

University Hospitals of Morecambe Bay NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Requires improvement



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospitals of Morecambe Bay NHS Foundation Trust is a large acute hospital provider serving the population of South Cumbria and North Lancashire. The trust was established in 1998 and gained teaching status in January 2006. It has been a foundation trust since 2010. Services provided at the trust are commissioned by two clinical commissioning groups based in Lancashire and Cumbria.

The trust provides services from three principal sites to a population of 365,000, covering South Cumbria, North Lancashire and surrounding geographical areas. The hospital sites we inspected were: Furness General Hospital in Barrow; Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal.

We carried out this inspection to follow up on the improvements required in response to the findings of our inspection in February 2014. At the time of our February 2014 inspection we had significant concerns regarding the trust's ability to assure safe and well managed services for patients. There were particular concerns relating to medical services and critical care services as well as significant concerns regarding the trust's strategic approach to service provision, its leadership capacity and its governance systems. The safety and well led domains were rated as inadequate.

Our inspection findings led to a recommendation that the trust be placed in 'special measures'. Special measures is a status applied by regulators of public services in England to providers who fall short of acceptable standards. In response an improvement director was appointed by Monitor to support the trust in making the required improvements. The trust developed a detailed action plan to address the identified shortfalls. Since that time we have worked closely with the trust and Monitor regarding the implementation of the required improvements.

We carried out a further inspection between July 14 and July 17 2015 (inclusive) to assess and evaluate the impact of the improvements made on the safety and quality of services provided to patients, and to evaluate how well the trust was led and managed. We looked at all the core services provided by the trust which are;

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

We also looked at the progress the Trust had made in implementing the recommendations made by Public Health England (PHE) following a review of the Breast Screening Service undertaken in response to concerns raised by staff. In addition, we reviewed the progress the trust was making in implementing the recommendations made following the enquiry into maternity services by Dr Bill Kirkup.

The trust had made progress in all the areas we identified in our inspection in February 2014. However, there were still a number of areas that required further and ongoing improvement. Key concerns related to the recruitment of nursing and medical staff. There were also a number of midwife vacancies. The trust acknowledged that further work was required and there were plans and initiatives in place to secure additional staff at the time of our inspection.

Our key findings were as follows;

Leadership and staff engagement

The Executive Team had stabilised and was working well together to secure service improvements, a new Chief Operating Officer had been appointed. Senior managers were more visible and accessible to staff and staff were positive about this development.

The trust had approved its Quality Improvement Plan 2014-2017, 'Better Care Together'. This document detailed clear objectives with expected outcomes and indicators for the improvement trajectory.

To support the delivery of 'Better Care Together' and staff engagement overall, the trust had commenced the 'Listening into Action' programme. The first year of Listening into Action (LiA) resulted in clinical teams leading 16 quality improvement schemes through a 20

Summary of findings

week improvement cycle. A further 13 teams are now being supported through the next improvement cycle and 10 priorities have been identified for accelerating LiA as the key approach for engagement and improvement in 2015/16 onwards.

The trust had also appointed a 'freedom to speak up guardian' in response to the Freedom to Speak Up Review into whistleblowing in the NHS. The intention was to support staff so they could raise concerns in the public interest with confidence that they would not suffer detriment as a result. This work was in progress at the time of our inspection.

However, there were areas regarding staff engagement and support that still required improvement. One area of particular concern was the Workforce Race Equality Standard (WRES) submission which highlighted that BME staff had a disproportionate employee experience compared to non-BME colleagues. These views were confirmed in our meetings and focus groups with BME staff. Some staff felt they were very well supported, however others alleged a bullying culture where they felt marginalised and unable to raise concerns without there being repercussions. We raised this matter with the trust who confirmed that they were aware of the issues and, in response, had met with BME staff representatives to hear their concerns and had committed to working with staff to agree what actions needed to be taken to improve this. The trust had reviewed its leadership on diversity and inclusiveness, and as a result had appointed a designated Board lead and leads for both workforce and service issues. There were plans in place to involve and include staff from a BME background in all of the work streams intended to secure improvements and promote an open and just culture.

However, there were concerns regarding the culture in the paediatric service in Furness General Hospital. Senior clinicians reported a bullying culture where concerns were slow to be heard and addressed.

Leadership development

The trust had a Leadership Development Strategy that was approved on the 24 June 2015. This document described the trust's strategic approach and included values-based leadership, staff engagement/Listening into Action, Human Factors and alignment with the NHS Healthcare Leadership Model. A scoping exercise for

Clinical Leadership Development was planned for the summer, to complement the Kirkup recommendations on reviewing clinical leadership training. A bespoke development programme for ward and clinical team leaders had been commissioned, with the second cohort now undertaking this programme.

Governance and risk management.

Governance and risk management systems had improved considerably since our last inspection. A comprehensive Risk Management Strategy (2015-16) was in place that set out the roles and responsibilities for risk management. The appendices of the strategy gave clear guidance on how to undertake a risk assessment for inclusion on the risk register.

The Board Assurance Framework (BAF) had been reviewed in relation to its structure and appropriateness for the organisation. The BAF was reviewed and presented to the board at the April 2015 Board meeting. The framework was aligned to the trust vision, values, objectives and priorities. Controls, mitigation, assurance, gaps in assurance, rating and rationale for rating were clearly documented. The BAF linked to the corporate risk register identified appropriate risks and there was evidence of the Board reviewing corporate risks in both January and April 2015. This was an improvement since our last inspection.

Nurse staffing

Nurse staffing levels had improved. Ward staffing establishments were calculated using a recognised dependency tool and regularly reviewed. There were minimum staffing levels set for all wards and departments. The 'red rules for safety' initiative was being implemented across all wards and departments.

The principals of this initiative included one registered nurse should deliver care to no more than eight patients and the minimum skills mix on a ward should be 60% registered nurses to 40% health care assistants.

