Furness General Hospital

Quality Report

Dalton Lane
Barrow in Furness
Cumbria
LA14 4LF
Tel: 01229 870870
Website: www.uhmb.nhs.uk

Date of inspection visit: 18 - 19 December 2019
Date of publication: 19/03/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Furness General Hospital is operated by University Hospitals of Morecambe Bay NHS Foundation Trust. We inspected maternity services and services for children and young people at Furness General Hospital

We inspected the services provided by this trust as part of a focused inspection. We had concerns about the quality of services and we received concerning information about the safety and quality of the services.

Where it is considered necessary to arrange a focused inspection outside of the regular core service inspection schedule, the focused inspection covers a targeted part of the service response to a specific concern. We do not assess or report on all the key lines of enquiry (KLOEs) in a focused inspection.

As we do not rate a trust following a focused inspection, we cannot update any provider level ratings following this inspection.

Throughout the inspection, we took account of what people told us.

We found the following areas that required improvement:

- The trust's care pathway for 16 and 17 year-old patients was unclear and had resulted in delays in patients obtaining treatment. We raised this on inspection and the trust took immediate action to ensure there was a clear patient pathway with policies and procedures.
- The services did not have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance which we also found at our previous inspection. However, due to consultants working overtime and flexibility of other grades of medical staff, patients were kept safe from avoidable harm and there were sufficient staff to provide the right care and treatment.
- Some staff felt there was a lack of any support and debriefing following an incident.
- It was not always clear in the incident records, where an incident was graded as moderate or above, that appropriate duty of candour actions had been undertaken or recorded.
- The senior leadership teams were based across the trust and were required to cover all three hospital sites. Staff told us the senior leadership team were not visible to them.
- Not all staff felt respected, supported and valued. Whilst we found that staff were focused on the needs of patients, some staff raised concerns to us about the culture within the services.
- There had been a deterioration in culture since our last inspection. Staff morale was low and there were strained relationships between clinicians and nursing staff.
- Senior leaders did not consistently operate effective governance processes throughout the services. Not all staff at all levels were clear about their roles and accountabilities or had regular opportunities to meet, discuss and learn from the performance of the service.
- The services did not manage risks, issues and performance well. Not all staff were aware of risks in their area of work.

However, we found the following areas of good practice:

- The services provided mandatory training in key skills to all staff and worked towards ensuring that everyone completed it.
- Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff completed and updated risk assessments for each patient, took action and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Summary of findings

- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care
- The service managed safety incidents. Staff recognised incidents and near misses. Some staff told us that managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The services made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Maternity	Good 	We previously rated maternity service as good in 2017. However, this inspection was a focused inspection and no new rating could be made.
Services for children & young people	Good 	Children and young people's services were a small proportion of hospital activity. We previously rated this service as good in 2017. However, this inspection was a focused inspection and no new rating could be made.

Summary of findings

Contents

Good

Furness General Hospital

Services we looked at

Maternity; Services for children & young people

Summary of this inspection

Background to Furness General Hospital

Furness General Hospital (FGH) is one of three hospital sites of University Hospitals of Morecambe Bay Foundation Trust's (the trust) three hospitals. Furness General Hospital (FGH) is one of two main hospital sites of University Hospitals of Morecambe Bay (UHMB). FGH serves the population of Furness and the surrounding areas in South Cumbria.

Furness General Hospital (FGH) has a range of 'General Hospital' services, including a full Accident & Emergency Department, Critical care unit and trust wide consultant led beds. FGH also provides a range of planned care including outpatients, diagnostics, therapies, day-case and inpatient surgery.

This inspection was a focused inspection that looked at maternity services and services for children and young people.

Our inspection team

The team that inspected the services comprised two inspection managers, two CQC lead inspectors and specialist advisors with expertise in governance, maternity and services for children and young people. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Furness General Hospital

At this focused inspection we visited maternity services and services for children and young people.

At Furness General Hospital the maternity department consisted of one ward of 14 en-suite rooms where obstetricians midwives provided antenatal, intrapartum and postnatal care, two maternity theatres adjoined this area and a specialist bereavement suite, a day assessment area with two examination rooms and a separate antenatal clinic area. There was also a two-bed transitional care unit where midwives and consultants provided postnatal care whilst the neonatal staff provided specialised neonatal care to the babies. In relation to services for children and young people, they consisted of one ward set out in cubicles and bays with 15 inpatient beds, a four bedded assessment unit, eight day-case beds, a children's play area, teenage area and a children's outpatient department. The special care baby unit is a level one unit with four cots. (A level one unit looks after babies who need more care than healthy newborn babies but are relatively stable and mature).

