Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Internal Inspection December 2014

10 things to Celebrate

Resilience of systems despite pressure

RAID Services

Play services for children

Safeguarding for children

Paediatric community

Thomas Linacre Centre

Staffed to establishment

Patient Feedback

Care, compassion and commitment of staff

Hector the Horse

10 things to Improve

Hospital Security at night

JDA and CCOT at night

Large number of medically discharged patients still in hospital

Antenatal setting in Leigh

Duplication of IT systems

Slow computers

Play in PECC

Theatre iv fluids in children

Staffing escalated beds in CCU

Clinics should start on time

+ The 3rd WWL internal inspection

This is the 3rd internal inspection completed at WWL. We took time to refresh the team during November, and whilst the team is similar to previously there are new members. This helps to maintain a balance, particularly with junior doctors and nurses.

As a team we agreed that this inspection would try to address areas that have not been covered in detail previously. We have not been to Leigh, or to Outpatients at Thomas Linacre Centre. We were aware that despite the importance of Maternity and Children's Services they have had only superficial reviews. We also considered that we had mostly seen emergency services during the daytime.

Like with the first two inspections, the findings are predominantly positive. Like with the first two inspections there are issues to be addressed.

It is right and proper to once again note how positively patients tell us of the experiences they have had, and how they feel well cared for. They reflect a clean, well organised hospital, where the vast majority of the care is excellent.

Gratitude to the December 2014 Inspection Team:

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Gratitude also, to the staff, patients and visitors who welcomed and spent time the inspection teams on the day of the visit.

Services Visited During the Inspection:

Maternity Services

Children's Services

Services Overnight

Critical Care Services

Outpatients at Leigh Infirmary and Thomas Linacre Centre

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Executive Summary

Night Services

By design, hospitals are staffed less fully at night when compared to during the day. Workloads are less, but the fall off in workload does not always match the fall off in staffing. This is not unique to Wrightington Wigan and Leigh NHS Foundation Trust (WWL), but it means that systems are more likely to fail at night.

On the night that we inspected, Junior Doctors Assistants (JDAs) or the Critical Care Outreach Team (CCOT) were not available. Both teams were said to be absent due to sick leave. Unlike other services, they are "non essential". There was no cover. We are told this has occurred previously at WWL. The Royal Albert Edward Infirmary (RAEI) site visit was at an exceptionally busy time, described by one staff member "as busy as I have seen it in 26 years". The medical night time cover is at best described as tight, but is eased by the presence of JDAs and the CCOT. These improve the ability of the medical staff to complete tasks and review patients. When they are not present there can more pressure put on to an already pressured team. The medical teams point out that even when the JDAs are there, they are not present overnight.

The night inspection team visited most wards on the RAEI site and reported them to be coping well despite immense pressures. They noted the wards to have remarkably large numbers of patients who were "medically discharged" awaiting predominantly social assessment or care resolution. This is one of the factors that can contribute to bed pressures. They also noted issues with discharge processes.

The inspection highlighted concerns regarding security at night. All entrances to the hospital are open. The team were able to wander freely including to some areas as most of the Christopher Home Building and Radiology.

Maternity Services

The teams visited Antenatal Services, the Delivery Suite and Postnatal Ward. Once again there were very positive views expressed by patients, and services were relatively quiet at the time of review. We were informed of concerns regarding staffing, sickness and recruitment which are known to the service.

The team noted that antenatal care at Leigh was provided by a midwife working in challenging circumstances. Her colleague was off sick, and single handedly was providing a very caring and well received service. The environment at Leigh does require improvement and again, this is known to the service. The ward based facility for Maternity Triage at RAEI is part of the Post Natal Ward. This service was staffed and in good facilities.

Delivery Suite and the Post Natal Ward were positively reviewed, though there were some issues. The most notable was that checks on resuscitation equipment for neonates had not been done, and it became clear that this was not an isolated event.

A common issue was raised by staff in all of the Maternity areas. The Information Technology (IT) systems lead to much duplication, and sometimes triplication of documentation. The staff reported that this was challenging and, at times, extremely irritating. That is made worse by slow computers.

Children's Services

Childrens services were noted to be very good. The inspection team particularly commented on the "self supporting" nature of the services. This is best exemplified with the nursing team aiming to not utilise agency staff or cross cover arrangements. The Neonatal Nurses have a particularly variable workload. They aim to take leave when it is quiet and extra shifts when it is busy. Staff informed the inspection team that there is a strong sense of ownership and pride in services provided.

