, patients and their relatives and opportunities were given to ask questions.
- Staff gave verbal advice to patients post-operatively and contact numbers were given prior to discharge if patients needed any advice.

**Emotional support**

- Wards have bereavement link nurses to support team members, patients and relatives.
- We observed staff offering emotional support and listening to patients' concerns.

## Are surgery services responsive?

Good

We rated the surgical services as 'Good' for being Responsive.

Elective, short stay and day case surgery was undertaken on the Leigh Infirmary site. Service planning and delivery was undertaken to meet the needs of the local population and staff. Theatre utilisation was variable. Referral to treatment times of 92% in October 2015 exceeded the national average of 90%. Urology services offered a 'one stop shop' to complete treatment at each visit.

Individuals had their needs assessed and adjustments were made accordingly. Wards had identified dementia champions and utilised the 'forget me not' symbols.

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

- Three theatre lists were running on the day of inspection due to low patient numbers, however there were usually four.

# Surgery

- There were 18 cancelled operations in March 2015 and two of those were not re-booked within 28 days.
- The latest data between April and June 2015 showed that out of the 129 cancelled operations in this trust, 15 were not treated within 28 days. Senior managers told us that utilisation of theatres and efficiency was being reviewed to reduce cancellations and increase efficiency. The manager on duty was contacted if theatres were over running and any potential cancellations.

**Access and flow**

- Between April 2015 and September 2015, the trust exceeded the 90% standard for the proportion of patients waiting 18 weeks or less from Referral to Treatment. The latest figures for October 2015 showed that the trust's performance was 92% of patients were seen within 18 weeks.
- The site provided three theatres and a treatment room covering several specialties including gynaecology, ophthalmology, general surgery, ear, nose and throat (ENT) and Urology.
- Theatre utilisation in June to August 2015 ranged from 57 to 86% across six sessions in three theatres.

**Meeting people's individual needs**

- Wards had 'forget me not' symbols to indicate a diagnosis of dementia and dementia champions were in place to support patients and relatives.
- Symbols on white boards behind patient's beds indicated the risk of falls, patients living with dementia, or if assistance is required with eating.
- The trust utilised interpretation and translation services, which could be face to face, via telephone, written or sign language.
- The trust had a seven day chaplaincy and spiritual care department. The service was accessible at any time and also completed routine weekly visits to all wards.
- Wards and clinics had information leaflets available for patients and relatives.
- The Urology centre had a counselling room available for patients and relatives to use.

**Learning from complaints and concerns**

- Patient advisory and liaison service (PALS) details were displayed on wards and leaflets made available.
- Monthly performance reports included complaints, and the responses and timeliness of the response.
- Staff aimed to resolve complaints locally. The patient relations team triage all formal complaints.

## Are surgery services well-led?

Good

We rated the surgical services as 'Good' for being Well-led.

Staff at all levels were aware of the trust values and vision. Staff felt supported and worked collaboratively to meet patients' needs.

Systems in place recorded completion of risk assessments, incidents and audits. Staff and patient surveys were recorded and acted on. Managers attended meetings and cascaded information to staff.

Lesson learned from compliments and complaints received were shared. Lessons learned were shared and discussed in team and divisional meetings.

**Vision and strategy for this service**

- Staff understood the trust vision and values and could show us information relating to these on notice boards.
- Staff could attend chief executive briefing sessions.

**Governance, risk management and quality measurement**

- Incidents and risk assessments were completed and discussed at communication meetings called 'Comm Cells attended by senior staff.
- Divisional meeting minutes showed discussion of current risk and any incidents, lessons learned and subsequent investigations.
- The trust had an audit plan and staff participated in the audits. Action plans were written and implemented.
- There were regular team meetings and huddles to discuss issues and wards displayed information on notice boards.

# Surgery

- The Quality Champions Programme commenced in 2013. Subsequently, the Trust had 320 Quality Champions Trust-wide.

**Leadership of service**

- Staff stated that the executive team and board members were accessible and responsive.
- Managers stated they were proud of their teams and that they worked well together.
- Staff felt supported and able to discuss issues as they arose.
- Staff received an annual appraisal and could access support when required.

**Culture within the service**

- Staff were positive and enthusiastic and felt valued. They felt they worked well with colleagues and supported each other where required.
- Staff could access the Raising Concerns Policy and were encouraged to raise issues and concerns.
- Staff helped to cover any sickness or staff shortages to ensure safety for patients.

**Public and staff engagement:**

- Surgical services participated in the NHS Friends and Family test enabling people to feedback about their care and treatment.
- Staff received regular email communication from the trust providing updates on changes and improvements.
- Staff reported being encouraged to put forward ideas for improvements and cost efficiencies. Staff felt their views were listened to.

**Innovation, improvement and sustainability**

- The urology unit had a 'one stop shop' where investigations and treatments could all be offered in one visit. Senior staff showed us examples of cases from the current clinic where patients had received a seamless service.
- Effective eye surgery checklist utilised at Leigh Infirmary.

# Maternity and gynaecology

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

## Information about the service

Antenatal clinics are held at Leigh Infirmary as well as at a number of locations within the community including the Thomas Linacre Centre (TLC), Longshoot Health Centre, Hindley and Chandler House (Poolstock). There is no maternity ward or delivery suite at Leigh Infirmary.

There is an early pregnancy assessment unit service (EPAU) located next to ward two, at Leigh Infirmary, on weekday mornings. There is a gynaecology clinic is situated in the dedicated women's centre in the Hanover unit at Leigh. There is no dedicated ward for gynaecology patients but patients usually are admitted to ward two at Leigh, which is a female surgical ward. Leigh provides elective day case surgery on weekdays only. At Leigh Infirmary between April 2015 and November 2015, 2470 antenatal appointments were attended and a total of 305 medical terminations of pregnancy (TOP) were carried out and 66 surgical TOP's.

As part of the inspection, we visited the inpatient area at Leigh Infirmary, including the EPAU areas. We also visited the women's centre and antenatal clinic areas.

At Leigh Infirmary, we spoke to 12 members of staff, of different grades, including medical staff, managers, midwives, and nurses. We observed care and reviewed records for 14 patients.

We received comments following our listening event and from people who contacted us to share their experiences, as well as reviewing information received about the service.

## Summary of findings

The maternity and gynaecology services at Leigh Infirmary required improvement in the effective domain but were good in the other domains.

Staff knew how to report incidents. Lessons were shared and learned using techniques such as roleplay scenarios that included both midwifery and medical staff, however; there was no integrated trust wide learning system. All areas were visibly clean and tidy and staff followed hygiene procedures. Safeguarding processes were in place and under review. Medicines were stored in secure cupboards and daily checks completed. Records for patients receiving surgical care and termination of pregnancy were reviewed and completed appropriately. Staff had received mandatory training relevant for their role, however; there was room for improvement in the uptake of basic life support training by medical staff and delirium training by all staff. Medical staffing numbers were adequate for the patient's needs. Any shortfall in staffing levels was supported by bank nurses.

Two guidance documents for the management of termination of pregnancy gave differing guidance. The trust participated in a number of local and national audits which had resulted in actions being taken to improve. The TOP service audit had identified good outcomes and patient experience; however, audits of services were not current. Women were assessed for pain relief and supported individually postoperatively. There was a choice of meals available. Patients breast

feeding was supported in the community. Midwives had received additional training to gain competencies to support the delivery of some services. Staff in the women's centre and surgical ward two had been appraised. Midwives did not routinely rotate following completion of preceptorship induction. Services were available on weekdays only. Ward two carried out elective day-case surgery and clinics were for routine antenatal and gynaecology appointments. Community staff had limited access to computers and therefore electronic records, however; the trust was moving to an Electronic Patient record in summer 2016.

We observed positive interactions between patients and staff both in the clinic areas on the surgical ward two where gynaecology patients were admitted for elective day case surgery. We observed staff actively engaging with patients in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed. The trusts performance in the Friends and family test for August and September 2015 for those who would recommend the service was 100%.

The service had been planned across the geographical location. Gynaecology clinic services were based in the women's centre at Leigh Infirmary. The antenatal clinics were being supported by main outpatients as they are in the process of relocating to refurbished premises in the former ward one. Each maternity patient was allocated a named midwife, in the community. Antenatal clinics were available across the Wigan and Leigh areas in GP surgeries. Ward two, a female surgical ward, admitted elective day-case gynaecology patients and included an early pregnancy assessment unit. Outpatient gynaecology patients attended the women's centre.