From July 2018 to June 2019, the trust had 7,776 admissions for paediatric patients at Furness General Hospital and Royal Lancaster Infirmary. A total of 2,877 babies were delivered within Morecambe Bay Maternity services.

During the inspection, we visited all relevant units. We spoke with 51 staff including registered nurses, midwives, health care assistants, reception staff, medical staff, governance staff, trust board members, local managers and senior managers. During our inspection, we reviewed 21 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We did not rate safe at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

We found the following areas that required improvement:

- The trust's care pathway for 16 and 17-year-old patients was unclear and had resulted in delays in patients obtaining treatment. We raised this on inspection and the trust took immediate action to ensure there was a clear patient pathway with policies and procedures.
- The services did not have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance. However, due to consultants working overtime and flexibility of other grades of medical staff, patients were kept safe from avoidable harm and there were sufficient staff to provide the right care and treatment.
- Some staff felt there was a lack of any support and debriefing following an incident.
- It was not always clear in the incident records that where an incident was graded as moderate or above that appropriate duty of candour actions had been undertaken or recorded.

However, we found the following areas of good practice:

- The services provided mandatory training in key skills to all staff and worked towards ensuring that everyone completed it.
- Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.
- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- Staff completed and updated risk assessments for each patient, took action and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Summary of this inspection

- The service managed safety incidents well. Staff recognised incidents and near misses. Some staff told us that managers investigated incidents and shared lessons learned with the whole team and the wider service.

Are services effective?

Good

We did not rate effective at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

We found the following areas of good practice:

- The services made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Are services caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

Are services responsive?

Requires improvement

We did not inspect responsive at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

Are services well-led?

Good

We did not rate well led at this inspection as this inspection was a focused inspection. A focused inspection differs to a business as usual inspection as it is more targeted, looking at specific concerns rather than gathering a holistic view across a service.

We found the following areas that required improvement:

- Senior leaders did not consistently operate effective governance processes throughout the services. Not all staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.The services did not manage risks, issues and performance well. Not all staff were aware of risks in their area of work.
- The senior leadership teams were based at another location and were required to cover all three hospital sites across the trust and were required to cover all three hospital sites.

Summary of this inspection

- Staff told us the senior leadership team were not visible to them.
- Not all staff felt respected, supported and valued. Whilst we found that staff were focused on the needs of patients, some staff raised concerns to us about the culture within the services.
- There had been a deterioration in culture since our last inspection. Staff told us morale was low and there were strained relationships between clinicians and nursing staff.
- We were not assured that processes to monitor equipment competencies were effective.

However, we found the following areas of good practice:

- Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Good

Maternity

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

Are maternity services safe?

Good

We did not rate safe at this inspection as this inspection was a focused inspection.

Mandatory training

The service provided mandatory training in key skills to all staff and worked towards ensuring that everyone completed it.

Training was accessed either via e-learning or within a classroom setting.

We were told staff received reminders when mandatory training was due and compliance with mandatory training was monitored by the matron and ward manager. Following our inspection, the trust told us mandatory training was overseen by the clinical business group with monthly unit meetings, care group performance reports and matron one to one meetings.

Following our inspection, we requested all mandatory training compliance for maternity staff at this location. However, the trust told us they were only able to provide overall compliance for the women and children's care group across the trust.

Data provided showed overall compliance of 94% with individual modules ranging from 87.7% (departmental fire safety awareness) to 97.7% (equality, diversity and inclusion).

Maternity multi-professional emergency training, included skills and drills training specific to maternity services, was provided as part of mandatory training. Data showed in October 2019, 94.7% of staff across maternity services at the trust had attended the training.

Safeguarding

Staff had training on how to recognise and report abuse, and there were processes in place to escalate concerns.

Staff were aware of the designated named midwife for safeguarding who was part of the corporate safeguarding team across the three hospital sites. This staff member was also the female genital mutilation lead for the trust.

Staff told us that they were unable to provide site specific training compliance, therefore these figures represent maternity staff across all three sites.

Safeguarding children's and adults training were delivered as part of the mandatory training. We observed compliance for the women and children's care group showed as of October 2019:

- Safeguarding Children and Adults (NHS Core Skills) - Level 1 (94.9%)
- Safeguarding Children and Young People (Core Skills - Level 2) E-learning (94.5%)
- Safeguarding Children (NHS Core Skills) - Level 3 (87.8%)
- Safeguarding (Level 3) Supervision (89.1%).