Play is particularly notable on Rainbow. It is built in to the service and appreciated greatly. There were particularly caring episodes noted, and excellent child focussed facilities. This focus on play does not appear to extend to the Paediatric Emergency Care Centre (PECC) where despite great facilities, play and distraction does not receive the same focus. This was something that families had noted.

Safeguarding children is embedded into practice and is now a crucial part of the service. This was independently reviewed by an external expert. The service was found to be effective, and well understood.

Outpatient Services

The Thomas Linacre Centre (TLC) is a very busy outpatients unit. There are examples of exceptional care and of well-considered systems which are appreciated by the patients.

There are areas to be addressed. There are clinics that regularly start late because Consultants arrive late. The phlebotomy service is very good but finishes at 4.30pm well before the last patient is seen. Notes for clinic are not always available.

The environment at TLC is very good, but there are some problems. There is not enough parking. Some of the clinics struggle with waiting areas. Wheelchair access could be improved. Computers are generally slow and there are regular problems with 'BigHand' the digital dictation system.

Leigh Infirmary

The services at Leigh Infirmary are predominantly day case and outpatient. The Hanover Unit is newly opened and was reviewed in a 'mini-inspection' recently. Services were noted as excellent. Antenatal care at Leigh Infirmary is challenging and commented in the Maternity Services on page 7.

On the day of the inspection the clinics visited by the inspection team in Outpatients were working well and running on time. Positive comments were received from patients.

Dermatology is a major service only provided at Leigh Infirmary. The environment is somewhat dated, but the services are highly valued by patients.

There are no children's facilities despite the clinic seeing large numbers of children. Storage for notes is limited and consequently there can be notes held in unsecured places.

Services are caring and responsive. Areas highlighted by the inspection team included the Peer Network, Skin Cancer Service and training provision for staff.

Whilst services are good, there are clouds on the horizon. There is uncertainty expressed by the service regarding what will happen when dermatology services are tendered next year.

Sick leave was reported as a concern and two of the Consultants are Locums. There is a heavy workload with sometimes long clinic waits. There are improvements that could be undertaken such as a truly one stop service for Skin Cancer.

Overall, we reviewed some great clinical teams providing great services. There are some simple changes that would make them even better services. However, there are also some broader problems such as the high number of medically discharged patients, which are more complex and more difficult to resolve.

1.0 Maternity Services

The areas visited by the team were Maternity Ward (this includes post natal care, and antenatal triage), Delivery Suite, Maternity Theatres (part of Delivery Suite) and Gynaecology Clinic (part of Swinley Ward).

A separate team reviewed the Antenatal Clinic at Leigh Infirmary. That is included in the 'Outpatients at Leigh Infirmary and Thomas Linacre Centre' section on page 16.

1.1 Safe

Delivery Suite and Maternity have well-controlled environments. There was good security noted for both areas. Patients reported feeling safe. The boards were up to date and staffing was as per establishment. Midwives and Doctors reported feeling well-supported. Whilst wards were staffed to establishment there are issues reported regarding high sickness levels.

Infants who require antibiotics and who move from the Maternity Ward to the Neonatal Unit multiple times each day do so by going along the corridor. This does not seem to be the best way to take them. There is a shorter and safer way through Delivery Suite.

Maternity staff commented on the problems with staffing levels. Whilst they are at establishment they felt that they were getting higher risk patients and the throughput was greater. The team noted problems with patients who are absent. Most patients are young and mobile. They leave the ward to go outside, but there is little if any knowledge of where they are during this time. This does cause problems with medicines, but also infants are left on the ward.

1.2 Effective

There were many effective systems of care noted. The teams commented on the excellent breast feeding support and the more general support of parents within the Delivery Suite and Maternity Ward. Triage pathways were observed as working well. Hourly rounding was in place and preceptorship was good. Staff told us they liked where they worked and felt valued.

Gynaecology Clinic was particularly commendable for its systems of care. These are paperlight and efficient. There is a relatively small core team of nurses who work together well and provide direct access. They have good links with Maternity.

There were areas that could be improved such as discharge processes. There is duplication, slow computers and delays with multiple assessments (babies must be ready to go home as well as mum). Some mums are only in hospital because their baby is on the Neonatal Unit. Mums are provided with the option to be discharged but understandably often choose to stay.