The staffing issues in the High Dependency Unit had been comprehensively addressed and there was sufficient numbers of nurses to meet the needs of patients at all times. In other wards and departments throughout the trust staffing levels met the needs of the patients at the time of our inspection; however, the skill mix on ward 39 and ward 20 at Royal Lancaster Infirmary was still variable

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and did not always meet the 'red rules' requirements of one registered nurse to eight patients. E-rostering data excluded bank and agency. Safer staffing data demonstrated that ward 39 and ward 20 had sufficient staffing for the month of June 2015. There were times when skill mix had been reduced this was due to additional health care support staff being employed to support dependent patients on these wards. The data demonstrated that staff were used flexibly over a 24-hour period. In Furness General Hospital staffing levels met the needs of the patients at the time of our inspection, however, on reviewing staffing rotas over the previous month there were concerns regarding the staffing levels and skill mix on some wards. It was evident that there were still nurse vacancies in some specialities. There was an escalation process in place for managers to respond to staffing challenges, however there were times when wards were not always appropriately staffed.

In May 2015 the trust reported a registered nurse vacancy rate of 13.1%. The trust was engaged in the ongoing recruitment of staff at the time of our inspection.

The trust also continued to develop additional solutions to respond to staff shortages, including Physician's Assistants, Advanced Practitioners and Non-Medical Consultant roles. In addition, the trust had successfully appointed a cohort of 36 Apprentices in Clinical Healthcare and was currently advertising for a further 36 apprentices to commence in September 2015. The trust continued to work with external recruitment agencies to undertake bespoke recruitment overseas.

Medical Staffing

There were a number of concerns regarding medical staffing including middle grade cover in surgery at Westmoreland Hospital; In addition there were concerns regarding the sustainability of the paediatric consultant on call cover and lack of junior doctor cover in the service for children and young people. There were ongoing challenges in addressing the concerns within the breast screening unit and there were consultant vacancies within End of Life Care with no post at Furness General Hospital.

The trust however performed within expectation for 11 categories out of 13 in the GMC National Training Scheme survey.

Incident reporting

The trust was actively reporting patient safety incidents. The most recent NRLS report (March 2015) detailed a ratio of 43.49 patient safety incidents reported per 1000 bed days. The average for all acute trusts is 35.1. This indicates good performance by the trust in this regard.

The trust had a process for the management of serious incidents and held a weekly 'Patient Safety Summit' to review all incidents causing moderate harm or above, alongside any significant near misses. The weekly summit had the responsibility of identifying trends that were then allocated to task and finish groups, completing root cause analysis investigations and providing a quarterly summary to the 'SIRI Panel'. The SIRI Panel provided a quarterly report to the Quality Committee. The Quality Committee in turn reported to the Board.

Paediatric medical staff remained concerned about their lack of involvement in the 'rapid review process' in relation to Serious Incidents Requiring investigation (SIRI) and felt excluded from the process in incidents relating to babies referred from maternity services.

Implementing recommendations and securing improvement.

Public Health England (PHE) had undertaken a review of the Breast Screening Service in response to concerns raised by staff. The review concluded that film reading and clinical practice at the assessment stage in the breast screening service was currently operating within national minimum standards, however the working environment within the service was extremely poor and if not addressed urgently the service would be unlikely to be able to continue to provide a safe service.

The trust had made progress in implementing the technical and recording recommendations made in response to the PHE review. However, the pace at which the required management changes were being implemented was slow and had become very protracted. It was acknowledged that the trust did have some complex staffing issues to address, however the pace of change meant that professional relationships and the culture within the Breast Screening Unit remained a cause for concern.

The trusts maternity service had been subject to an independent enquiry established to review the management, delivery and outcomes of care provided by the maternity and neonatal services between January

Summary of findings

2004 and June 2013. (Kirkup Enquiry). The trust had developed a comprehensive plan to respond to the recommendations made in the report and there was evidence that the trust was making progress in this regard. However, there was still work to do, in particular, embedding the improved governance and risk management systems, improving the maternity dash board and aligning investigation processes. Joint working across the maternity and paediatric services had improved; however, there was still work to be done to assess the impact of the improved arrangements on the functionality of teams.

Importantly, the trust must:

- Ensure that all premises used by the service provider are suitable for the purpose for which they are being used and properly maintained. This is particularly in relation to physiotherapy services and medical care services provided from medical unit one.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients.
- Staff should receive appropriate support, training and appraisal as is necessary to enable them to carry out their role.
- Ensure that staff understand their responsibilities under and act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

- Ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in medical care services and critical care services.
- Ensure referral to treatment times in surgical specialities meet the national target.
- Ensure that the resuscitation trolleys on the children's ward are situated in areas that make them easily accessible in an emergency. All staff must be clear on who has responsibility for the maintenance of the resuscitation trolley on the delivery suite.
- Ensure that they maintain an accurate, complete and contemporaneous record in respect of each service user.

It is apparent that the trust is on a journey of improvement and progress is being made both clinically and in the trust's governance structures. I am therefore happy to recommend that University Hospitals of Morecambe Bay NHS Foundation Trust is now taken out of special measures. This is subject to establishing a partnership arrangement with another provider specifically to support the ongoing improvement required in maternity services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust is a large acute hospital provider serving the population of south Cumbria and north Lancashire. The trust was established in 1998 and gained teaching status in January 2006. Services provided at the trust are commissioned by two clinical commissioning groups based in Lancashire North and Cumbria.

The trust provides services from three principal sites to a population of 365,000, covering south Cumbria, north Lancashire and surrounding geographical areas. The sites are: Furness General Hospital in Barrow; Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal. The trust also provides outpatient services at Queen Victoria Hospital in Morecambe, at Ulverston Health Centre and in a range of community-based facilities. The trust has approximately 5,000 staff. In 2012/13 the trust had an income of £280 million.

Furness General and the Royal Lancaster Infirmary have a range of general hospital services, with full A&E departments, critical/coronary care units and consultant-led beds. Westmorland General Hospital provides a range of general hospital services, together with a Primary Care Assessment Service (PCAS) with GP-led inpatient beds, operated by the Cumbria Partnership NHS Foundation Trust.

All three sites provide a range of planned care, including outpatients, diagnostics, therapies, day-case and inpatient surgery. In addition a range of local outreach services and diagnostic services are provided from a number of community facilities across the community.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, North Region, Care Quality Commission

Head of Hospital Inspections: Ann Ford and Amanda Stanford, Care Quality Commission

We carried out this comprehensive inspection as a follow-up from our inspection in February 2014.

The team included consultant surgeons, physicians and anaesthetists, senior nurse managers, nurse specialists, allied health professionals and 8 CQC inspectors and 2 inspection managers.

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 eight core services at University Hospitals of Morecambe Bay NHS Foundation Trust:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

Summary of findings

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the clinical commissioning groups (CCG), Monitor, the Royal Colleges and the local Healthwatch.