The safeguarding policy included child sexual exploitation.

Babies did not wear security tags. There was keypad access to maternity unit, with cameras in situ at points of entry and on the corridors. Access to the wards was via an

intercom. This was used for people entering and leaving the wards, minimising any unauthorised access. Access to the units was monitored by the ward administrative staff who worked from 9am to 5pm Monday to Friday and by maternity staff at other times. However, we observed instances of tailgating during our inspection, which we escalated to the trust. Tailgating refers to the habit of holding a door open for whoever is behind you.

The service had an infant and child abduction policy that documented that either table top exercises and/or practical testing should be performed every six months with the drills being included in the skills and drills programme for maternity services.

Following our inspection, we requested the date of the last baby abduction scenario at the hospital. We did not receive any evidence that the practical process staff should follow in the event of a baby abduction had been tested specifically within the maternity areas at the hospital.

Following our inspection, we also requested staff compliance in abduction training, but the trust did not provide this data and confirmed it was not delivered as part of the 'skills and drills' training for maternity services. We did, however, note that staff needing to familiarise themselves with the baby abduction policy was an agenda item in the October and November 2019 monthly governance meeting minutes.

Assessing and responding to risk

Staff completed and updated risk assessments for each woman and, where appropriate, all babies, and took action and removed or minimised risks. Staff identified and quickly acted upon women and babies at risk of deterioration.

Staff used nationally recognised tools to identify women and babies at risk of deterioration and escalated them appropriately.

Staff completed risk assessments for all women and babies at appropriate points in their care.

Shift changes and handovers included all necessary key information to keep women and babies safe.

There were two transitional care beds for babies over 34 weeks adjacent to the labour ward to ensure mother and baby to remained together. Neonatal nurses provided care to the neonates 24 hours a day, seven days a week, including the administration of IV antibiotics that were prescribed.

We were told of, and observed in a woman's maternity records, that one doctor had refused to carry out a pre and post-operative swab count. This had been escalated to the labour ward coordinator at the time. Following the inspection, we requested and received copies of the "World Health Organisation five steps to safer surgery" audits. However, whilst we received data that highlighted that in the period May 2019 to December 2019 inclusive 100% compliance had been achieved consistently, there were no data of audits of procedures carried out in the birthing rooms.

Midwifery and support staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

We reviewed data provided by the trust around midwifery staffing and sickness and found these to be well managed.

We were told that the head of midwifery utilised a nationally recognised midwifery staffing review tool to review skill mix and the number of births to ensure the right staff were in the right place.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The senior leadership team acknowledged that recruitment for permanent medical staff was difficult because of the location of the hospital. However, we were told that the service used locum staff to ensure safe care provision.

Good

Maternity

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patients' records were electronic apart from those completed in the delivery suite and theatre.

We reviewed seven records of women and babies and we observed risk assessments had been completed and there was a clear plan of care for each patient through their pregnancy and labour.

Incidents

The service managed safety incidents. Staff recognised incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

We reviewed the incidents that the department shared with us and they appeared to be appropriately investigated.

Some staff told us that managers debriefed and supported staff after any serious incident. However, others felt there was a lack of any support and debriefing following an incident.

One staff member told us they felt they were being investigated, as opposed to the incident itself and the support and debriefing was poor.

Incidents were managed within thewomen's and children's care group. We were told all incidents relating to maternity services were reviewed by the matron, labour ward coordinators and the risk manager and any concerns were escalated to the director of governance and head of health and safety.

We observed a staff handover. Findings and actions from investigated incidents were shared with staff at three-minute briefing sessions during staff handovers. Staff confirmed lessons learned were shared as part of the staff handover or via the three-minute brief (dedicated time at each handover to share with staff important messages) that was emailed to staff. Investigations and lessons learned following serious incidents were shared within staff areas.

Staff told us that they received a monthly lessons learnt email to keep them updated in the event that they had missed the aforementioned three-minute brief.

Staff we spoke with gave us examples of types of incidents they reported. There was evidence of changes; for example, following an incident a change included ongoing measuring and recording of blood loss.

We reviewed the 12 incidents provided to us by the trust. They were open and transparent and gave women and their families a full explanation when things went wrong. However, it was not always clear in the incident records, where an incident was graded as moderate or above, that appropriate duty of candour actions had been recorded. However, post inspection the trust provided assurance that this had been completed where required.