The flow of patients between Delivery Suite and Maternity seems to cause some problems. Both units feel the other is controlling flow, though by the judgement of the inspection team, the Delivery Suite seemed to be mostly in control of flow. This may link to the teams' observation that the quality of the handover from night to day teams could be improved. Despite the proximity of the two units, they did not seem to talk to each other particularly well. Both Delivery Suite and Maternity noted that there is a great deal of duplication and sometimes triplication in patient records.

They enter the same information multiple times. The slow computers and lack of IT facilities compounds this problem.

1.3 Caring

All of the wards reviewed by the team were considered to be caring and compassionate. There is a strong sense of ownership and of a caring team within each of the areas. There is good support reported by nurses, midwives and doctors. Patients reported feeling involved in decision making and having had a good positive experience.

Gynaecology Clinic has a new hydration room to manage patients with pregnancy induced vomiting (hyperemesis). This has been well-received. Sadly, the staff there felt that they were largely unnoticed. We would hope that they feel that they have been noticed by the inspection team who considered them to be caring and effective.

1.4 Responsive

The team used the '15 step challenge' (the impression a ward gives in the first 15 steps) as a starting point for their assessment.

They found each of the areas to be welcoming and uncluttered. There was good security on Maternity and Delivery Suite.

Dads visiting Maternity reported frustration at the lack of a visitor toilet.

Gynaecology Assessment Clinic on Swinley Ward is poorly signposted and therefore difficult to find. Maternity has a lot of visitors, and they are often queuing outside the ward. There was a delay to being let in to the ward. When the team got into the ward, they found the Ward Clerk was in the ward office and that the door was manned by the Midwives. Managing the reception and welcoming visits was also undertaken by the Midwives. The slow answering of the door is frustrating to visitors, and the continual manning of the door is frustrating to the midwives. The visitors also find the layout of the ward confusing. They suggested using footsteps on the floor to guide people.

Patients reported that they found staff to be caring and responsive. There are times when the unit is very busy and provision of a caring and responsive service may be compromised. The same issues are noted about Maternity Triage which works well except when the service is very busy and may become unmanned.

1.5 Well Led

The inspection team noted that the units were to be well-led. Staff on each of the units reported being well-supported and able to ask for help. The junior doctors felt particularly well supported by the Consultants. There was clear multi-disciplinary team (MDT) working within the teams. The Delivery Suite were generally less positive than Maternity and indicate that some shifts are better led than others.

2.0 Children's Services

The areas visited by the inspection team were Rainbow Ward, Neonatal Unit (NNU) and Paediatric Emergency Care Centre (PECC). The team was notably joined by an external expert from the Royal College of Paediatrics and Child Health (RCPCH) who has extensive experience of inspections of children's services. Her role in this team was to review Safeguarding Services.

2.1 Safe

Safety and security are of particular importance for children's areas. Children tell us of their need to feel safe, but the threat to their security to them is unfortunately real and has to be a high priority for children's services. Security systems were specifically tested and found to be effective. The doors are swipe accessed and there is no unsecured way in. There is also video surveillance. Rainbow ward has reception staff by the main access point. We specifically observed entry and exit, looking for "tailgaiting" and doors left open. This was not observed, but considerate challenge by the reception staff was noted. There is a back corridor to the ward which is mostly used as a service access. This is again secure, however, the outer doors to this have a sign indicating the doors should remain closed. That is probably reasonable however, the doors are never closed.

Videocameras are widely used on the ward and help to maintain security. Whilst most are well positioned, one or 2 seem to give unhelpful views. The videos are recorded.Rainbow Ward has a difficult balance between wanting parents to be with their children and exposing children to risk from adults. The ward allows adults to sleep next to their children. This is often in bay areas and therefore leaves adults sleeping in areas where other children are present.

Staffing levels seemed to be appropriate on the day the team visited and staff reported staffing levels to be reasonable. The wards were staffed to establishment.

Medicine management was noted to be excellent. There were no omitted drugs on any chart reviewed. All charts were filled in completely and to a high standard. There is excellent drug information provided by the Childrens Pharmacist. This is particularly notable on the NNU where there is an extensive file of information about the drugs the NNU uses and the particular issues of small doses in infants.

Controlled drugs were all locked away and the controlled drugs (CDs) book was well completed. There had been an error in documentation in the days before the inspection, but this had been noted immediately and had been corrected and signed for.