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.

What people who use the trust's services say

- In the Cancer Patient Experience Survey 2014 the trust scored in the top 20% of trusts for ten of the key performance indicators this included patient's rating their care as excellent/very good; doctors and nurses not talking in front of the patient as though they were not present; side effects explained in an understandable way. The trust was in the bottom 20% of trusts for patients not being given the name of their Clinical Nurse Specialist.
- The trust scored higher than the England average in the Patient-led Assessments of the Care Environment (PLACE) for privacy, dignity and well-being in 2014 with a score of 94 compared to the England average of 87.
- In the Friends and Family Test March 2014 to February 2015 overall the trust scored below the England average (ranging from 89.1% to 95% compared to 94% to 95%)

Facts and data about this trust

Activity

Activity Type

Jan 2014 – Dec 2014

Inpatient admissions

Outpatient (total attendances)

438,436

Accident & Emergency (attendances)

87,772

Key Figures

Beds: 708

- 647 general and acute
- 39 maternity
- 14 critical care

Staff: 4409

- 471.4 WTE medical and dental

- 1989.4 WTE nursing
- 2039.9 WTE other

Intelligent Monitoring –

Priority banding for inspection Recently Inspected

Number of 'Risks' 3
figures)

Number of 'Elevated risks' 2

Overall Risk Score 9


Number of Applicable Indicators 96

Percentage Score 4.69%

Maximum Possible Risk Score 192

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Since our last inspection the trust had continued to recruit nursing staff and staffing levels had improved. The staffing issues in the High Dependency Unit had been comprehensively addressed and there was sufficient numbers of nurses to meet the needs of patients being cared for in this area at all times. In other wards and departments throughout the trust staffing levels met the needs of the patients at the time of our inspection; however, the skill mix on Ward 39 and Ward 20 at Royal Lancaster Infirmary was still variable.</p> <p>There was still a reliance on bank and agency staff to maintain appropriate staffing levels in some areas. In cases of short notice unplanned absences there were times when some wards were not appropriately staffed. The trust acknowledged that this was not a sustainable position in the longer term and was actively recruiting additional nursing staff nationally and internationally at the time of our inspection</p> <p>The trust had improved its patient safety incident reporting. The most recent NRLS report (April 2015) detailed a ratio of 43.49 patient safety incidents reported per 1000 bed days. The average for all acute trusts is 35.1. This demonstrated an improved safety reporting culture within the organisation.</p> <p>The trust had made good process regarding the management of Serious Incidents Requiring Investigation (SIRIs) and a weekly 'Patient Safety Summit' was in place to review all incidents causing moderate harm or above, this process also included any significant near misses. However, Paediatric medical staff remained concerned about their lack of involvement in the 'rapid review process' in relation to Serious Incidents Requiring investigation (SIRI) and felt excluded from the process in incidents relating to babies referred from maternity services.</p> <p>The trust had launched a monthly 'Learning to Improve' communication for staff in March 2015. This shared lessons from incidents, complaints and other safety/governance issues. A website has also been launched on the intranet to improve sharing and staff understanding in this area.</p> <p>The trust has a process for the management and implementation of safety alerts from the Central Alert System Broadcasts. This was monitored at the Health and Safety Committee and reported as a performance indicator to the trust board. The latest NHS England report (June 2015) had no overdue alerts for the trust.</p>	<p>Requires improvement</p> 

Summary of findings

There were policies and procedures in place in relation to the safeguarding of adults and children. Staff were supported with training and were able to identify and escalate issues of abuse and neglect appropriately. Safeguarding training had been delivered to 97% of the staff.

There was appropriate practice in relation to the duty of candour regulatory requirements.

Cleanliness and Hygiene

- The trust had infection prevention and control policies in place that were accessible to all staff.
- Patients received care in a visibly clean and suitably maintained environment. However the cleanliness in the Accident and Emergency Department at Royal Lancaster Infirmary required improvement.
- Staff were aware of and applied infection prevention and control guidelines.
- There were good practices in relation to hand hygiene. 'Bare below the elbow' guidance was followed and personal protective equipment, such as gloves and aprons, was used appropriately while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.

Duty of Candour

- The trust was aware of its obligations in relation to the Duty of Candour requirements.
- Since the duty of candour regulations were introduced in 2014, an audit of compliance had been carried out by the trust. We reviewed the period April 2015 to June 2015, we saw evidence that people had been appropriately informed of an incident in line with duty of candour principles and the actions that had been taken to prevent recurrence.

Safeguarding

- The trust had appropriate Safeguarding policies and procedures were in place for both adults and children. The policies and procedures were supported by staff training.
- The trust compliance target for safeguarding training was 95%. 97% of staff had completed safeguarding adults level 1 training and 90% had completed level 2 training.

Summary of findings

- For safeguarding children training the compliance rate for Level 1 training was 85% and for level 2 training was 90%. The compliance rate for level 3 safeguarding children training was 85% in July 2015.
- Staff were able to identify issues of abuse and neglect and refer appropriately.
- Data suggested that staff were raising safeguarding concerns in accordance with the trust's policies and procedures. Between July 2014 and July 2015, 326 referrals were made to the adult safeguarding team. This was 35% of the total number of patient safety incidents reported during the last 12 months.

Incidents

- There is a reporting and managing incidents policy which sets out the purpose and scope of the policy. The roles and responsibilities of all staff are identified at all levels. The reporting structure to the various committees and groups is clear. Staff were able to describe the process for reporting incidents
- The trust was actively reporting patient safety incidents. The most recent NRLS report (March 2015) detailed a ratio of 43.49 patient safety incidents reported per 1000 bed days. The average for all acute trusts is 35.1. This indicates good performance by the trust in this regard.
- Between May 2014 and April 2015 the trust had no never events and reported 65 serious incidents predominantly split between slips, trips and falls, grade three pressure ulcer damage and delayed diagnosis. In total the trust reported 9,453 incidents.
- A weekly patient safety meeting attended by the Chief Nurse and Medical Director, patient safety teams and representation from each of the divisions was held weekly. The purpose of this meeting was to review and re-score incidents with regard to risk and then to escalate accordingly ensuring identification of any serious incidents if not already identified. Assurance is gained at this meeting that Duty of Candour has been applied.
- The Chief Nurse and Medical Director are informed of all serious incidents and never events and there is a Serious Incident panel held on a monthly basis.
- Paediatric medical staff remained concerned about their lack of involvement in the 'rapid review process' in relation to Serious Incidents Requiring investigation (SIRI) and felt excluded from the process in incidents relating to babies referred from maternity services.