There were specialist midwives including public health, safeguarding and a mental health nurse. Also diversity and dementia champions were available. Any patient identified with a learning disability or mental health issue were supported on an individual basis as needed.

Surgical staff understood the trust vision and strategy. Staff felt that they were supported by their managers with opportunities for development. Staff worked collaboratively across the maternity and surgical gynaecology services to meet the needs of the local population. Systems were in place that recorded completion of risk assessments, incidents and audits. Staff and patient surveys were recorded and acted on. Managers attended meetings and cascaded information to staff. Monthly multidisciplinary team meetings were held in order to review current guidelines and practices that included a variety of grades of doctors and midwives; however, the guidelines we reviewed were not consistent. Lesson learned from compliments and complaints received, from the public, were shared and discussed in team and divisional meetings.

# Maternity and gynaecology

## Are maternity and gynaecology services safe?

Good

Maternity and gynaecology services at Leigh Infirmary were good in terms of being safe.

Staff knew how to report incidents. Lessons were shared and learned using techniques such as roleplay scenarios that included both midwifery and medical staff, however; there was no integrated trust wide learning system. All areas were visibly clean and tidy and staff followed hygiene procedures.

Daily checks of equipment were completed. Safeguarding processes were in place and under review. Medicines were stored in secure cupboards and daily checks completed. Records for patients receiving surgical care and termination of pregnancy were reviewed and completed appropriately.

Staff had received mandatory training relevant for their role however there was room for improvement in basic life support training by medical staff and delirium training by all staff. Medical staffing numbers were adequate for the patient's needs. Any shortfall in staffing levels was supported by bank nurses.

### Incidents

- Incidents were reported via the trust-wide electronic system.
- A total of 255 incidents were reported for maternity services between May 2015 and August 2015. There were monitoring arrangements in place for all activities. For the same time period, there were 28 incidents reported for gynaecology across the trust. Most of the incidents were reported as no harm.
- Lessons learned from incidents were shared across the multidisciplinary teams of medical, nursing and midwifery staff in a newsletter. All the incident investigations and action plans were reviewed at monthly multidisciplinary team (MDT) meetings. 'Skills and drills' training was in place at the trust. Incident scenarios were used to deliver learning using 'role-play' in order to support learning. regular debriefing sessions take place across the maternity service with "Hot Debrief" taking place at the time of, or as close to, the occurrence of an incident".
- Community midwives maintained a file of incidents, complaints and learning in their respective clinic bases following monthly emails that included incidents.
- If staff were involved in an incident they may be contacted by the medical director for a learning meeting. There was, however no integrated system in place for learning from incidents trust wide such as medication errors.
- Staff understood their responsibilities with 'Duty of Candour' (the regulation for all NHS services, introduced in November 2014 that means they should be transparent and open following any incident).

### Safety thermometer

- In ward two and theatre, information was displayed for infection rates, nursing care indicators and Friends and Family Test (FFT) using the NHS safety thermometer (a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care.) All information was within the expected parameters.

### Cleanliness, infection control and hygiene

- All areas and equipment were visibly clean but the 'dirty utility' room was unlocked on ward two.
- The bed curtains all included stickers to indicate when they were last changed.
- Cleaning schedules were in place in theatre. All grades of staff were observed following hand hygiene procedures and 'bare below the elbow' guidance on entry to the unit, including teams of doctors attending for ward rounds from other areas.
- The trust monthly hand wash audit results showed that women's health care and Leigh Infirmary anaesthetics scored 100% from April 2015 to August 2015. Ward two scored 94% in May 2015 and 100% from April to August 2015. Leigh theatre scored 94% in June 2015, there was no data submitted in May and the scores in April, July and August were 100%. Leigh recovery scored 100% in May and June, but scored 89% in April and August 2015 and 67% in July 2015.

### Environment and equipment

- Gynaecology patients were nursed on surgical wards and were admitted to the female surgical ward two for elective surgery. This ward had a capacity of 14 day case beds for minor procedures.

# Maternity and gynaecology

- Ward two and theatre equipment were maintained via a loan store arrangement, however; stickers attached to equipment were not consistently used. Staff told us they had sufficient equipment in the Women's centre.
- The resuscitation trolley and the fridge, in the women's centre, theatre and ward two included completed records of daily checks when the centre was open.
- The antenatal clinic environment provided at Leigh Infirmary had been identified, by senior managers as, "below acceptable standards for Maternity Services and are not fit for purpose". Patients were attending the main out patients department for antenatal appointment when there was no capacity in the limited space of the antenatal clinic. The former ward one was currently being refurbished to accommodate these new facilities prior to the planned opening later in the year.

**Medicines**

- Medicines were stored appropriately in locked cupboards.
- Daily checks of controlled drugs were carried out daily in theatre and on the ward in line with trust policy.
- Drug fridge temperatures were recorded daily and showed they were within optimum range of 2-8 degrees.
- There was recording of allergies on prescription and nursing assessment documents.
- Medicine charts were in booklet form and included nil by mouth guidance
- Staff had access to medicine management training which had been attended by 98% of nursing and midwifery staff.

**Records**

- All inpatient records, in use, were paper based for maternity and gynaecology care.
- Records for maternity patients included their 'hand-held green notes' as well as paper in-patient records and gynaecology patients records were paper-based following the surgical pathway.
- We reviewed five sets of patient's surgical records, on ward two which all included pre-operative checklists. We also reviewed nine sets of records for termination of pregnancy, which all included completed consent forms.

**Safeguarding**

- There was a nominated safeguarding lead that was accessible to staff to provide safeguarding advice.
- Safeguarding children level 2 training had been completed by 100% of allied health professionals and nursing and midwifery staff.
- Safeguarding children level 3 training had been completed by 100% of relevant medical staff and allied health professionals and 82% of nursing and midwifery staff.
- Staff were able to describe the safeguarding referral process with a recording system in the patient's notes or electronically.
- Staff training was provided about female genital mutilation (FGM) by the safeguarding team. Midwives told us that they would report any FGM they suspected and there was a question in the green hand held notes. There was good support network available for patients.
- Midwives said they had concerns about the levels of support required for some of their caseloads. There were specialist public health midwives for patients with specific needs such as drug and alcohol problems. They could take up to 75 patients.

**Mandatory training**

- Staff confirmed that they received training and induction specific to their roles.
- Nursing staff in the women's centre were 100% compliant with mandatory training requirements.
- Midwives received mandatory training in adult basic life support, internal neonatal life support, safeguarding children level three and e-learning modules including mental capacity act (MCA) and deprivation of liberty (DOL's), dementia training, inclusion & diversity and moving and handling. Mandatory training was delivered using face to face training and e-learning. Moving and handling training was delivered by e-learning only rather than face to face.
- Nursing and midwifery staff uptake of training was good except in basic life support which only had 88% uptake.
- Thirty five midwives, across the trust, had completed an external neonatal life support training (NLS) course that was valid for four years. All midwives had received in house NLS training within the last 12 months.
- The role of the practice development midwife identified and co-ordinated education delivery and training needs within maternity services.

**Assessing and responding to patient risk**

# Maternity and gynaecology

- The trust early warning system (EWS) was in operation on ward two and staff verbally explained the system. The EWS paperwork was included in the trust booklet: 'surgical pathway.'
- The World Health Organisation (WHO) 5 steps to safer surgery was utilised prior to surgery. It was completed electronically and we observed the utilisation of this tool and saw evidence of challenges.
- There was a surgical guideline for the transfer of surgical patients from Leigh Infirmary to RAEI if required. This included guidelines regarding the safe transfer for patients whose condition had deteriorated and needed to transfer to RAEI for further management.

### Nursing and Midwifery staffing

- The surgical division used the 'safer staffing' tool to assess the acuity of patients and staffing needs four times per year. Staff on ward two rotated to ward three if required.
- Newly qualified midwives and midwives new to the trust had an induction programme that included rotation to all areas. Core midwives, across the trust, were allocated to areas that included the delivery suite, maternity ward, antenatal clinics and community midwives. Staff were able to request changes to increase their skills if required.
- The target for utilising midwifery bank nurses was 5%, however 14% were employed in November 2015 and 8.9% in December 2015.
- Ward two, gynaecology, was fully staffed with a sickness rate of 6.35% in the last financial year. The bank usage on ward two between April 2014 and March 2015 was on average 9.7% per month.