Whilst the CD cupboard was secure, there were unlocked fridges and an unlocked cupboard. These were inside a numerical pad locked room, and were therefore still secure. One of the fridges had a lock on it, but the lock was not working correctly. This did not represent a security failure but particularly the unlocked fridge with a lock that was not required seemed odd.

Nurses on the ward informed the inspection team that they have to complete mandatory training for intravenous (IV) drugs. There is a half day session as part of this training which is only relevant for adult nurses. They consider this a waste of time.

2.2 Effective

All the notes of patients reviewed had clear if not comprehensive care plans. All weights were present.

Handovers were observed as being good. A digital Dictaphone is utilised by Rainbow Ward during the nursing handover. This reduces the number of people who need to be off the ward at any one time. The NNU nursing handover is done as a group meeting. The medical handover was thorough and well-led by the consultant present. Handover of postnatal babies is done at the same meeting and seemed to be skimmed over. Whilst the quality of the handover was good, the doctors commented that the handover rarely starts on time.

There is a new 'communication cell' which is being trialled on Rainbow Ward which focuses on ward functions and priorities. The day of the inspection was during the first week that the 'communication cell' had taken place. This seemed to be very effective and the board from it is particularly good. It brings both medical and nursing staff together, something that is missing from the handovers.

Safeguarding is about children's safety, but our review was about safeguarding's effectiveness. The services were found to be easily accessible. Staff were aware of the importance of safeguarding and were able to talk about it confidently. They were able to tell us what they would do if they had a concern, and who they would contact. The Safeguarding Team was well known to all the people spoken to. Staff knew how to access guidelines. These were reviewed and were considered to be comprehensive and up to date. All staff were Level 3 trained and were encouraged to undertake a Physical Injury Course. Two Band 5 nurses are Safeguarding Champions. Links with Social Services are well developed. The NNU is well aware of its responsibilities for safeguarding infants and the links with Midwives are established. There is a good peer review meeting in place.

Staff in PECC spend a great deal of time managing Safeguarding issues. They are particularly skilled and aware. They note that there is probably a role for a safeguarding nurse specifically for the PECC area given the volume of work they deal with.

Computers on the wards were noted to be slow and difficult to use. The complaints were from all users. They also noted that there were not enough computers. Regularly there is one or more unavailable because of faults.

2.3 Caring

Staff on each of the three areas reported that they were proud of their wards. Rainbow Ward and NNU aim to never utilise agency staff. They will use their own staff either as swaps or as bank shifts. On the NNU when a shift is quiet staff will volunteer to take leave, and vice versa when it is busy. The wards will also support each other when one area is busy. What becomes apparent is that these areas function as self sustaining communities. Unlike some other areas, there are no problems with recruitment. NNU in particular has students who would love to join the unit but there are no posts.

Play is unique to Children's areas. There is a team of playworkers. The inspection took a particular interest in play and play facilities. These were very good. Toys were plentiful, well cared for and available.

Areas for play were well set out. Play workers encourage and develop play around children. They are also proactively involved in distraction for children undergoing treatments.

Children told us how they were cared for going to theatre and how they enjoyed this. The sensory room on Rainbow is particularly deserving of commendation, as was the episode of care we observed using the sensory room for a child with cerebral palsy during a procedure.

Parents told us about things that they would like to change. They were very positive about play on the ward, but noted areas of concern. The first was when children were returned from theatre. They came back with IV fluids attached, but these were as open (not pumped) fluids, with the bag lying on the bed, and some back flow of blood along the IV line. One parent told us that this was the only thing that their child had found frightening. Parents also told us that whilst play was excellent in Rainbow Ward, when they had been in PECC there was relatively poor play facilities, and more importantly no play workers.

There are three bays of beds for children on Rainbow Ward. These provide relatively poor privacy, particularly for sensitive conversations. There is a well-used room for such discussions, but the lack of privacy in the bay areas was noted.

Pain is important and difficult to manage in children. Entonox is a treatment that could be used for children returning from theatre, but is not used. Consideration should be given to developing this.

2.4 Responsive

Services in the three areas are built around the needs of children. They are responsive to their needs and to the comments from families. Rainbow Ward has been designed with the input of children. Play facilities work around children and ensure that the atmosphere in Rainbow is positive and fun. The NNU is centred on infants, but is particularly caring of parents. PECC has a heavy throughput which is managed in a timely way with care and compassion.