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- Incidents are reported through an electronic reporting system and staff were able to articulate the process for reporting incidents. The electronic system does not allow staff to move on through the programme unless all fields are completed appropriately including Duty of Candour.
- Staff undertaking root cause analyses (RCA) for serious incidents have received training via e-learning and face to face sessions. We were told that the trust has rolled out incident training to all staff and this has been delivered face to face since April 2014 and an E-learning module was added to staff training management system records for completion by all staff from June 2015 onwards. We were told that the trust plans to roll out RCA training by December 2015.
- Eight incidents were reviewed and all used an appropriate tool following NPSA guidance. The reports identified a clear chronology, an RCA investigation (of variable quality), lessons learnt and an action plan. The reviews identified the following themes:
- Under good practice staff were identifying things that should be expected rather than areas of exceptional practice e.g. fully completed prescription, good documentation.
- Some documentation identified the incident as the root cause rather than the actual cause of the incident
- There was limited 'drilling down' into the causes to establish why an incident occurred.

Nurse and Midwifery Staffing

- The trust had 21 Whole Time Equivalent vacancies in maternity however we were informed that following recruitment of midwives this would be reduced to 15 Whole Time Equivalents (WTE) and these vacancies were predominantly in community service.
- Agency midwives were being used however these had been working in the trust for the last three years.
- The staffing issues in the High Dependency Unit had been comprehensively addressed and there was sufficient numbers of nurses to meet the needs of patients at all times.
- In other wards and departments throughout the trust staffing levels met the needs of the patients at the time of our inspection; however, the skill mix on Ward 39 and Ward 20 at Royal Lancaster Infirmary was still variable and did not always meet the 'red rules' requirements of one registered nurse to eight patients.
- In Furness General Hospital Staffing levels met the needs of the patients at the time of our inspection, however, on reviewing

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staffing rotas over the previous month there were concerns regarding the staffing levels and skill mix on some wards. It was evident that there were still nurse vacancies in some specialities.

- There was an escalation process in place for managers to respond to staffing challenges, however there were times when wards were not always appropriately staffed.
- The trust has recruited a number of overseas nurses who are not counted in the ward qualified staffing numbers until they have their PIN number.
- Nurse staffing on Ward 39 remained a concern from the previous inspection although improvements in staffing establishments had been made.

Medical Staffing

- Medical skill mix showed that the trust had a higher than England average proportion of Consultants (41%, England average 39%) and higher proportion of middle grade doctors when compared to the England average (18%, England average 9%) although they had a lower proportion of registrars.
- There were concerns regarding the staffing at a junior doctor level at Westmorland Hospital, this related to a middle grade locum post within the surgical speciality. We were told that this post was a locum post provided by an agency and if the post holder left the agency would replace the post. Concerns were raised regarding the future sustainability of the current arrangements within the surgical out of hour's medical cover.
- There were concerns regarding the sustainability of the paediatric medical rotas as there was no junior doctor cover at the time of inspection. The paediatric team were currently undertaking a job planning review and that there were plans in place to address the lack of junior doctor cover.
- In end of life care two fixed term nursing band 6 educator posts had come to an end as well as the end of life nursing lead and there was concern regarding the impact this would have on the provision of end of life care services. The trust had plans in place to integrate end of life care services into the 'Better Care Together' strategy. The planned Consultant post at Furness General Hospital was not in place.
- There had been recent recruitment to the Consultant Obstetrician vacancies.

Are services at this trust effective?

Patients care and treatment was delivered in accordance with evidence based practice and national guidance. Care pathways

Requires improvement



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including pre-operative assessments and enhanced recovery programmes were based on relevant national guidance. The trust was an active participant in national audits through the advancing quality programme. Where audits identified improvements were required the trust developed action plans to improve performance and outcomes. However, there were elements of care and treatment that needed improvement as patient outcomes in some areas were below the national average. In addition the average re-admission rates for trauma and orthopaedics, both elective and non-elective, were above (worse) than the England average.

Evidence based care and treatment

- Care and treatment was delivered in accordance with evidence based practice and national guidance.
- Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance
- The trust was an active participant in national audits through the advancing quality programme.

Patient outcomes

- Stroke outcomes were recognised by the trust as a concern and were classed as a risk for In-hospital mortality in the CQC Intelligence Monitoring report December 2014. Stroke care and management was identified by the trust as one of five projects that form part of the Sign up to Safety Campaign commenced in January 2015 with a view to improving patient outcomes.
- The trust was matching the improvement seen nationally in Patient Recorded Outcome Measures (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the England average.
- In the Hip fracture audit 2014 Royal Lancaster Infirmary scored better than the England average for 6 of the 10 indicators. However the hip fracture audit data showed the hospital was below the England average for pre-operative assessment by a geriatrician. The England average in 2014 was 51.6% and Royal Lancaster Infirmary was 13.8%. We were told this was due to a lack of consultant geriatricians employed by the trust.
- In the Lung cancer audit 2014 the trust scored better than or similar to the England average in all three questions.
- The average re-admission rates for trauma and orthopaedics, both elective and non-elective, were above (worse) the England average. This indicator had not previously been monitored by the trust as part of their measure of outcomes for patients. When it had been requested as part of the data collection for this inspection, the trust undertook a retrospective audit using

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patient records for the three months from April 2015 to June 2015. The audit confirmed that 100 patients were readmitted in that time. 33% of the trust wide admissions were as a result of the previous admission. An action plan was developed which included consideration of a rapid review for any patients readmitted with an infection and a further analysis of 800 patients.

- The trust scored well for two indicators, and better than the England average for two indicators in the National Bowel Cancer audit 2014. The trust scored worse than the England average for “Seen by clinical nurse specialist”.
- There was a Clinical Audit & Effectiveness Steering group that is a sub-group of the Quality Committee, chaired by a Deputy Medical Director. All audits and NICE Guidance are reviewed by the group on a monthly basis. In future all audits and NICE guidance will be reported on the electronic reporting system: ‘Safeguard’. There was guidance and timescales for divisions to acknowledge receipt of audit or NICE guidance (7 days) and for undertaking a gap analysis (35 days) and reporting back to the steering group.