### Medical staffing

- Trust wide obstetrics and gynaecology medical staff included: 10 obstetric consultants, one long term locum, five specialist trainees in obstetrics and gynaecology, one speciality hospital doctor, one GP innovative post, one full time and one part-time speciality trainee (ST2) in obstetrics and gynaecology, three GP trainees and four foundation year ( FY2) doctors.

### Major incident awareness and training

- A trust wide major incident plan and corporate business continuity plan was provided.
- Midwifery staff were not clear about their roles and responsibilities in the event of a major incident, although; mandatory training requirements included a module 'emergency planning' which had been attended by 98% of nursing and midwifery staff but only 79% of medical staff.
- Following a request for the escalation policy on ward two, the 'departmental business continuity plan' for ward three at Leigh Infirmary was provided with guidance for potential disruption in service.

## Are maternity and gynaecology services effective?

**Requires improvement**

Maternity and gynaecology services at Leigh Infirmary required improvement in terms of being effective.

The trust participated in a number of local and national audits which had resulted in actions being taken to improve. The TOP service audit had identified good outcomes and patient experience; however, audits of services were not current. Trust guidelines were in place, however; two we reviewed for termination of pregnancy did not give the same guidance and therefore one did not meet the RCOG guidance which could render the treatment less effective. We informed the trust.

Women were assessed for pain relief and supported individually postoperatively. There was a choice of meals available. Patients breast feeding was supported in the community.

Midwives had received additional training to gain competencies to support the delivery of some services. Staff had been appraised, however; below the trusts target. Midwives did not rotate following completion of preceptorship induction.

Services were available on weekdays only. Ward two carried out elective day-case surgery and clinics were for routine antenatal and gynaecology appointments. Community staff had limited access to computers but electronic patient records were to be introduced in Summer 2016.

### Evidence-based care and treatment

- The processes for administration of medication for termination of pregnancy were within two trust guidance documents. However there was a lack of

timescale for administration on one of the guidelines. Staff explained the processes and procedures for termination of pregnancy (TOP). MTOP medical termination of pregnancy (MTOP) included the administration of medication. We were told that the initial medication was mifepristone followed by misoprostol approximately six hours later. The Trust started this model following discussions with a leading provider of TOP services but has ceased the practice since the CQC inspection.

- The trust guideline referred to administration four hours later, however; another trust guideline referred to medication 24 to 72 hours later. This could lead to differing practices, which do not meet current professional guidance. RCOG guideline seven includes 24 to 48 hours gap between doses of medication. Although the practice is acceptable if the women are fully informed this could result in less effective treatment.
- The trust informed us that consent always formed part of the patient assessment in clinic to discuss treatment options which included the risks and extent of bleeding and the success/failure rates. Informing the patient of the possible reduced effectiveness of undertaking the treatment in this way was discussed as part of the consent process.
- We were told the patient could choose either to remain in the ward or leave between administrations.
- All records were completed and included consent signatures from two individuals. The medical termination of pregnancy service was a nurse led clinic with support from the doctors. Any patient under 16 years old was seen by the consultant obstetrician
- The trust guideline for a low risk woman requesting a home birth was ratified by the clinical cabinet by a virtual meeting on 18 June 2014. There were no terms of reference for a virtual meeting. It was confirmed that a teleconference had taken place. Mental health guidance referred to accessing a 'public health midwife', but the flow chart in appendix one didn't include 'public health midwife'.

**Pain relief**

- Staff recorded Patients pain scores for surgical patients and we observed that staff asked if they required pain relief.
- Pain link nurses were allocated to wards to offer support and training to ward staff.
- Staff assessed pain for patients with dementia utilising the Abbey pain score (this tool is used for measurement of pain in people with dementia who cannot verbalise).
- For the termination of pregnancy service, analgesia was provided as per guidelines.

**Nutrition and hydration**

- Staff offered surgical patients refreshments and assessed their nutritional needs with a choice of meals, where appropriate.
- There was a community-based infant feeding team with a network of peer supporters to promote and support breast feeding. There were three midwife lactation consultants that had undertaken externally accredited training. The trust had full accreditation baby friendly status (an initiative to promote breast feeding). It was initially awarded in 2012 and reassessed in 2015. Midwives who were participating in the preceptorship programme were now required to spend a week with the infant feeding team.

**Patient outcomes**

- Between April 2014 and March 2015, a total of 305 medical terminations of pregnancy (TOP) were carried out and 66 surgical TOP's, for the same period, at Leigh Infirmary. The last audit of the TOP service was in 2013 when it was concluded that there were "Minimal adverse outcomes between Home Vs Hospital MTOP" and "Service provided high level of patient satisfaction." Referrals to treatment (RTT) times were requested for the TOP service, however; the trust reported that this data was unavailable. Doctors were pro-active with contraceptive implants following TOP and worked with the family nurse partnership to reduce further pregnancies.
- The ablation service was last audited in 2012 and was planned for re-audit in February 2016.
- The colposcopy accreditation report was last completed in 2011 and all action plans had been completed.

**Competent staff**

- Newly qualified midwives completed an 18 month preceptorship programme that included experience in

all obstetric departments. For regular midwives, there was no mandatory requirement to rotate between departments, unless a request was made; therefore skills may not have been up-to-date in all areas.

- All staff reported that they were up-to-date with appraisals and supervision. The compliance rates, at Leigh Infirmary, ward two, the women's' centre, were 100%.
- The supervisors of midwives (SOM) were allocated 15 hours per month for their supervisory responsibilities which they said were adequate. Midwives reported a concern regarding revalidation and feel that the roles of the supervisor of midwives were not being acknowledged in this process. They had linked with the revalidation head of professional practice for the nurses in the trust who confirmed that the band seven staff would be the confirmers and not the supervisors of midwives.
- Across the trust: one midwife sonographer was able to carry out scans for dating the pregnancy, first trimester screening, and anomaly and growth scans. There were 7.9 (whole time equivalent) sonographers and a trainee sonographer, who carried out gynaecology, early pregnancy scans, cervical length, dating, anomaly and third trimester pregnancy scans. All consultants performed basic obstetric scans with one who performed more detailed obstetric scans. The speciality trainees (ST2 – 7) carried out basic third trimester pregnancy scans.
- The nurse, with responsibilities for the early pregnancy assessment unit (EPAU) was able to interpret blood results and sign off blood forms.
- For the termination of pregnancy service (TOP), two registered nurses had been assessed for 'delegation of consent' as per trust policy and standard operating procedure (SOP). One of the nurses was assessed 25 October 2011 for 'termination of pregnancy (medical / surgical)' and 30 January 2012 for 'medical evacuation of retained products of conception'. The other nurse was assessed 23 July 2013 for 'termination of pregnancy'. Both were assessed by a consultant in obstetrics and gynaecology. The trust confirmed that two gynaecology nurses performed early pregnancy scans for the TOP service.
- Delirium training was a newly introduced module at the time of the inspection and as such not all staff had yet received the training. Breastfeeding for midwives training, which is not a Trust mandatory training requirement, had an uptake of 75%.

**Multidisciplinary working**

- Midwives and doctors reported good multi-disciplinary team working including sonographers who were involved in antenatal care.
- Some maternity patients were supported across trusts, for example antenatal care in Wigan, whereas delivery booked at another hospital. There were agreements in place when transfers required to other specialist sites when needed.
- The community midwives received discharge referrals, from the maternity ward, daily by phone. There was a good process in place in respect of communicating an abnormal result as GPs had full access to the hand held records as well as access to the electronic pathology system.
- Following a visit to the EPAU, we were told that a record was forwarded to the patients GP but not given to the patient.
- In surgery and maternity, there were regular 'Comm Cells' meetings for all staff to attend where they were encouraged to raise any concerns.

**Seven-day services**

- Gynaecology services were elective day cases on weekdays only and the early pregnancy assessment unit (EPAU) was open on weekday mornings.
- The termination of pregnancy (TOP) clinic was available once a week, however; during inspection, the clinic had been cancelled due to a lack of competent staff.
- Routine antenatal clinic appointments and gynaecology appointments were available on weekdays.

**Access to information**

- Staff accessed the trust-wide intranet system for policies and guidelines. Community midwives based in surgeries did not have access to blood results for patients attending for antenatal clinics and there was a lack of availability of computers in these locations to check email communications.
- Following a visit to the EPAU, we were told that a record was forwarded to the patients GP but not given to the patient.