Children cannot give feedback about services in the way that adults can. The ward has developed an app called ‘Fabio the Frog’ to seek children’s views about their care. This is innovative and commendable.

PECC is part of the Accident and Emergency Department (A&E) and so part of the 4 hour target. There are very few breaches and parents report that waiting times are generally appropriate. Parents tell us that they would prefer wait in the waiting area where there are toys and space, than the cubicles where they are often left to wait.

Our team of inspectors was delighted with the play that was observed on the ward, as were the parents we spoke to. However, one parent had a particularly poignant suggestion. He suggested that there should be a request system for toys. This could perhaps utilise “request cards”. His son would have loved to use the Wii on the ward. They were unaware that there was one. It was unfortunately sat outside their room, but it is in a big yellow robot and they did not know.

The bay areas on Rainbow Ward for medical children are split according to gender. This is part of single sex accommodation. However, this means that babies and teenagers are next to each other. It is tolerated by children, but the teenagers are not keen on babies being next to them.

2.5 Well Led

There should be little doubt that the Childrens services are well led. There are however no single areas of “stand out” leadership. It would be fair to note the excellent play leaders, and the new ‘communications cell’. There is clear safeguarding leadership and there are great facilities. During the inspection Hector the Horse (a remarkably popular rocking horse) needed his mane replaced. The ward was raising money for this. We have no doubt that the ward will be successful in raising money for Hector. It is that sense of community which is most remarkable. This seems to be the leadership of many, rather than the leadership of an individual.

3.0 Critical Care Services and Services Overnight

There were two inspection teams, one who reviewed services overnight and the other who reviewed critical care services during the day.

3.1 Safe

The hospital site is easy to access during the day. What is surprising is that it is just as easy to access at any hour during the night. In the past doors were locked and access restricted. That no longer seems to be the case. Discussions with porters and security indicate that the open access may not have been by design. The teams found they had access to the Christopher Home building and to areas where notes were stored (specifically on the 3rd floor). They were also able to wander freely though Radiology where there was a lone worker. Parts of Radiology are key pad locked, but by no means all.

The site was appropriately staffed for the night of the inspection. This is measured according to the established staffing figures. During the evening visit to Shevington Ward the team noted that there were 6 patients requiring 1:1, and 8 patients requiring 1:1 on Standish. There was not 6 (or more) staff on the ward. The patients were cohort nursed. A number of these patients had dementia.

The Critical Care Unit (CCU) has 'escalated' beds. Whilst the ward is staffed appropriately to its designed function when beds within the unit are 'escalated' staffing levels remain the same. The Intensive Care Unit (ICU) was thought to be appropriately staffed.

The environments for both CCU and ICU were excellent, with remarkably calm uncluttered space.

There was a concern expressed regarding Telemetry. The use of telemetry for patients who are on wards other than CCU is common. This is fine as long as the telemetry is being used as a way of detecting abnormal rhythms that do not require immediate action. CCU staff are not watching the telemetry screens all of the time and so cannot monitor patients. They will only be able to inform the wards some time later if there is a rhythm problem.

3.2 Effective

The inspection was completed at one of the busiest times of the year. The RAEI site was extremely busy and A&E was struggling. The inspectors were particularly surprised therefore to find so many problems with discharging patients. The most striking of these was the number of patients who were medically discharged waiting to go home. Whilst no case is exactly the same, the common thread seemed to be the wait for community services and the most obvious concerns were for patients with Dementia. The team noted that there were important numbers of patients waiting for Elderly Mentally Infirm (EMI) beds. This was particularly true on Shevington Ward.

Given how busy the site was, the teams were very concerned to find that the Critical Care Outreach Team (CCOT) and the Junior Doctor Assistant (JDA) for that night were not present. This was said to be because of sick leave, but it was also noted that this seems to be a fairly common issue. There is no cross cover, and so for this night, the teams were even more stretched.

To make the whole situation worse, there was no Medical Registrar for the late shift and the Consultant Physician was carrying his bleep and therefore undertaking his role.