Multidisciplinary working

- There good examples of multi-disciplinary working to secure good outcomes and seamless care for patients. Staff in all disciplines worked well together for the benefit of patients.
- There were trust wide multidisciplinary teams with established links to local speciality teams.
- A multidisciplinary complex discharge team was available to assist staff to plan for the safe discharge of patients with complex health or social care needs.
- A multi-disciplinary meeting took place on the orthopaedic wards each morning. This included physiotherapists and occupational therapists along with the trauma co-ordinators who would discuss each patients care and any planned transfers or discharges.

Competent Staff

The trusts’ target for appraisal rates was 95%. Information we received indicated that this target was met in two of four staff groups .However 73% of nursing staff in bands 1 to 7 were compliant , 83% of medical staff and 85.6% of 154 staff across the trust at 8a and above with management responsibility had an appraisal on 17 July 2015.

- In maternity services a training needs analysis had been undertaken and a training programme for midwives was now in

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place. Three teams of midwives had received PROMPT training this was delivered by a Practice Development Midwife and at the time of inspection was being rolled out across the service. It was intended that all staff would attend this training on an annual basis.

- The clinical director confirmed that the revalidation process was well managed. Reminders for non-compliance were sent to the Responsible Officer for follow up. All eligible staff members had been revalidated.
- The process for the new requirements for the revalidation of nurses had not yet been implemented. Nursing staff were aware of the requirements for revalidation but not the trusts intended approach.
- The trust carried out regular training needs analysis that was reviewed and actions agreed by the Workforce Committee.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust provided training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards that was a component of the safeguarding mandatory training. (97% of staff had received Safeguarding training)
- We found that staff had a varied level of understanding of the implications and responsibilities that resulted from a patient's lack of mental capacity. Some staff could not explain when an assessment might be indicated, how it would be requested or who would complete it. These meant patients may not receive an appropriate assessment of their mental capacity or the support that may be required.

Are services at this trust caring?

All patient groups including children and young people, their families, relatives and representatives were positive about the care and treatment provided by staff. Patients and those close to them felt that staff were caring and compassionate and treated them with dignity and respect. Staff were sensitive to patients needs and were emotionally supportive when assisting them come to terms with their current medical situation or accept difficult messages.

We saw some good examples of staff responding to patients in a sensitive and person centred way.

Compassionate care

- Patients and those close to them were positive about their interactions with staff. Patients felt their individual needs were met in a professional, sensitive way. Staff were observed

Good



Summary of findings

spending time talking with patients and relatives explaining treatment and care options in a way patients could understand. Patients living with dementia were cared for in a kind and sensitive way.

- Care was delivered with dignity and respect and took into account the personal preferences and wishes of the patient.
- In the Cancer Patient Experience Survey 2014 the trust scored in the top 20% of trusts for ten of the key performance indicators this included patient's rating their care as excellent/very good; doctors and nurses not talking in front of the patient as though they were not present; side effects explained in an understandable way. The trust was in the bottom 20% of trusts for patients not being given the name of their Clinical Nurse Specialist.
- The trust scored higher than the England average in the Patient-led Assessments of the Care Environment (PLACE) for privacy, dignity and well-being in 2014 with a score of 94 compared to the England average of 87.
- In the Friends and Family Test March 2014 to February 2015 overall the trust scored below the England average (ranging from 89.1% to 95% compared to 94% to 95%).

Understanding and involvement of patients and those close to them

- Patients and their relatives felt involved in their care. There were good examples of patients and those close to them being actively involved in care and treatment and being able to make decisions in an informed way.
- Opportunities to speak with medical and nursing staff were provided and questions answered honestly and openly.
- In the Care Quality Commission (CQC) In-patient Survey 2014 the trust performed the same as other hospitals for providing understandable answers to important questions; and for all the indicators relating to being involved in the decisions about their treatment and care.

Emotional support

- The trust had a Christian chaplaincy service that provided spiritual support to patients and those close to them if and when required.
- Spiritual leaders from other faiths were also available to provide support to patients and see that their religious wishes were adhered to.
- This trust had a volunteer programme and volunteers were able to help support the emotional needs of patients, particularly those at the end of life.

Summary of findings

- In the Care Quality Commission (CQC) In-patient Survey, 2014 the trust performed the same as other hospitals for whether patients felt they received enough emotional support

Are services at this trust responsive?

The trust had improved its strategic planning for the future delivery of services. Over the last two years the trust and its strategic partners have been reviewing and planning the future configuration and delivery of services across the area. This work has resulted in the Better Care Together strategy that sets out the trusts plans for future service provision based on the needs of the local population and acknowledging the significant geographical challenges faced by the trust. The plans were being finalised for implementation at the time of our inspection. Transformation and reconfiguration of services was planned for July 2015 – October 2019.

However, the trust had experienced some difficulties in responding to the needs of the people in a timely way. The emergency care pathway had been under considerable pressure with 2014/15 Quarter 4 performance against the 4 hour standard at 92.68% and year end at 92.5%. This was below the national target of 95%. The standard was however achieved in May and June at 95.35% and 95.86%. It was then achieved in Quarter 2 2015/16.

In addition the trust had struggled to meet the standard Referral to Treatment time of 18 weeks or below for 7 of the months in the period January 2014 to February 2015, in surgery the trust continued to struggle to meet this target in June and July 2015. In June 2015 however the admitted and non-admitted referral to treatment time targets changed to the standard for incomplete pathways, during the period January 2014 to February 2015 the trust achieved this standard for 11 out of the 13 months. During this time the non-admitted standard was however met in all months but March 2015

There were some good examples of initiatives to meet the needs of patients whose circumstances or illness made them vulnerable, for example the butterfly scheme was used to identify patients living with dementia. The Trust had also signed up to Mencap's 'Getting it Right Charter' that provided resources to ensure patients with a learning difficulty would be cared for and managed in accordance with best practice. Interpreters were available on demand for patients whose first language was not English. British Sign Language interpreters were also available for patients who were deaf.

Service planning and delivery to meet the needs of local people

Requires improvement



Summary of findings

- The trust had improved its strategic planning for the future delivery of services. Over the last two years the trust and its strategic partners have been reviewing and planning the future configuration and delivery of services across the area.
- This work has resulted in the Better Care Together strategy that sets out the trusts plans for future service provision based on the needs of the local population and acknowledged the significant geographical challenges faced by the trust.
- The plans were being finalised for implementation at the time of our inspection. Transformation and reconfiguration of services was scheduled for July 2015 – October 2019.

