Care Quality Commission
Cityate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Silas Nicholls
Chief Executive
Southport and Ormskirk Hospital NHS Trust
Town Lane
Kew
Southport
PR8 6PN

Date: 16 July 2019

Your account number: RVY
Our reference: INS2-6197305121

Dear Mr Nicholls

CQC inspection of Southport and Ormksirk Hospitals NHS Trust

Following your feedback meeting with Jonathan Driscoll and Deborah Lindley on 11 July 2019. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues at the feedback meeting.

This letter does not replace the draft report and evidence appendix we will send to you, but simply confirms what we fed-back on 11 July 2019 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence appendix, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

Urgent and emergency care – Southport and Formby District General Hospital

- We observed caring staff throughout the service.
- The privacy and dignity of patients had improved since the last inspection.
- We saw improvements since the last inspection in areas we said the trust must take action, including the environment, escalation processes, infection prevention and control, staffing and ambulance handover times.

- In some areas where we said the trust must take action issues further work was needed such as record keeping, risk assessments and medicines management, specifically out of date medicines.
- The service was not properly checking resuscitation trolleys, there were gaps in the checks and some equipment was out of date.
- The service told us Royal College of Emergency Medicine audit data had improved, we plan to add the new data if it is available before publication.
- Pathways and guidance had improved since the last inspection.
- We did not see issues with management of pain relief on site but audits indicated that this still needed improvement.
- The service was not fully meeting requirements of the Mental Capacity Act for every patient who lacked capacity.
- Performance standards were not being met, including the 4 hours standard. There were 12 hour breaches although the number of black breaches had improved.
- There were no issues with patient flow during the inspection, despite the day before being one of the department's busiest.
- Staff informed us that the culture amongst nursing staff had been challenged and there was still work to do. Medical staff were positive about the culture.
- The risk register had improved since the last inspection and leaders understood the risks.
- Staff reported that divisional leadership were very visible and 'hands on'.

Medicine - Southport and Formby District General Hospital

- We observed caring interactions between staff and patients but privacy and dignity was not always respected, for example on one ward we saw three patients during visiting hour in their underwear.
- Mandatory training levels were below trust targets (we would be requesting more up to date data).
- Records were not secure on every ward.
- We saw evidence of action not been taken when National Early Warning Scores indicated it should have been.
- We saw issues with medicines management including with self administration, medicines charts, thickener not securely stored on the stroke ward, out of date medicines and medicines unavailable.
- We saw hazardous substances not secured in dirty utility rooms on different wards.
- We saw issues with infection prevention and control on Ward 15A with side room doors open and no sink for washing equipment on the medical day unit.
- We saw issues with understanding and application of the Mental Capacity Act, including for patients lacking capacity with Do Not Attempt Cardio Pulmonary Resuscitation orders and Deprivation of Liberty Safeguards in place.
- We saw gaps in Malnutrition Universal Screening Tool and fluid balance charts

- The service was managing access and flow well and we saw examples of well managed discharge planning.
- We saw limited use of ‘this is me’ booklets and passports.
- We recognised there was a new management team. Staff said the divisional leadership were visible.
- Leaders were aware of issues and risks.
- Leaders told us about plans to change things and improve but we did not see evidence that they had been implemented or embedded yet.
- Staff reported mixed views about the culture. Some staff did not feel supported, although staff felt that they could speak up and challenge.

Surgery - Southport and Formby District General Hospital

- We observed good care of surgical patients.
- We had seen improvements in areas we said the service must take action.
- The theatre staffing at night time did not appear to be sufficient.
- We observed the World Health Organisation five steps to safer surgery checklist but saw that this was not fully completed as the surgeon was not present for sign out.
- We saw issues with medicines management including gaps in prescription chart and issues with disposing of drugs. We shared details of a controlled drugs cabinet which did not appear to meet requirements.
- We saw improvements to maintenance and use of equipment, including checking of resuscitation trolleys.
- Records were not secure on every ward.
- We saw issues with understanding and application of the Mental Capacity Act.
- The service had mixed outcomes in national audits
- Staff reported the recovery area being used for patients awaiting a bed. Staff told us they felt pressure to send patients to theatre without beds being available.
- Some theatre staff told us they felt they were not listened to and were concerned about pressures compromising standards. Staff told us they were expected to stay beyond hours. Culture amongst ward staff had improved.
- Leaders were cited about risks and issues which were recorded on the risk register.

Services for Children and Young People – Ormksirk District General Hospital

- We were concerned that there was not adequate paediatric medical cover at weekends. We were told that after 1pm there may be one ST7 doctor covering the paediatric ward, neonatals, maternity and the children’s emergency department. We would be requesting further information in relation to this.
- Concerns were raised with us that medical staff had not listened to nursing staff about deteriorating patients, we were given examples of two serious incidents.

- We saw equipment which was out of date and resuscitation and emergency trolleys were not properly checked or secure.
- We saw that the safeguarding systems were working well.
- We did not find any medicines issues although temperature checks for fridges were not consistently completed.
- Pathways appear to have improved since the last inspection.
- We observed good care and positive feedback from children and parents.
- The complaints process appears to have improved.
- Staff told us that leaders were generally approachable and were proud of staff.
- Staff told us about good teamwork between staff and the service “feeling like a family”.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS Improvement/NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

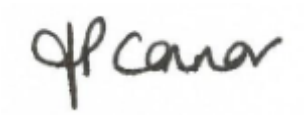
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Judith Connor

Head of Hospitals Inspection

c.c. Neil Masom, Chair

Marie Boles, NHS England/NHS NHS Improvement

David Fryer, CQC regional communications manager