Perhaps unsurprisingly Discharge Lounge was struggling. We have visited Discharge Lounge previously and would note that extra resources have been allocated. However, on this night, the discharge lounge was still open at 9pm. It should have closed at 8.30pm and there were people who had been there for more than 4 hours. Patients were actually very satisfied with the care given, and the staff were remarkable. They had 27 patients through during that day, and staff were staying on to complete these discharges. The staff on the unit noted that there were problems with delays to ambulances and that there were delays getting medicines to the Discharge Lounge. It is not rare for Discharge Lounge to close after 10pm to complete discharges for patients.

Communication is one of the keys to excellent care. The teams observed handover meetings. They attended the Bed Manager Handover, and the Hospital at Night handover. These were effective meetings. The teams particularly noted the very good leadership given by the Medical Registrar at the Hospital at Night Handover.

Bleep systems are already known to cause problems, but they were the source of irritation to junior doctors once again. There are well known issues with large numbers of bleeps and not being able to get through to the ward. There is evidence that doctors are using their mobile phones more as a way of being contacted.

Patients are selected for CCU according to a risk stratification system. The junior doctors and the CCU nurses reflected that this sometimes causes problems such that there could be very elderly patient on CCU whom there is no intention to treat aggressively and a younger patient on the ward. This probably needs reviewing.

There is a new IT system on ICU and CCU. The staff told us they were very impressed with the system and how it had been set up. The system runs well and they find it simple to use. It is used as an Electronic Patient Record system and is separate from the one the rest of the hospital use. It integrates with monitors etc.

3.3 Caring

Whilst the hospital as a whole was very busy, the wards were remarkably peaceful. There had been transfers during the night and consequently wards had lights on later than usual. The inspection team noted that wards were uncluttered and that on all of the wards they visited at night they were greeted positively.

The majority of the feedback from staff members was positive with doctors and nurses telling us how much they liked working at WWL. They told us there was good support, with various stories cited. However, this was not universal and we were also told of a nurse who had left because of the pressure. Staff at night also indicated that they were rather “forgotten”. They did not always get feedback from incidents, though some thought this had improved.

Wards are places where patients “live”, albeit for what we hope will be a short time. Nurses felt that there should be more for patients to be able to do. They particularly felt that there should be a dayroom or dining room for diversion and stimulation.

Both of the teams on CCU and ICU told us that they did not like the orange gowns that they currently used. They described them as rather like prison garments, and they were not good for maintaining dignity. We liked the fact that they cared.

3.4 Responsive

“My worst day in 23 years” was how one nurse described the pressure in A&E. We noted that services were coping remarkably well. There was a patient waiting 6 hours for a side-room, but this was because the side-room needed “fogging” and preparation. Triage was difficult. The triage nurse told us it was a rather isolated situation, but also that it was pressured. The waiting time for triage was 1 hour, where it is normally 15 minutes.

In our first inspection we had noted problems with the assessment of acutely distressed and confused patients. Since that inspection the RAID team (Mental Health Liaison Team from 5 Boroughs Partnership NHS Trust) has developed and the team in A&E were very pleased with the progress made. There is good assessment made in a timely way. Whilst the RAID team is a very welcome development, it is still of note that we have problems discharging patients experience mental health problems. They are well assessed, and we know what they need. It seems that mental health facilities in the borough to provide this are few and far between.

Patient flow from A&E to the wards is a major focus. This was understood by the wards, but they commented on the fact that they felt they came “second to A&E”.

Both ICU and CCU have problems stepping patients down from themselves to the wards. This is because the beds on the wards are typically full and that means that patients stay in unsuitable areas longer than is sometimes necessary. This is perhaps an understandable problem, but it is still a problem.

There is no patient toilet on ICU. At first this seems irrelevant, but some patients stay past the point that they are “bedbound” and they need to be able to go to the toilet. They do not like having to use “alternative facilities” on the ward such as a commode.

3.5 Well Led

The night team went on an extensive exploration of the wards at night. They visited all of the wards on the acute site. What they found were well run, calm wards. Staff were welcoming. Junior doctors told us they were happy working at WWL. Porters told us they enjoyed their jobs. Domestics felt valued and well trained. Most areas were tidy and uncluttered. They were all clean. There is a sense to which there is evidence of wide spread leadership. Confident well led teams who are delivering good care.

ICU was reported as having particularly well led ward rounds and that there was an inclusive non hierarchical nature to the rounds. Everyone was heard and valued.

Whilst the team on ICU provide good standards of care, the care could be improved if there were more medical staff and surgeons involved. It has long been an irritation on ICU that medical staff and Surgeons rather “leave ICU to get on with it”, and don’t see the patients who were escalated from the ward to ICU until they are ready to return to the ward.