Meeting people's individual needs

- The Trust had also signed up to Mencap's 'Getting it Right Charter' that provided resources to ensure patients with a learning difficulty would be cared for and managed in accordance with best practice.
- Interpreters were available on demand for patients whose first language was not English.
- British Sign Language interpreters were also available for patients who were deaf.
- There was a paucity of patient information leaflets for patients whose first language was not English and for patients who had a visual impairment. The provision of written information for these groups of patients had not been improved since our last inspection.
- Accessible information leaflets for people with a learning disability were seen in some wards.

Dementia

- The butterfly scheme was used to identify patients living with dementia. In some ward areas there was enhanced décor to support and help people living with dementia.
- The trust had begun to implement a buddy system for people with dementia that had been financially supported through charitable funds. This has allowed the training of volunteers to support people with dementia during their stay in hospital.
- There was a memory wall developed at Westmorland General Hospital that was opened in July 2015.
- As part of its approach to service provision for patients living with dementia the trust had committed to a number of work streams including:
- Specialist training for staff.

Summary of findings

- Quality standards for delirium and dementia care within the acute hospital setting. These standards are aimed at ensuring that care delivery and person centred pathways were dementia orientated, and involved families and carers in the process of planning, delivery and evaluation of care.
- The Establishment of a dementia Café at FGH and RLI to offer support to patients, those close to them and the wider public
- A Volunteer Programme supported by RVS in place to offer dementia reminiscence activity on in patient areas, plus outreach sitting support where needed (e.g. Emergency Departments, Out Patient Clinics)

Access and flow

- The emergency care pathway had been under considerable pressure with 2014/15 Quarter 4 performance against the 4 hour standard at 92.68% and year end at 92.5%. The standard was however, achieved in May and June at 95.35% and 95.86%. It was then achieved in Quarter 2 2015/16
- The trust had struggled to meet the standard Referral to Treatment time of 18 weeks or below for 7 of the months in the period January 2014 to February 2015. This was in response to an agreement with commissioners to reduce the number of people waiting longer than 18 weeks for their treatment. In surgery the trust continued to struggle to meet this target in June and July 2015. In June 2015 however the admitted and non-admitted referral to treatment time targets changed to the standard for incomplete pathways, during the period January 2014 to February 2015 the trust achieved this standard for 11 out of the 13 months. During this time the non-admitted standard was however met in all months but March 2015
- There were times, as a result of bed pressures, when patients were placed in areas not best suited to their needs and condition. The process for the medical review of this group of patients was not clearly understood by all staff.
- The trust has a cross bay operational team that meets four times a day, it was led by the on call senior manager, the purpose of the meeting was to identify any system pressures and agree remedial actions.
- There were escalation plans for all three hospitals sites in the event of increasing system pressure and demand on the bed base.
- There were 12,494 delayed transfers of care between April 2013 to November 2014 of which the majority (64%) were awaiting nursing home placement; residential home placement or care package being provided in their own home.

Summary of findings

- Senior staff confirmed that managers were developing a 'winter pressures plan' to cope with increased demand for beds in the coming winter months. The trust was engaged with partner organisations, such as the local authority and clinical commissioning groups, to address and manage this difficult period.

Learning from complaints and concerns

- The Chief Nurse had an overview of all complaints and staff or teams involved in a complaint are asked to submit a reflective piece of work to provide the Chief Nurse with assurance that they have considered any learning from the complaint.
- Lessons from complaints are shown on the ward boards and this was seen by the inspection team.
- The trust had received 489 complaints between April 2013 and March 2014. This had significantly decreased from the previous year.
- There were concerns regarding the quality and timeliness of the trust response to complaints. However we acknowledge that from 2014 the trust has month on month onwards, achieved 100% acknowledgement (within 3 days) and achieved above 95% response rate targets (within 35 days) set by the Trust Board demonstrating improved timeliness. We also acknowledge that while the Public Health Service Ombudsman (PHSO) have investigated more cases they upheld 22% less indicating that the quality of the case investigation and response letters has improved. There remained a small number of complaints however where the trust had missed deadlines which resulted in complainants remaining dissatisfied with the complaints process.
- Prior to our inspection concerns had been raised with the Care Quality Commission regarding the trust responding to complaints in a timely and empathic way. Through the performance reports provided the Trust evidenced how they are meeting their complaints response target of 35 days consistently at 95% or above. Case Officers carry out a full review of policies and procedures ensuring each case has a much more patient focused approach, for example: case officers now make an initial call to the complainant agreeing how they would like their case to be handled, regular courtesy calls updating complainants of the progress of their complaint are made throughout the duration of the case.
- It was evident that some complaint responses would have benefitted from a more personal approach. The Chief Nurse acknowledged that the language used in complaint responses could be improved and the Trust are working to address this.

Summary of findings

Are services at this trust well-led?

The trust had made significant improvements to its governance and management systems since our last Inspection.

The trust's vision, values and objectives were articulated in The 5-year Strategic Plan commenced in 2015. The key objectives included in the strategy are aligned with those in the Board Assurance Framework. The trust had approved its Quality Improvement Plan 2014-2017, 'Better Care Together'. This document detailed clear objectives with expected outcomes and indicators for improvement.

The trust had developed a Risk Management strategy 2015-16 that clearly set out the roles and responsibilities for risk management. The appendices of the strategy gave clear guidance on how to undertake a risk assessment for inclusion on the risk register.

To support the delivery of 'Better Care Together' and staff engagement overall, the Trust has commenced the 'Listening into Action' programme. Staff were, in the main, positive about the improved staff engagement and the Listening into Action programme; however, there was still work for the trust to do to address the concerns of staff from a BME background. The Trust had acknowledged this and had plans in place to address staff concerns and to promote and secure equality in the workplace. In addition there were cultural issues in both the breast screening service and paediatric service that required focussed work and support.

Vision and strategy

- The trust's vision, values and objectives are articulated in the 5-year Strategic Plan commenced in 2015. The key objectives included in the strategy are aligned with those in the Board Assurance Framework.
- Trust had approved its Quality Improvement Plan 2014-2017, 'Better Care Together'. This document details clear objectives with expected outcomes and indicators for improvement.
- Divisions had developed their own strategic plan that linked to the overarching trust strategic plan.