Staff spoken with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Following the inspection, we requested the minutes of the perinatal mortality review meetings. We received the minutes of the December 2019 quarterly audit meeting which appeared to be reviewing mortality cases. This meeting was well attended in person and also via videoconferencing with attendees such as midwives, student midwives, paediatricians, obstetricians and managers of differing grades. This meeting was also attended by a neonatal consultant from a different trust and two representatives from the neonatal network.

Are maternity services effective?

Good

We did not rate effective at this inspection as this inspection was a focused inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Good

Maternity

Staff had access to clinical educators to support learning and development.

Staff had the opportunity to discuss training needs with their line manager and were supported and given time to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women and their babies.

Managers gave all new staff a full induction tailored to their role before they started work.

Cardiotocography (CTG) training was included in the annual maternity mandatory training and data provided showed 89% of all maternity staff had completed the training. Cardiotocography is performed to record a fetal heartbeat and uterine contractions during pregnancy.

The service used 'fresh eyes' where another clinician would review the CTG trace at two hourly intervals.

Following our inspection, we requested appraisal rates for all maternity staff, including medical staff at this hospital. However, we were provided with overall data for the women and children's care group as the trust could not provide separate data.

Data showed the following staff had received an appraisal within the last 12 months

- 92 % Medical staff
- 100 % band eight and above
- 87% band one to seven.

The trust provided data for all staff within the women's and children's care group in relation to staff competency assessments against individual pieces of equipment they may be required to use in their roles. The data showed only 5,193 (35%) of 14,655 of assessments had been completed. However, the systems meant that the data was not aligned to job roles or hospital site. Following our inspection, the trust told us that it was aware of this issue and was putting in measures to address this. However, we have not seen any evidence to support this.

The trust told us that the figure for the number of assessments to be completed was high as activities on each staff members 'to do list' was based on where they worked rather than their job role. Also, if staff worked across the different sites, the equipment would be added for each site, which meant the same piece of equipment was logged several times. We were told staff were required to review the training needs analysis and mark any equipment that was not applicable. This did not assure us that the trust had robust oversight of staff competencies.

Are maternity services caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection.

Are maternity services responsive?

Good

We did not inspect responsive at this inspection as this inspection was a focused inspection.

Are maternity services well-led?

Good

We did not rate well-led at this inspection as this inspection was a focused inspection.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.However, the senior leadership team were based at another location and most staff we spoke to told us they were not visible.

The senior leadership team for maternity services consisted of a head of midwifery, interim deputy head of midwifery, clinical director and clinical lead. The head of midwifery, interim deputy head of midwifery based at another location. The clinical director and site lead were based at the hospital and worked clinically in this area.

The local leadership team consisted of a maternity ward manager, maternity matron and a clinical site lead on site at the hospital.

We were told that the head of midwifery and deputy head of midwifery both visited the maternity unit one day per week most weeks to discuss operational issues such as staffing and service improvements. However, whilst the specialist midwives that we spoke with saw these leaders when working across sites, most of the other maternity staff that we spoke with told us they rarely saw them. Some staff told us they had not seen them for months.

The trust had recently removed the senior midwife on-call for maternity, which was replaced with the trust wide manager on call who did not usually work in maternity. Staff told us they were concerned about this move. However, some staff told us that the maternity matron was contactable should they need her.

Most of the staff that we spoke with told us that the leadership up to and including the matron was good, but less so above that.

Culture

Not all staff felt respected, supported and valued. Whilst we found that staff were focused on the needs of women and babies receiving care, some staff raised concerns to us about the culture within the service.

Senior leaders in the department told us that they had introduced behavioural standards that the trust had introduced. Leaders told us they challenged staff to achieve the standards.

Staff satisfaction was mixed. Staff told us they did not always feel actively engaged or empowered. Staff did not always raise concerns, or their concerns were not always taken seriously. Some staff told us that they did not always feel listened to or valued.

Some staff told us there were high levels of stress which had led to sickness absence following allegations of bullying. Due to a lack of support from leaders several staff confirmed their intention to leave the service. We observed evidence of a meeting held on 7 October 2019 which was documented as being convened because the band five preceptorship midwives were feeling 'exhausted, burnt out and unsupported'. Post inspection the trust told us the care group understood the challenges created in the service and the stress it had caused some staff. Allegations of bullying had been escalated through the freedom to speak up guardian, anonymous concerns to CQC and CE. The trust told us initiatives had been put in place including occupational support and the option of temporary redeployment. All areas of concern were to be addressed.