4.0 Outpatients at Leigh Infirmary and Thomas Linacre Centre

One team went to Leigh Infirmary and one team visited Thomas Linacre Centre (TLC) to review services there. They were tasked with reviewing services, other than in the Hanover Centre at Leigh Infirmary.

4.1 Safe

Staff and patients felt safe at Thomas Linacre Centre (TLC). There is a good chaperone service.

The space provided for Pharmacy in TLC is very small. Storage presents problems, and there is no “private” working area for pharmacists.

Toilets at TLC are also rather small. A patient told us they banged their head. They also do not like the sample windows.

There are potential issues with storage for notes in the Dermatology Unit at Leigh Infirmary. Notes were noted to be lying on the floor in one room.

Liquid Nitrogen is used in Dermatology and has some potential safety issues.

4.2 Effective

Clinics at TLC were generally well run and well liked. The centre is easy to access and popular. The areas are bright, clean and comfortable. There is a good text reminder service which is appreciated however this would be more effective if the name of the Consultant was included in the text. There are bleeps used for patients to be able to leave the area and be bleeped back when their appointment is about to happen. Volunteers provide a well valued service.

In the past there have been significant problems with letters inviting patients to clinic. Knowing this, the team specifically looked at letters and found that they were accurate and simple to follow.

Preparation of notes for clinics causes problems. This mostly works well; however, notes are prepared for the day but not prioritised by clinic time. There are two deliveries of notes per day and there can be problems with notes arriving for the morning clinics because of this lack of prioritisation.

Phlebotomy services are popular and well used. Unfortunately the phlebotomy area closes at 4.30pm and many clinics are running till after 5pm. This causes problems and return visits.

Sometimes there is low utilisation in one area of TLC that should lead to assistance in areas where it is busy. This does not seem to happen.

Clinics at Leigh Infirmary were noted to be on time and have little if any waiting time. This was probably a fortunate moment to visit, but all the same there were no issues noted.

Dermatology services currently have two locum consultants out of three consultants. There are also relatively high levels of sickness within the department reported.

Skin Cancer services are felt to be very good. There is a good peer review network and training is good. Cancer Services are said to be one stop, but they are not always. The reviewers felt that it was possible to make this always one stop.

4.3 Caring

TLC was a great environment with very good services. The inspectors commented particularly on the positive nature of all the responses from patients and the exemplary attitudes of staff in TLC. The inspectors enjoyed the staff singing Happy Birthday to a patient.

Even in an excellent service we can improve. TLC has relatively poor wheelchair access. It is accessible, but it could be better. Radiology uses a corridor for patients who are in gowns for them to wait. One clinic was overflowing into the lift corridor.

Dermatology is a well liked and widely used service. It is valued by patients. Dermatology has a limited amount of waiting space, and because the waiting times were relatively long, this was full at the time we visited. We also noted the lack of children's facilities despite the regular children's appointments.

4.4 Responsive

TLC is able to provide large numbers of appointments and clinics. It does so and still is able to expand to cope with extra clinic (72 in November 2014) without extra resource. The volume of some clinics is remarkably large. Anticoagulation Clinic can see over 100 patients and still provide a safe effective and caring service.

Computers were noted to be slow. This causes particular problems with 'Big Hand' the digital dictation system.

4.5 Well Led

Clinics were well led. Despite where there were problems patients were kept up to date on the progress of the clinic. There was an honest open nature to the communication.

There are problems with some clinics being cancelled. They can be cancelled very late. Some clinics are reliable in not starting on time.

Glossary

WWL	Wrightington Wigan and Leigh NHS Foundation Trust
RAEI	Royal Albert Edward Infirmary
TLC	Thomas Linacre Centre
PECC	Paediatric Emergency Care Centre
A&E	Accident and Emergency Department
NNU	Neonatal Unit
CCU	Critical Care Unit
ICU	Intensive Care Unit
EMI	Elderly Mentally Infirm
MDT	Multi-disciplinary Team
CCOT	Critical Care Outreach Team
JDA	Junior Doctor Assistant
CD	Controlled Drug
IV	Intravenous
IT	Information Technology
RCPCH	Royal College of Paediatrics and Child Health
RAID	Mental Health Liaison Team from 5 Boroughs Partnership NHS Trust