Governance, risk management and quality measurement

- A Risk Management strategy 2015-16 had been developed that clearly sets out the roles and responsibilities for risk management. The appendices of the strategy gave clear guidance on how to undertake a risk assessment for inclusion on the risk register.
- The Board Assurance Framework was presented to the Board quarterly with an overview of the main components of the framework and a summary of the trust's vision, values,

Requires improvement



Summary of findings

objectives and priorities. The Framework was aligned to these objectives. Part A of the Framework was a dashboard, which provided the Board with a commentary on changes in the risk profile over the last quarter, a progress update on the management of the risk, a position statement on the level of assurance and the page number where the detail can be found in Part B of the Framework.

- Part B provided the detail regarding risks. This included an inherent risk rating and a residual risk rating. There is a target risk rating for the Board to aim to achieve referred to as the residual risk rating. Appropriate controls are listed although gaps in controls are not acknowledged in this framework. There is a list of mitigating actions but not future actions with planned timescales, identified leads etc. The assurances were largely limited to internal sources with appropriate gaps in assurance identified. There was a section towards the end of the template for each risk asking what the assurance position is and the Board's risk appetite. This was completed inconsistently (in terms of the language used and whether risk appetite is commented on at all) and did not appear to link to any recognised risk appetite model.
- There was a structured governance framework in place that was referred to as 'WESEE' which included workforce, efficiency, safety, effectiveness and experience. This was in place from ward level with monthly governance meetings feeding into the Divisional Governance Assurance Group. All terms of reference, business schedule, reporting template and agenda are standardised across the divisions to ensure consistency. This group reports into the Divisional Performance Review by means of exception reports and then into the Quality Committee. The governance framework was still being embedded. Although there was still work to do to finesse the management of risk, it was evident that there had been significant improvement in governance and risk management systems since our last Inspection.
- The risk descriptions did not include the cause of the risk because such information is listed on the BAF and Corporate report as a separate data field entitled: 'Source of Risk'.
- The Trust used the Risk Register Module of Ulysses Safeguard as its 'Risk Register', when supplied by the manufacturer this module contains around 110 data fields that can be used if required, as at July 2015 the Trust used around 50 of these data fields
- The trust has a Quality Committee, which was a subcommittee of the Board. The duties of this committee included reviewing and seeking assurance around the Board Assurance Framework

Summary of findings

and Risk Register. All Divisions were represented and presented a quarterly exception report from their areas. The work-plan of the Committee was appropriate to its terms of references and included areas such as CQUIN, Serious Incidents, Mortality, Quality Impact Assessments, Complaints, Patient Experience, Clinical Audit, Advancing Quality, Claims, NICE, CQC and integrated governance reports.

- The trust had implemented a 'RAISE' programme that involved a range of 'mock inspections' to wards. Staff were given immediate feedback that was then confirmed in writing. Immediate improvement actions were highlighted for implementation. This approach had secured some operational improvements and improved the quality of care delivered to patients.
- There had been internal audit of the Board Assurance Framework, Corporate Governance Framework and Complaints all of which had reported high assurance. External audit of the annual report and quality accounts benchmarked against other trusts was identified as being 'very good'.
- There was integration of lessons learnt from complaints, incidents and claims. The trust had developed a 'Learning to Improve' steering group that was chaired by a Non-Executive Director. All divisions attend this group and present divisional and organisational learning. Steering group identify themes, recent examples of this included Venous Thromboembolism (VTE) forms not having prophylaxis being identified. This has resulted in the instigation of an internal audit of the process of completion of VTE.
- There was a performance management framework in place which held managerial and clinical leaders to account for performance within their services. Performance Management meetings, chaired by the recently appointed Chief Operating Officer were held monthly and Integrated Performance reports were used. The meetings would report into the sub-committees for finance, quality and workforce by exception. Management teams who were identified as having poor performance would have a buddy identified and intensive support would be provided to address the performance issues. The Chief Nurse was able to provide examples of managing poor performance within nursing which included informal support followed by a more structured approach in the event of further incidences of the same type including competency based assessment.
- There were concerns regarding the rigour of the Matron Assurance Framework as there were areas of poor

Summary of findings

documentation and lack of documented patient risk assessments identified during the inspection. It was unclear how frequently Matrons undertook audits of documentation and the Chief Nurse was unable to clarify this position.

Leadership of the trust

- The senior team had worked well together to include staff in the change and improvement agenda. The senior team was more visible and accessible. Staff were positive about the improved visibility of managers and executives. The executive team rotated their weekly meeting across all three hospital sites to improve visibility and accessibility across the organisation.
- The trust was developing a leadership development strategy which was outlined in the public part of the Board Papers for June 2015 that was part of the overarching Organisational Development Strategy and focussed on the development of values-based leadership linked with culture change.
- At the governors focus group attended by 12 public governors we were told that there was strong leadership and that there was a good relationship between the governors and the trust board. Governors at the focus group spoke highly of the trust Chair.
- Clinical Directors were able to access a leadership programme to support the development of their management skills.
- There were a number of concerns regarding leadership, an example of this was in Paediatrics that related to lack of managerial support to the Clinical Leads. We were informed that work was planned to make improvements in bringing together management and clinical teams. Plans included support from a senior clinician.
- The middle management teams were in the process of undertaking a development programme to strengthen leadership capability and capacity across the organisation.
- Nursing leadership was provided by the Chief Nurse and three Deputy Chief Nurses based on each site. Each division has an Assistant Chief Nurse (or Lead Allied Health Professional (AHP) who managed Matrons and AHP leads in each of the services. The Matrons (and AHP leads) had responsibility for several ward managers and AHP team leaders. This approach had improved lines of responsibility and accountability and had improved the visibility and accessibility of senior nurse managers.
- There were concerns raised regarding the capacity of the Executive Team to deliver the strategic plan and take forward its strategic aims. The trust was looking to establish additional support in this regard with a focus on the following areas: finance and estates; transformational skills and legal expertise.

Summary of findings

- The Director of Finance confirmed that all business cases and cost improvement plans had a quality impact assessment and were signed off by the Chief Nurse and Medical Director prior to implementation.