Staff did not always work together. Staff told us there were concerns about behavioural issues in the antenatal clinic between midwifery, obstetric and paediatric staff. We were told that the team were working to resolve these issues and we saw that they were recorded on the risk register.

We were told that some paediatricians and obstetricians were fantastic and helpful. However, we were also told that the attitudes of other paediatricians and obstetricians were poor and that it could be challenging to get some of them to attend when requested.

Staff told us that most obstetricians would attend when requested to do so. However, several said that there were still issues with obstetricians of senior grades sleeping whilst on night duty and not attending when requested.

Some staff told us the culture did not always encourage openness and honesty at all levels within the organisation, in response to incidents. For example, an incident was reported to us by staff where a doctor attempted to infiltrate a woman's perineum (injecting pain relief, usually prior to an episiotomy) twice. However, it was not clear if this had been investigated as an incident and concerns from staff indicated that incidents were not always being reported.

Whilst some staff told us this was a good place to work, several others told us that they would not recommend the service as a good place to work.

Some staff confirmed they were aware of the trust Freedom to Speak Up Guardian.

A culture and engagement survey performed in April 2018 across maternity services showed areas where positive responses were below 45%. These included team work and burn out. We did not see evidence of any actions taken to address this at the time of our inspection.

Governance

Good

Maternity

Leaders did not consistently operate effective governance processes throughout the service. Not all staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance structure within maternity services and processes were in place to ensure there was escalation and the cascading of information to and from the senior management team to frontline staff.

Maternity services had dedicated safety champions who produced bi-monthly reports that were presented to the quality committee with plans to share these with the board.

The service facilitated monthly ward/departmental governance meetings where issues such as medical devices, the risk register, staffing and incidents were discussed. There were ten attendees at each of the three meetings that we reviewed. However, it was unclear who these attendees were or whether there was any obstetric attendance as this was not recorded on the attendance list.

We were not assured that the overarching trust governance processes were robust as there were discrepancies in information that was held locally with centrally held trust data (see information section for more detail). This included the system regarding staff competencies relating to equipment, which highlighted a 35% compliance rate with competencies that was inaccurate.

We were told information was escalated to the trust board by the executive chief nurse who attended board meetings. We observed reports prepared by the head of midwifery and clinical governance partner were presented at board by the executive chief nurse.

Some staff told us that they were not included in the labour ward meetings. Following the inspection, we requested the minutes of the last two labour ward meetings but did not receive these specifically. We did receive minutes from band five, band seven and governance meetings. Upon review of these meetings we observed that issues that would normally be discussed at a labour ward meeting were discussed across these.

Managing risks, issues and performance

The service did not manage risks, issues and performance well. Not all staff were aware of risks in their area of work.

Risk, issues and performance for maternity services were reported and managed within the women's and children's services care group and were discussed at key governance meetings.

Risks on the risk register each had a date identified, review date, responsible person, risk score actions taken to mitigate risk. However, it was not clear when the risk had last been reviewed. We observed on one risk (security) where we could not see evidence of actions or controls taken to mitigate the risk identified and the overall effectiveness of controls was recorded as mostly effective. We requested an update in relation to this risk and we were provided with evidence to show the risk had been reviewed in November 2019 and it was documented that the fire doors were going to be discussed with the fire officer and security. The risk had been added in March 2019 therefore we were not assured actions had been taken to address the risk in a timely manner.

Furthermore, in this care group 23.2% of mitigating actions against known risks were beyond their review date.

We observed there were three risks specifically recorded for maternity services with a current risk score; security (risk score 12), unable to record serum results in patient electronic record (risk score 16), and staffing (risk score 6). However, there were also risks recorded across all services; for example, risk of child abduction in the women and children's care group areas (risk score of five).

We saw this risk had been added in 2012; actions taken to mitigate the risk had been completed in 2017, including review of staff awareness and abduction training and undertaking of testing in high and low risk areas. The only open action (regular testing to be completed across all areas) was due for review in March 2020. We are therefore not assured that appropriate actions were being taken to mitigate this risk. However, following our inspection we were informed the action remained open to make sure the policy was regularly discussed with staff.

There was a process in place for an emergency call which involved clinicians passing through a series of doors with access codes. The care group leads told us they had carried out an initial drill when the keypad system had

been installed but had not reviewed the process since. However, at the time of inspection the direct route tested for the drill was blocked due to a ward closure and staff had to follow an alternative route. This was escalated during our inspection for investigation.