# Maternity and gynaecology

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

- The safeguarding lead was available and supported best interest meetings if required.
- Staff training included an e-learning module for mental capacity act (MCA) and deprivation of liberty safeguards (DOL's).
- Uptake of Mental Capacity Act training was 100% for health care assistants, 70.6% for nurses and midwives and 90% for medical staff.
- A NHSLA (litigation authority) audit of consent documentation, across obstetrics and gynaecology was carried out in 2014. The results showed 'significant assurance'; apart from in response to the question "all / some of the actual risks that were discussed are stated" the score for gynaecology was 47%.
- In surgery, flow charts were displayed in staff areas and resource folders for the Mental Capacity Act and Deprivation of Liberty Safeguards were available for staff to refer to. In two sets of the patients records reviewed, the consent forms were not available.

## Are maternity and gynaecology services caring?

Good

Maternity and gynaecology services at Leigh Infirmary were good in terms of being caring.

We observed positive interactions between patients and staff both in the clinic areas on the surgical ward two where gynaecology patients were admitted for elective day case surgery. We observed staff actively engaging with patients in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed. The trusts performance in the Friends and family test for August and September 2015 for those who would recommend the service was100%.

**Compassionate care**

- We observed positive, caring interactions between staff and patients on ward two, including when giving post-operative information.
- There were no signs, on the doors in the women's centre which meant that it was not clear if a room was occupied with a patient.
- The NHS friends and family test (FFT) (a survey which asks patients whether they would recommend the NHS service they have received to friends and family) results showed that the percentage of patients who would recommend the antenatal services was 96% compared to the England average of 95%. The percentage of patients who would recommend the postnatal community services was higher than the England average of 97%. The trusts performance for August and September 2015 for those who would recommend the service was100%.
- The trust performed similar to other trust's for 16 of 17 questions in the CQC survey of women's experiences of maternity services, 2013. The question that scored better than other Trust's was: "Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?"

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

- On ward two, we observed patients were sensitively accommodated in a side room when necessary. Patients were able to be accompanied by a relative or carer if required.
- The Picker institute report dated October 2015, was a survey that included 90 patients. This was a response rate of 31%. The average response rate for the 64 trusts that ran the maternity survey 2015 was 41%. Results included that, 80% of patients said that the midwives listened to them during their antenatal check-ups, 94% felt that their partner was involved in their care during labour and birth and 82% of respondents had confidence and trust in the midwifes they saw after going home.

**Emotional support**

- The community midwives, based at Leigh Infirmary, shared an example of responding to a postnatal patient who needed support. The midwife had other commitments but located immediate support for the patient by another midwife diverting and adding to her own scheduled workload.
- Patients undergoing TOP were given appropriate emotional support and information.

# Maternity and gynaecology

## Are maternity and gynaecology services responsive?

Good

Maternity and gynaecology services at Leigh Infirmary were good in terms of being responsive.

The service had been planned across the geographical location. Gynaecology clinic services were based in the women's centre at Leigh Infirmary. The antenatal clinics were being supported by main outpatients as they are in the process of relocating to refurbished premises in the former ward one. Each maternity patient was allocated a named midwife, in the community. Antenatal clinics were available across the Wigan and Leigh areas in GP surgeries. Maternity inpatient services were located at the Royal Albert Edward Infirmary although; ward two, a female surgical ward, admitted elective day-case gynaecology patients.

There were specialist midwives including public health, safeguarding and a mental health nurse. Also diversity and dementia champions were available. Any patient identified with a learning disability or mental health issue were supported on an individual basis as needed.

### Service planning and delivery to meet the needs of local people

- Each GP surgery was allocated a named midwife with responsibilities for a woman's antenatal and postnatal care within a multidisciplinary team, The contact details of the named midwife were included in the woman's 'hand held notes'. The trust aimed for each woman to be seen by their named midwife at each appointment, whenever possible.
- The maternity and gynaecology services were provided at both hospital sites and community locations. There were three consultant clinics weekly at the Thomas Linaker Centre (TLC), close to RAEI, two for high risk patients and one for patients with pre-existing medical conditions. There were two consultant antenatal clinics at Leigh Infirmary for patients in that local area.
- There were women who chose to combine the community and inpatient care with other trusts. There was also a recently developed 'tongue tie' clinic service available.
- Midwifery led clinics, for low risk women were available at TLC, although the capacity there was limited as the consulting rooms were shared with other clinics.

### Access and flow

- There was an Early Pregnancy Assessment Unit (EPAU) at Leigh Infirmary, based next to ward two, where patients could attend up to 12 weeks pregnant and the unit on Swinley ward at Royal Albert Edward Infirmary was for up to 18 weeks pregnant. The service on Swinley was available 24 hours a day, whereas at Leigh Infirmary it was not available overnight.
- Between April 2015 and November 2015, a total of 25,040 women were seen across all trust sites antenatally. With an average of 3,130 per month. The busiest of clinics was the Thomas Linacre Centre with a total of 6,658. At Leigh Infirmary, 2,470 appointments were attended.
- For the same time period, the average wait time in weeks for women attending their first obstetric appointment was 1.7 weeks across all sites, with an average wait time at Leigh Infirmary was 3.1 weeks and 3.6 weeks at TLC.

### Meeting people's individual needs

- There was no area of ward two specifically allocated for gynaecology patients; although staff tried to accommodate women appropriately and sensitively, including if a single side room was required.
- In the women's health centre, we observed a patient who was awaiting hospital transport home. Staff were attentive in providing the patient with food whilst chasing up the transport.
- There were specialist midwives including practice development midwives, screening co-ordinator, quality and safety, safeguarding and public health midwives. The public health midwives held a collective caseload of 75 patients providing individual support to patients with specific requirements such as drug and alcohol support or domestic abuse.There was a teenage pregnancy midwifery support team who provided care for the teenage pregnancy caseload across all areas, and worked closely with the family nurse partnership. There was a normality group, family nurse partnership and family planning services were available.

- Some midwives were diversity champions which meant they helped support patients with a visual or hearing impairment. There was a dementia champion who was able to support visitors and other staff.
- There was a mental health pathway and the Whooley questions (screening for depression) were used during an assessment in accordance with National Institute for Clinical Excellence (NICE) Guidance with a formal referral system in place. A mental health research nurse was recently appointed with the trust.
- There was a trust-wide interpreter and translation service available if needed.
- Midwives told us there was no current weight management service. Until earlier this year, a dietician, psychologist and physiotherapist helped to support patients with a body mass index (BMI) of 35 and above. The midwives did an information pack before they left the service with information and guidance.
- For gynaecology, we were told that a patient with a complex need or learning disability was likely to be admitted to Swinley ward at RAEI rather than Leigh Infirmary as a day case. As part of mandatory training requirements, there was an e-learning module regarding best interest meetings in order to plan individual supportive care pathways.

**Learning from complaints and concerns**

- There were posters displayed in the corridors and the lifts indicating how to access the complaints system. The complaint reporting system indicated that a total of 22 complaints had been received, for maternity and gynaecology, between September 2014 and July 2015. The majority were closed within a timely manner including apologies to complainants. There were four complaints recorded as open.

## Are maternity and gynaecology services well-led?

Good

Maternity services at Leigh were good in terms of being well-led.

Surgical staff understood the trust vision and strategy. Staff felt that they were supported by their managers with opportunities for development. Staff worked collaboratively across the maternity and surgical gynaecology services to meet the needs of the local population.

Systems were in place that recorded completion of risk assessments, incidents and audits. Staff and patient surveys were recorded and acted on. Managers attended meetings and cascaded information to staff.

Monthly multidisciplinary team meetings were held in order to review current guidelines and practices that included a variety of grades of doctors and midwives; however, the guidelines were not clear or consistent.

Lesson learned from compliments and complaints received, from the public, were shared and discussed in team and divisional meetings.

**Vision and strategy for this service**

- Surgical staff understood the trust vision and values and could provide information about the vision displayed on notice boards.
- Staff could attend briefing sessions with the chief executive and senior management team.

**Governance, risk management and quality measurement**

- Following the Kirkup report (enquiry into maternity services), an action plan was developed that was presented at the matron's meeting, and then cascaded to the ward areas. The recommendations included mandatory training and communication workshops; however there was a lack of consistency between the manager's report of the actions taking place and the midwives view.
- The community band seven midwives were able to attend the monthly meetings which were formal and minuted.
- Surgical Incidents and risk assessments were completed and discussed at communication meetings that were attended by senior staff. Divisional meeting minutes showed discussion of identified risks and any incidents, subsequent investigations and lessons learned.
- The trust had an audit plan in place which staff participated in.
- Surgical team meetings and 'huddles' were held to discuss issues as well as information being visible on ward notice boards.