Culture within the trust

- Staff were proud of the work they did and were committed to providing patients with good quality services. Staff, in the main, were positive about their line managers and felt supported.
- The trust had also appointed a 'freedom to speak up guardian' in response to the Freedom to Speak Up Review into whistleblowing in the NHS. The intention was to support staff so they could raise concerns in the public interest with confidence that they would not suffer detriment as a result. This work was supporting the trusts ambitions to embed an open, transparent and learning culture within the organisation.
- However, there were areas in the trust where there was a negative culture and staff felt isolated and marginalised. This was evident in the Breast Screening Service. A PHE review of the services had led to a number of recommendations including the improvement of professional relationships and the implementation of the changes in the management of the service.
- However, the pace at which the required management changes had been implemented was slow and had become very protracted. It was acknowledged that the trust did have some complex staffing issues to address, nevertheless the pace of change means that professional relationships and the culture within the Breast Screening Unit remained a cause for concern.
- The trust was aware of the concerns relating to a BME employee experience from the WRES submission and had started to engage with clinicians from a BME background to address these. This included reviewing the processes for investigating the conduct and capability of clinicians from a BME background, including increasing the cadre of trained investigators so that an investigator from a BME background could be utilised. In addition, the Trust was actively involving BME employees in planning and delivering a Diversity Conference to focus on the WRES, to start addressing the concerns and to bring diverse groups together. Senior medical staff in the paediatric service in Furness General Hospital reported a bullying culture where concerns were slow to be heard and addressed. There were plans in place to improve managerial and clinical support, however the issues raised by doctors remained concerning and indicated a poor culture within the service.

Summary of findings

Fit and Proper Persons

- The trust was prepared to meet the requirements of the Fit and Proper Persons regulation (FPPR). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, employment history, professional registration and qualification checks.
- It was part of the trust's approach to conduct a check with any and all relevant professional bodies and undertake due diligence checks for senior appointments.

Public engagement

- The trust was working with external organisations to support the development of improved public engagement.
- The trust had a number of people who had previous experience of the maternity services involved in one of the maternity services project groups and on the sub-committee for the Morecambe Bay Investigation. A lay person was also a member of the Clinical Quality Group; the individual also had previous experience of maternity services.
- The trust had been involved with a local community initiative in Millom to improve health care services within the community in response to the people of Millom contacting the local healthcare organisations. This has resulted in improvements in health care for this community.

Staff engagement

- To support the delivery of 'Better Care Together' and staff engagement overall, the Trust has commenced the 'Listening into Action' programme. Staff were, in the main, positive about the improved staff engagement and the Listening into Action programme. Trust governors felt that the Listening into Action had made a positive change and had resulted in an atmosphere of team working.
- The trust recognised that staff engagement although improved remained challenge. The latest 'pulse checks' for staff with regard to the 'I am kept up to date about what's going on in the Trust' question have seen a decrease. In September 2014, the positive response to this question was up to 77%. However, this had significantly reduced in February and April 2015 at 58% and 46% respectively. The Trust used two different Pulse Surveys to

Summary of findings

test levels of engagement throughout the year. The Listening into Action Pulse Survey in July 2015 showed overall improvement of 17.3% across all indicators compared to November 2014.

- There were areas regarding staff engagement and support that still required improvement. One area of particular concern was the Workforce Race Equality Standard (WRES) submission which highlighted that BME staff had a disproportionate employee experience compared to non-BME colleagues. These views were confirmed in our meetings and focus groups with BME staff. Some staff felt that they were very well supported; however others alleged a bullying culture where they felt marginalised and unable to raise concerns without there being repercussions. We raised this matter with the Trust who confirmed that they were aware of the issues and, in response, had met with BME staff representatives to hear their concerns and had committed to working with staff to agree what actions needed to be taken to improve this the Trust had reviewed leadership on diversity and inclusiveness, with a designated Board lead and leads for both workforce and service issues. There were plans in place to involve and include staff from a BME background in all of the work streams intended to secure improvements and promote an open and just culture. The Chief Executive sent out a 'Friday Message' to staff and the Chief Nurse sent out a monthly newsletter to nursing, midwifery and Allied Health Professional staff
- The trust has a monthly 'star award' programme to recognise staff contribution and an annual award ceremony.
- The trust have a monthly team brief which staff attend and then take back messages and information to their own areas of work.

Innovation, improvement and sustainability

- The trust had a research programme in place and participated in national trials. The Medical Director informed us that there was good recruitment to trials and that a joint working group had been set up to look at further development of research in the trust. The trust was working closely with the medical school to develop Senior Lecturer posts within the trust to support the research programme and the workforce requirements.

Overview of ratings

Our ratings for Royal Lancaster Infirmary

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

Our ratings for Westmorland General Hospital

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

Overview of ratings

Our ratings for Furness General Hospital

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

Our ratings for University Hospitals of Morecambe Bay NHS Foundation Trust

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

Notes

Outstanding practice and areas for improvement

Areas for improvement

Action the trust **MUST** take to improve

Action the trust **MUST** take to improve

- Ensure that all premises used by the service provider are suitable for the purpose for which they are being used and properly maintained. This is particularly in relation to physiotherapy services and medical care services provided from medical unit one.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. Staff should receive appropriate support, training and appraisal as is necessary to enable them to carry out their role.
- Ensure that staff understand their responsibilities under and act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in medical care services and critical care services.
- Ensure referral to treatment times in surgical specialities improve.
- Ensure that the resuscitation trolleys on the children's ward are situated in areas that make them easily accessible in an emergency. All staff must be clear on who has responsibility for the maintenance of the resuscitation trolley on the delivery suite.
- Ensure that they maintain an accurate, complete and contemporaneous record in respect of each service user.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)</p> <p>Regulation 18(1)(2) Staffing</p> <p>The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to medical care, children and young people services, and radiology, dermatology and allied health professionals.</p> <p>The provider must ensure that staff receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform, particularly in Accident and Emergency, medical and surgical services and Children and Young People services.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)</p> <p>Regulation 15 (1) Premises and equipment</p> <p>The provider must ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used,</p>

This section is primarily information for the provider

Requirement notices

properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided in critical care and outpatients.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 12 (2)(a)(g) Safe care and treatment

The provider must ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The provider must ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in children and young people and critical care services.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)

Regulation 17 (2)(b)(c) Good governance

The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including medical and nursing, and food and fluid charts, particularly in medical and surgical services.

This section is primarily information for the provider

Requirement notices

Ensure referral to treatment times in surgical specialities improve.