- Quality champions were evident, trust wide, with staff attaining bronze, silver or gold level champion status.

**Leadership of service**

- The head of midwifery was approachable, visible, and could be contacted; although she had a dual role across children and maternity services. The board were approachable and midwives viewed a monthly video presented by the trust chief executive officer.
- The community midwives said they felt supported by the matron to participate in development opportunities promoting a sense of pride and there were opportunities for all staff to develop. It reportedly worked well for the community although hospital midwives felt that there were fewer opportunities to develop.
- Surgical staff stated that they felt supported and able to discuss issues with senior managers and that the executive team and board members were accessible and responsive. Surgery managers were proud of their teams and that they all worked well together.

**Culture within the service**

- Staff said they were proud of the services and liked working for the trust. They provided good care for patients with good team work and long serving employees.
- Staff were described as approachable and helpful with senior staff available if required for support.
- Staff were positive and enthusiastic and felt valued. They felt they worked well with colleagues and supported each other where required.
- Staff could access the whistle blowing policy and were encouraged to raise issues and concerns.

**Public engagement**

- In surgery, an in-patient survey had similar results to all questions asked to in the national audit. An example being 'Do you feel you got enough emotional support from hospital staff during your stay? The trust scored 7.3 against the national average of 7.1.

**Staff engagement**

- The head of midwifery visited the clinics, except; these were informal visits.
- Staff received regular email communication from the trust providing updates on changes and improvements.
- Staff reported being encouraged to put forward ideas for improvements and cost efficiencies and felt their views were listened to.

**Innovation, improvement and sustainability**

- Current innovations have included a four stage antenatal programme with input from a neighbouring trust, breastfeeding peer support, midwives and health visitors. The four sessions included "nurturing the needs of your bump and baby", "labour and birth", " breastfeeding workshop" and " getting it right for you and your baby"
- Twelve midwives received training in hypnobirthing to provide holistic care during the antenatal and intra-partum periods. Acupuncture will commence later in 2016.
- The maternity service had been part of the saving babies in the north of England project (SABiNE) which has being led by NHS England and the perinatal institute since June 2015. This aimed to reduce the numbers of stillbirths and neonatal deaths, using a package of care and training monitoring patients antenatally. Areas that were focused on included antenatal surveillance of growth and outcomes (gestation related optimal weight – GROW), smoking cessation, reduced fetal movement pathways and training for staff relating to fetal heart rate monitoring.

# Outpatients and diagnostic imaging

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

## Information about the service

A range of outpatient services are provided by Wrightington Wigan and Leigh NHS Foundation Trust at the Leigh Infirmary site and adjoining Hanover Diagnostic and Treatment Centre which opened following refurbishment in 2013. Approximately 63 consultant led clinics and 10 nurse led clinics take place each week.

The main outpatient clinic areas are situated on the ground floor of the infirmary in six 'areas'. These areas house a range of clinics covering colorectal, breast and orthopaedic surgery, diabetes, lipids, renal, urology, neurology, anti-coagulation, cardiology, chest, obstetrics and gynaecology. The Hanover Diagnostic and Treatment Centre provide clinics for women's health, urology and endoscopy patients.

Between January 2014 and December 2014 the service provided 188,707 patient appointments, 21% of which were new appointments and 53% were follow up appointments.

Diagnostic imaging and haematology services are also provided at Leigh Infirmary including ultrasound, plain film x-ray, barium enemas, and barium swallows with video-fluoroscopy and video-urodynamics. On average radiology staff see 85 patients each weekday and between 30 and 50 patients at the weekend.

During our inspection we spoke with two patients and 22 staff including managers, receptionists, nurses, and doctors. We also observed the interactions between staff and patients and reviewed three patient records. We analysed information provided by the trust before and after our inspection.

## Summary of findings

We have rated outpatient and diagnostic services at Leigh Infirmary and the adjoining Hanover Diagnostic Treatment Centre as good overall.

Whilst low numbers of incidents were recorded by the departments those that were reported were graded according to risk and shared to promote learning. There was an open and honest culture amongst staff. The environment differed depending upon location. Whilst the outpatient department was dated with little natural light, the Hanover Centre was light and spacious following refurbishment in 2013. The areas we inspected were visibly clean and tidy. Cleaning and hand hygiene audits were done regularly with compliance above 94%. Action was taken to improve scores when required.

Safeguarding was managed by a central team who could advise staff. Safeguarding training was completed by staff according to the level of contact with patients and those close to them. Patient risks were managed with resuscitation trolleys in departments.

Staffing was adequate with few vacancies and little or no use of agency staff. Staff used guidelines, procedures and policies to provide care for patients. Departments undertook audits and presented findings to colleagues to promote learning and improve services.

Staff received appraisals and were given opportunities to enhance learning. Radiology services were provided

# Outpatients and diagnostic imaging

seven days a week. Outpatient clinics were not routinely provided on a seven day basis but clinics were held in the evenings and occasionally on a Saturday morning to manage waiting lists.

Patient records contained the necessary information. However medical signatures were not always legible and registration numbers and printed names were not always included. Approximately ten patient records per month were unavailable for clinic appointments. Staff accessed the electronic systems or contacted GPs if information was not available.

Staff understood consent and we saw evidence that written or verbal consent was obtained when required.

Outpatient services documented standards to maintain high levels of service and these were displayed for patients and visitors.

Patients were happy with the care they received and said staff had a polite and compassionate manner. Patients felt supported by staff during appointments.

A range of initiatives were in place to meet people's needs. These included pagers which allowed people to leave waiting areas until called for their appointment, translation services, and quiet rooms. Information about care for people living with dementia was in place with further plans due to be implemented.

Access and flow was monitored in a number of ways. The hospital met the department of health target of providing appointments for patients within 18 weeks. Ninety seven percent of patients referred for an urgent appointment for suspected cancer were seen within the department of health target time of two weeks. On average patients received appointments within 19 days for non-obstetric ultrasound scans, and two days for x-ray.

Waiting times following arrival in clinic varied depending on the type of appointment. Records showed that for plain film x-rays patients did not have to wait at all. Fluoroscopy patients waited on average for 239 minutes but this data also included theatre patients. At the time of our inspection there were no visible delays for patients waiting to be seen. Reporting time for scan results was one to two days. However, in September 2015, 1,367 x-rays were waiting for reports to be completed across all sites. Further staff were being recruited to manage this.

Experienced staff planned clinics in advance. However; with no written process in place, we were unsure how resilient the process was or how staff would manage if an experienced staff member was unavailable.

Verbal concerns were dealt with at the time through communication if possible. Formal complaints were recorded and referred to the trust Patient Advice and Liaison Service (PALS). Those that were recorded were monitored with results shared monthly to promote learning.

Staff had ideas about how to improve services. Trust values were evident in the areas we inspected. Governance meetings were held monthly. Risk was managed through a local risk register which documented the issue, mitigation, risk score and review date of each risk.

Staff felt supported by managers and services engaged with the public, through forums and questionnaires.

The trust had a department dedicated to staff engagement and produced reports which demonstrated improvements.

Urology staff offered 'one-stop' appointments for haematuria patients which enabled patients to undergo biopsies during initial appointments rather than having to re-attend on another day.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good

We have rated outpatient and diagnostic services at Leigh Infirmary and the Hanover Diagnostic and Treatment Centre as good for providing safe care to patients.

Low numbers of incidents were recorded by the outpatient department. However, all reported incidents were fully described and graded according to the level of risk to patients. The trust promoted an open and honest approach when things went wrong and senior staff were aware of the Duty of Candour (a legal obligation to inform and apologise to patients if there have been mistakes in their care that have led to significant harm).

The older parts of the building which housed the main outpatient department were dated and consultation rooms were small. The refurbished Hanover Centre was light and spacious in comparison. Medicines were stored correctly and within expiry date but we found information relating to anaphylaxis medicines difficult to understand. Records were paper based, with some documents available electronically. Paper records were not always available but duplicate copies of some notes could be generated on the electronic system if required.

There was a focus on safeguarding practice with a dedicated trust team available to support staff. Mandatory training was monitored by managers and staff were given time to complete training. Data showed 99% of outpatient staff were up to date with mandatory training which met the trust target of 95%.

Patient risks were identified and managed with appropriate measures put in place. However we found 'local rules' relating to radiation were difficult to locate and past their review date.

Nurse and medical staffing was adequate with few vacancies and little or no use of agency staff. Experienced staff planned clinics in advance; however there was no written process in place to help less experienced staff organise clinics should the need arise.

Staff were familiar with the trust's major incident policy and were aware of the process should a major incident be declared.

### Incidents

- Staff reported incidents electronically and received email notifications to confirm receipt and outcome of investigations.
- There was a culture of learning from incidents amongst staff.
- The numbers of incidents reported in the outpatients department was low with only six incidents reported between May and August 2015. Whilst this may indicate that few incidents occurred, it could also indicate that staff didn't always report incidents when they occurred.
- Incidents were reviewed with findings shared at senior level and disseminated to staff in daily and monthly meetings.
- Staff were open and honest when things went wrong and senior staff were aware of the Duty of Candour principles. This is a legal duty to inform and apologise to patients if there have been mistakes in care that led to significant harm.

### Cleanliness, infection control and hygiene

- The areas we visited were visibly clean and tidy.
- Staff told us departments were cleaned and sanitised daily and we saw records which supported this.
- Audits in hand hygiene were completed in each department and action to improve results was taken if required. For example, outpatient staff scored 100% for hand hygiene between January and November 2015, except for May 2015, when the score fell to 94%. To improve this managers displayed reminders which improved scores.

### Environment and equipment

- The Hanover Centre was light and spacious following refurbishment in 2013.
- The six main outpatient areas were visibly clean and tidy but the infrastructure was dated and there was little natural light.
- Despite being fit for purpose, one of the sonography rooms was small, having been changed from a cleaning cupboard into a consultation room. A sonographer said there were plans to increase the size of this room in the future.

- Rooms in the urology department had been refurbished with patients in mind. For example, toilets were built into individual changing rooms for patients undergoing full bladder urology tests, to limit the need to walk through public areas in gowns. Patients completed 'flow' tests (to record the rate and amount of urine passed) in private rooms instead of consultation rooms. There was a quiet area for patients and those close to them to sit and read or watch television following procedures.
- At the time of our visit there was adequate seating for patients in the outpatient and urology waiting areas.
- Resuscitation equipment was available and ready for use. Records showed equipment was checked daily except for weekends when the areas were usually closed. Procedures were also stored with the trollies to support staff should they need to provide basic life support.
- Equipment displayed stickers indicating the required date for electrical checks. These were up to date.

**Medicines**

- The majority of outpatient areas did not require the use of medicines or controlled drugs. However, controlled drugs were stored in the urology department. Here we found records showing that stock was checked and dispensed correctly and was within the expiry date. Entonox gas (a type of gas used to relieve pain) was stored in the department with appropriate signs for compressed gas.
- Urology staff used a 'track and trace' system to record medicine use for individual patients. This ensured that medicine and equipment batch numbers could be traced to individual patients.
- Radiology medicines and contrast media were appropriately stored and within expiry date.
- Medicine to treat anaphylaxis (a severe allergic reaction which can be life threatening) were stored in the departments. Staff knew where to locate the kits. Inside were instructions for administering drugs to treat the reaction. However, in the radiology department we found instructions for dosage of adrenaline difficult to understand and review dates for flow charts explaining the process were 2013 for adults and 2008 for children.
- Fridges storing medicines requiring a low temperature range were checked and were all within the required temperature range. Records showed that fridges were checked on a daily basis.

**Records**

- Records were paper based but staff also had access to an electronic patient record (EPR) system where they could source duplicate copies of some notes if paper records were missing.
- Figures provided by the trust showed that between June and November 2015, an average of ten patient records per month were unavailable for clinic.
- We reviewed three patient records. These were complete with supportive documents to help staff complete referral forms and a pre-biopsy checklist adapted from the World Health Organisation Surgical Checklist. However medical staff signatures were not easy to read, and names and clinical registration numbers were not noted. The Royal College of Physicians Healthcare record Standards (June 2015) states that 'the name and designation of the person making the entry should be legibly printed against their signature'.

**Safeguarding**

- The trust had a team dedicated to safeguarding for children and adults which supported staff with advice if required.
- The department had safeguarding champions who ensured staff had a suitable contact for safeguarding queries. Staff champions have extra knowledge of particular topics and act as a point of contact when other staff require advice.
- Adult and child safeguarding training was mandatory and completed annually or twice yearly depending upon the level of contact staff had with patients. The trust target for safeguarding training was ninety-five per cent. Ninety-eight per cent of staff were up to date with adult safeguarding training. Child safeguarding training was provided in one of three levels dependent upon the level of patient involvement. Ninety-nine per cent of non-clinical staff were up to date with level one safeguarding training which they completed every two years. Ninety-six per cent of clinical staff were up to date with annual level one, 90% had completed level two and 88% had completed level three training.

**Mandatory training**

- Mandatory training was predominantly completed annually via e-learning modules, accessible via the trust intranet. Topics for mandatory training included basic

life support, manual handling and safeguarding adults. The exception to this was resuscitation, and high risk conflict resolution training which were both delivered face to face.
- Ninety-nine per cent of Leigh outpatient staff and 92% of radiology staff were up to date with mandatory training.
- All staff completed basic life support training as part of mandatory training. Other staff received advanced life support training. In the main outpatients' area, 100% of nursing staff were training in basic life support and two staff were trained in advanced life support.
- Staff received reminders via email that they were due to renew their training.
- Managers were sent details about training progress for each staff member. A 'red, amber, green' rating was used to ensure managers could easily identify staff approaching deadlines for renewing training.

**Assessing and responding to patient risk**

- There were reliable systems, processes and practices in place to assist in keeping patients safe. For example, the trust had a comprehensive resuscitation policy that defined the levels of competency each level of staff needed in order to manage a patient suffering a cardiopulmonary arrest. Basic life support training was given to any staff who had patient contact whether clinical or non-clinical
- Guidance was available for staff explaining the process should a patient's condition deteriorate whilst in the department.
- The trust had a policy in place for confirming pregnancy status prior to radiological imaging taking place.
- Ionising Radiation Regulations 1999 state that instructions about radiation must be available to keep patients and staff safe in radiology departments. These are known as 'local rules' and should be reviewed regularly and understood by staff working in the department. Whilst local rules were present, staff struggled to locate them. When these were found, there were several versions and records showed they had not been reviewed by staff since 2011.

**Radiology and Nursing staffing**

- There was a process in place to ensure enough nurses were available during clinic times. Staffing was organised six weeks ahead of clinic dates. Senior nurses calculated the number of staff required depending upon the acuity or number of patients in clinic. They were informed of medical staffing to help them organise staffing. Although staff planning rotas knew the staffing requirements for each clinic, there was no robust written process in place for this which would prove challenging if an experienced staff member was unavailable.
- There were no vacancies in the urology department. Senior staff told us there were two part time (16 hours per week) vacancies for health care assistants in the main outpatient department and figures provided by the trust supported this. Funding was being assessed for these posts prior to recruitment. In the meantime, part time staff who were happy to increase their working hours covered the short fall which ensured there was no requirement for bank or agency staff use. Staff were happy with staffing levels when asked, and this was reflected in records provided by the trust which supported their view.
- Figures from August 2015 showed funds were in place for 226 allied health professionals such as radiologists and physiotherapists across all trust sites. At the time of the inspection, there were 220 allied health professionals in post across the trust, resulting in six vacancies across all sites.
- In order to comply with the Ionising Radiation Regulation 1999, radiation protection supervisors should be employed by any organisation using radiation. The role of a supervisor is to advise and ensure staff comply with local rules. Since February 2015, there had been no radiation protection supervisors based at Leigh Infirmary. A senior radiographer was due to undertake training in March 2016 and in the meantime, staff had access to radiation protection supervisors at the other trust sites. Whilst we were concerned about the challenges remote supervision may present, the trust provided us with assurance that their designated advisory body was aware of and satisfied with the situation.

**Medical staffing**

- Medical staffing for clinics was organised by each speciality. Senior nurses told us that clinics were staffed appropriately, except when doctors were absent at short notice through sickness, or late for clinic due to delays such as surgery or emergency patients.

**Major incident awareness and training**

# Outpatients and diagnostic imaging

- A trust major incident policy and a business continuity plan were in place to help support staff and maintain core business during major incidents.
- Staff explained what they may be required to do should a major incident be declared, such as transferring to other sites to provide clinical support.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff used guidelines, procedures and policies to support them in providing care for patients. Pain relief was not routinely required for outpatient clinics and was not stored in the department. However, there was an onsite pharmacy which distributed pain relief to patients if required.

Departments regularly took part in audits and presented these to colleagues to promote learning and improve services. Nursing staff assisted medical staff and patients when collecting data for the audits. Hand hygiene and cleanliness audits were also completed regularly.

Staff received appraisals and were given opportunities to enhance learning. Staff worked together and shared knowledge to improve care. Radiology services were provided seven days a week. Outpatient services were not routinely provided on a seven day basis but clinics were held in the evenings and occasionally on a Saturday morning to prevent waiting lists growing.

Staff were able to access the information required to provide services to patients. Approximately ten records per month were unavailable for clinic appointments. Staff accessed the electronic system to print duplicate notes or contacted GPs if information was not available.

There was an understanding of consent and we saw evidence that written or verbal consent was obtained when required.

### Evidence-based care and treatment

- Staff used local guidelines (such as peri-operative anti-coagulant guidelines) and national guidelines (such as guidance for suspected cancer) by the National Institute for Health and Care Excellence (NICE), the Royal College of Nurses and the British Association of Urological Surgeons Limited.
- Guidelines, protocols and policies were available in laminated versions or on the trust intranet.
- Standard operating procedures (SOPs) had been devised by the trust and supported staff providing specific care for patients such as ultrasound scans of the abdomen or testes. We saw evidence that SOPs were reviewed and changed when required.
- Radiology staff used 'local rules' in line with Ionising Radiation (Medical Exposure) Regulations 2000 to ensure they administered radiation safely to patients. We saw evidence that these had been reviewed and updated in 2014. Reviews and updates for 2015 were due in January 2016.
- Trust policies and procedures such as the radiation protection policy were available on the internet and updated when required.
- Some staff were members of relevant organisations such as the International Continence Society.

### Pain relief

- Pain relief was not stored by outpatient or diagnostic services but was held in the Urology department where some outpatient clinics took place. Here, Entonox gas was appropriately stored for patient use when required. Staff in the main outpatient department told us there was no requirement for this in other clinics. However, there was a pharmacy on site for patients to obtain pain relief if necessary.
- Pain relief such as Entonox gas was available and appropriately stored in the urology department
- We saw evidence that Patient Group Directives (PGDs) for medicines such as saline and Buscopan were used across the radiology directorate. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. These were quality checked before being authorised by the medical director.

### Patient outcomes

- Different specialties contributed to internal and external clinical audits. For example, the urology department contributed to a national audit about bladder botox therapy. This resulted in a change to NICE guidelines with the introduction of antibiotics pre-procedure.
- Some local audits used patient data from clinics on multiple sites. For example, anticoagulant staff completed an audit in 2015 of patients with elevated

International Normalised Ratio (INR) levels. The audit identified both causes and symptoms of raised INR levels, as well as the need for good communication to enable effective monitoring and management of patients. Radiology staff completed audits in areas such as the classification of thyroid nodules which showed staff were performing above the required standards.

- Audit days were held monthly or twice monthly and gave staff the opportunity to share and discuss progress or audit results.
- The urology department formed part of a North West regional audit programme with colleagues in Manchester and Liverpool. Staff told us findings were shared at meetings to promote learning.
- Staff used audits to support concerns. For example, following increased numbers of urgent sonography requests, staff began an audit to review this which was in progress at the time of our inspection.
- Radiology staff across all sites adopted a practice where standardised monitoring helped identify any areas of poor practice before feedback was given to promote positive learning. For example, the work of radiographers was assessed by a core group of peers. Where staff identified scans that could be improved, these were labelled and discussed with the staff member. Staff involved in this process reported the benefits of the process and we saw that the numbers of scans reviewed as 'poor' were less than 0.07% between June and August 2015.

**Competent staff**

- Staff received annual appraisals where performance and development were discussed with a manager. Whilst 100% of outpatient staff were up to date with their appraisal, only 73% of radiology staff had completed theirs within the twelve months prior to the inspection.
- Staff had opportunities to enhance their skills. For example staff in the urology department were due to undertake training to enable them to teach self-catheterisation in January 2016.

**Multidisciplinary working**

- We saw evidence of staff from different specialities working together to learn and provide a good service for patients. For example, oncology nurses attended haematology meetings with medical staff; nurses also supported medical staff from different specialities when running clinics on a day to day basis.
- Nurses in the main outpatient department worked with local GP's to source patient referral letters, when required, at short notice.
- The radiology teams were working with colleagues in Greater Manchester to provide future joint services in a project called 'Healthier Together'. Monthly departmental meetings gave staff the opportunity to discuss aspects of the project.

**Seven-day services**

- At the time of our inspection clinics were not running on a seven day basis. However, some evening or Saturday morning clinics were held to enable patients to attend or to keep waiting lists down.
- Patients could attend the radiology department for x-rays or scans on Saturday and Sunday. The reception area was closed at weekends but a sign was displayed telling patients where to wait if attending at the weekend.

**Access to information**

- Staff reported having access to all the information required to see patients in clinic such as scan results, blood test results and GP referral letters. If information was missing, staff accessed the electronic patient record (EPR) system or made contact with GPs.

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

- Staff worked under the assumption of implied consent. Verbal and written consent was also obtained depending upon the care or treatment being provided. Plain film x-rays were performed under implied consent if the patient followed instructions without refusal, barium enemas required verbal consent and interventional radiology procedures required written consent.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services caring?

Good

We rated services as being good in caring for patients and those close to them.

Patients told us they were happy with the care and treatment received and cared for them in a polite and compassionate manner.

Outpatient services used set standards to ensure levels of service were maintained and these were displayed for patients and visitors.

Clinical leads were available to provide specialist advice and support to patients and those close to them. Patients felt supported by staff during appointments.

### Compassionate care

- We observed staff caring for patients in a polite and compassionate way.
- Staff took patients' needs into account when refurbishing the urology department. Toilets were placed within changing rooms to maintain dignity and privacy for patients undergoing bladder testing. As a result of this, patients did not have to use public toilets accessed via the main corridor.

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

- The services used a number of standards which were displayed for patients. One of the standards pledged to keep people informed about their care, in a way that they could understand. Senior outpatient staff met with 32 patients to seek their views about care and treatment. In June 2015 the results showed that some but not all patients felt involved and confident enough to ask questions. Staff were working to improve this and there were plans to review findings again in order to measure improvement.
- Patients attending sonography appointments described staff explaining processes and what was happening.

### Emotional support

- Clinical nurse specialists or 'leads' were available in areas such as haematology, oncology and venous thromboembolism. These staff were able to provide extra support and information to patients, enabling them to cope emotionally with their care, treatment or condition.
- Patients described sonography and x-ray staff as being 'reassuring' during appointments.

## Are outpatient and diagnostic imaging services responsive?

Good

We have rated services as good in responding to the needs of patients and those close to them.

Pagers were available for patients so they could leave departments while waiting for their appointment.

Access and flow was monitored in a number of ways. The hospital met the Department of Health target of providing appointments for patients within 18 weeks. Ninety-seven per cent of patients referred for urgent appointments for suspected cancer were seen within the Department of Health target time of two weeks. On average patients received appointments within 19 days for non-obstetric ultrasound scans, and two days for x-ray.

Waiting times following arrival in clinic varied depending on the type of appointment. Records showed that for plain film x-rays patients did not have to wait at all. Fluoroscopy patients waited on average 239 minutes but this data also included theatre patients. At the time of our inspection there were no visible delays for patients waiting to be seen. Reporting times for scan results, provided by the trust was between one and two days. However we found a contradiction when reviewing minutes of meetings and reports which highlighted a back log of 1,367 x-ray reports awaiting completion in September 2015. Further staff were being recruited to manage this.

Translation services were readily available and staff knew how to provide this service for patients if required. A room was available for mothers to breast feed or for patients with learning disabilities to wait somewhere quiet if they preferred. Dementia care was promoted on notice boards and outpatient staff showed us plans to decorate part of the waiting area to suit the needs of these patients.

# Outpatients and diagnostic imaging

The majority of complaints related to waiting times. Verbal concerns were dealt with at the time through communication if possible. Formal complaints were recorded and referred to the trust Patient Advice and Liaison Service (PALS). Those that were recorded were monitored with results shared monthly to promote learning.

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

- The outpatient departments had a pager system in place to improve the experience of patients' waiting. Staff issued one of 15 pagers to patients. This allowed them to leave the waiting area until the pager alerted them to return for their appointment.
- The waiting areas in radiology and the main outpatients' area did not have any toys or facilities for children, or magazines for people to read. A manager told us that these had been removed to reduce the risk of cross infection.

**Access and flow**

- Access and flow was measured in a number of ways. These included the percentage of patients referred for treatment within the Department of Health target of 18 weeks, waiting times following arrival at hospital, and time taken to report diagnostic imaging results. Clinic cancellation rates and patients who did not attend appointments were also monitored. Some figures were generated specifically for the Leigh Infirmary and Hanover Diagnostic and Treatment Centre, and others for the trust as a whole.
- Between January 2015 and October 2015 the trust performed better than the England average for referral times, with between 96.8% and 97.5% of patients seen within 18 weeks.
- The trust also performed better than the England average for the percentage of suspected cancer patients seen within two weeks. Between April 2013 and October 2015, a minimum of 97% of patients were seen within two weeks.
- Wait times for radiology appointments at this site varied according to scan type. Fluoroscopy patients waited the longest for appointments which were on average 239 minutes between March and August 2015. However, these figures also included patients from theatres. Patients waiting for plain film x-rays did not have to wait at all.
- Referral times for radiology patients also varied according to the type of scan required. Patients waiting for non-obstetric ultra sound scans waited an average of 19 days between March and August 2015. Patients waiting for fluoroscopy scans waited an average of half a day and those waiting for plain film x-rays waited an average of two days.
- The trust told us that across all sites, the average time taken to report scan results varied from two days for plain film x-rays to within one day for fluoroscopy scans. However a radiology report highlighted a significant back log of 1,867 reports (across all sites) waiting to be actioned in August 2015. The trust took action to reduce this by recruiting another staff member which reduced the number of outstanding reports to 1,367 in September 2015
- The radiology department worked to assist the wider hospital with access and flow by prioritising patients ready for discharge but awaiting scan or x-ray results. They also provided training to allow radiographers to report on specific scans usually done by consultants. This increased consultant availability for patient appointments.

**Meeting people's individual needs**

- Translation services were available for patients whose first language was not English. Staff were familiar with the process for organising translation by telephone or face to face. In addition staff also used a laminated card with key phrases to help identify which language patients preferred to use.
- Patients with a learning disability had access to a quiet room to use while waiting for their appointment which gave the option of a less stressful environment than the main waiting area.
- There was a room available for mothers to breast feed in the main outpatient department.
- Dementia 'champions' were employed in the outpatient department. Staff champions are staff who have extra knowledge in a particular area.
- Stickers displaying a blue flower were used in patient records to identify people living with dementia.
- We were shown an area of the outpatient waiting room which was due to be made into a dementia friendly area. Staff planned to display old photographs and play music from the past.

- Staff told us that, where possible, they ensured dementia patients were seen first to prevent them having to wait.

**Learning from complaints and concerns**

- Senior nurses told us formal complaints were rare and records confirmed this, with only three formal complaints received for outpatient and diagnostic services at the infirmary between September 2014 and December 2015.
- Senior outpatient staff told us that verbal concerns, dealt with at the time were not recorded as complaints. Not recording concerns causes a risk that trends may not be identified.
- Actions were taken following complaints. These included offering apologies, explanation and further consultations to reassure people where necessary. Further actions to limit recurrence were also taken such as widening the area of scans to ensure vital areas of the body were captured.

## Are outpatient and diagnostic imaging services well-led?

Good

We have rated services as good in providing well led services for patients and those close to them.

Staff at senior level were passionate about strategy, and trust values were evident in the areas we inspected. Governance meetings were held monthly. Risk was managed through a local risk register which documented the issue, mitigation, risk score and review date of each risk.

Staff felt supported by managers and there were weekly staff meetings. The outpatient department engaged with the public, holding public forums and obtaining feedback about services through questionnaires.

The trust had a department dedicated to staff engagement and produced reports which demonstrated improvements annually.

Urology staff offered 'one-stop' appointments for haematuria patients which enabled patients to undergo biopsies during initial appointments rather than having to re-attend on another day.

**Vision and strategy for this service**

- Senior managers had clear visions for the future and were passionate about their approach to improvement. Ideas included improving the reporting time for radiology results from within one day to within two hours. These ideas formed part of the radiology directorate's strategy for improvement. This strategy was in place to help the department achieve goals such as reducing reporting times, improving service delivery at weekends and succession planning.

**Governance, risk management and quality measurement**

- Monthly governance meetings were held in different specialities such as urology.
- Team meetings were held daily, weekly or monthly depending upon the department. Senior staff told us that minutes were taken at these meetings and emailed to staff or were available to view on the trust intranet. Copies were also displayed in staff rooms and on notice boards.
- The radiology department had a local quality improvement process in place. Here, initiatives which focused on improvement were put forward, such as standardising the way radiology work was monitored and devising ways of learning through practice. .
- There was a divisional risk register in place which recorded risks for each specialism. The register included a description of the risk, a risk score, current and additional mitigation action, a named person responsible for dealing with the risk and a review date. However, the items were not dated to show people when they were first recorded. This meant we were unable to review how long it took to manage and mitigate the risks recorded. Risks corresponded with the issues senior staff highlighted to us and their action plan for addressing those risks.

**Leadership of service**

- Staff felt supported by senior managers and said they made the time to visit departments.
- Staff attended regular meetings with managers either daily, weekly or monthly.

**Culture within the service**

- There was a positive culture in the areas we inspected and amongst the people we spoke to.

- Values were visible and staff were familiar with these.

**Public engagement**

- The outpatient department held patient forums and took part in the 'friends and family' test to capture the views of those using services.

**Staff engagement**

- Senior managers engaged with staff when improving services.
- A 'staff engagement' department employed practitioners to support teams in engaging with staff. The department also produced staff engagement reports. We reviewed the anticoagulation team staff engagement survey report dated August 2015 which showed improvements in aspects of staff engagement such as work relationships and staff mind set, since February 2015.
- Twenty two staff were recruited to be part of a project for redesigning the outpatient service in June 2015. Here staff met with 32 patients and carers to review their personal experience of services. Key themes were then identified and incorporated into practice. Further review of the themes was due to take place to measure the efficacy of the actions.

**Innovation, improvement and sustainability**

- The urology department aspired to offering one stop clinics for haematuria patients. These meant patients attending initial appointments could have biopsies done at the time of their initial consultation rather than having to return for a second appointment.
- By sharing audit findings amongst, teams learning could be shared with a view to improving services.

# Outstanding practice and areas for improvement

## Outstanding practice

- The urology department aspired to offering one stop clinics for haematuria patients. This meant patients attending initial appointments could have biopsies done at the time of their initial consultation rather than having to return for a second appointment.
- A trust 'pioneering staff engagement' programme was in place across a multi-disciplinary team with a number of innovating programmes in progress. The service had received several awards over the past two years.

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure safeguarding, mental capacity act (2005) and deprivation of liberty safeguards are in place and followed to ensure patients safety at all times. Processes must be clearly defined, understood and followed by staff.
- Ensure that there is adequate space on the wards for patients to receive safe and effective care.
- Ensure that there are adequate facilities to store clinical waste safely.
- Ensure care is delivered as per evidence based guidance

### Action the hospital SHOULD take to improve

- Improve the timeliness of patient discharges from Taylor ward.
- Improve staff annual appraisal rates.
- Keep trolleys containing patients notes locked
- Improve the completeness of records particularly with name and designation always clearly recorded and printed and consent forms available to review.
- Review local rules held in the radiology department and ensure staff can locate them if required.
- Review dosage instructions for adrenaline administration to treat anaphylaxis and ensure they are satisfied instructions are easy to interpret in an emergency.
- Review the benefit of documenting processes for organising staffing for outpatient clinics.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>Regulation 13 (1)(3)(4)b (5)<br>Service users must be protected from abuse and improper treatment. Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. care and treatment for service users must not be provided in a way that includes acts intended to control or restraint a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint. A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Regulation 18: Staffing 18(1) (2)<br>Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Persons employed by the service provider must receive appropriate support, training professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>Regulation 15: Premises and equipment 15 (1)<br>All premises and equipment used by the service provider must be clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. |
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Regulation 12: Safe care and treatment (12(1) 12 (2) (a,b)<br>care and treatment must be provided in a safe way for service users. The registered person must comply by assessing the risks to the health and safety of service users receiving care or treatment and do all that is reasonably practicable to mitigate any such risks. |