During our inspection there was an emergency call put out that most of the relevant staff attended in a timely way. However, we observed that four members of the emergency theatre team attended several minutes after all the other staff. When questioned the staff told us they had to travel from the other side of the hospital where their base was and enter one of three different codes into five different keypads to gain access though the hospital and into the maternity unit. We escalated our concerns to the senior leadership team at the time of the inspection. Following our inspection, the trust provided a thorough explanation of the incident. The emergency call out was responded to within three minutes, the theatre team set up theatre whilst the anaesthetist went to the patient's room.

We were told that the keypad codes were changed at the beginning of every month. We were told that there had been issues with the new code not being handed over by staff resulting in them not able to access all clinical areas. We escalated this to the trust who told us they would take immediate action to address this. Following our inspection, the trust informed us a standard operating procedure was now in place which detailed when the access codes were changed.

Following the inspection, we requested data relating to incidents submitted for keycode access issues. There were 14 incidents but only one directly related to a paediatrician having to telephone to get the correct code for access for the South Lakes Birth Centre.

We observed that it was documented in the December 2019 monthly governance meeting that risk "2354 – The new build at SLBC (South Lakes Birth Centre) has potential issues with security and the ability to respond to obstetric emergencies". However, on the risk register risk number 2354 related to a different risk. The risk register did contain a risk entry regarding access. Mitigations included unit managers providing relevant staff with the codes and incident reporting problems. We reviewed incident records post inspection and noted that staff had difficulty allowing us access to the building had not incident reported problems. Post inspection the trust told us to access the building, people could ring the buzzer and staff would open the door as no code was required to open the door remotely from the reception or staff station. We were not assured relevant staff would be able to access the maternity unit in a timely way in the event of an emergency if the access code was not known and there were no staff at reception or staff station.

The risk manager told us they reviewed outstanding actions on risks on a weekly basis and any issues were escalated to the Clinical Governance Assurance Group.

The risk manager gave us examples of trends and themes that had been identified as a result of incidents reported. However, not all senior staff that we spoke with were aware of these.

Serious incidents were reviewed at a monthly panel meeting with senior leaders within the service. Following our inspection, the trust told us all incidents relating to maternity services were reviewed by the ward manager or the labour ward co-ordinator. Incidents that needed further review were sent to the matron and obstetrician. The matron, deputy head of midwifery and head of midwifery had oversight of all maternity incidents. Following our inspection, the trust told us that all incidents submitted were reviewed by the local managers and senior team including the triumvirate daily. Themes and trends were scrutinised and escalated to the executive team. The care group governance team provided weekly reports and any incidents graded moderate or above were discussed at the weekly patient's safety summit which was chaired by the medical director or chief nurse.

In the last 12 months the service had been placed on divert and all new attendees were required to attend the trust's other consultant led maternity unit on 24 separate occasions for a total of 157.5 hours. This consultant led unit was 46.8 miles away, which was a car journey time of almost 70 minutes. We were told that there were no incidences whereby the other unit had been unable to take their admissions.

Managing information

The service collected data and analysed it. However, validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements.

Good

Maternity

The service had a maternity dashboard that we were told was used to plot against other comparable maternity services. We observed the dashboard was accessible to all staff on computers. However, we were told that this data was not always accurate, and the midwife who was the lead for digital had to add the correct data prior to sending. This meant staff did not always have access to accurate data as the dashboard was not a true reflection of current performance.

Following our inspection, we received a copy of the validated dashboard for October 2019. This included information such as the month's figures for bookings, live births, emergency caesarean sections and all other modes of births. However, there was no indication of whether such rates were improving or declining or whether they were achieving their targets. As such, we were not assured that they were effectively monitoring key safety information. In relation to training compliance, we noted that local service leads were managing compliance using different data than information that the trust's central governance team held.

Good

Services for children & young people

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

Are services for children & young people safe?

Good

We did not rate safe at this inspection as this inspection was a focused inspection.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust had a target of 95% compliance and above for annual mandatory training modules. Annual mandatory training for all staff included topics such as health and safety, basic life support, moving and handling, information governance, infection control level and fire safety. Mandatory training included early onset sepsis and neonatal sepsis training. Staff we spoke to were knowledgeable about sepsis and how to escalate concerns to medical staff.

Training was given as either e-learning or within a classroom setting. We were told staff received reminders when mandatory training was due and compliance with mandatory training was monitored by the matron and ward manager.

The mandatory training available met the safety needs of children, young people and staff.

During our inspection, we saw data regarding mandatory compliance for children and young people nursing staff at this location for basic life support (BLS) 100%, Neonatal basic life support (NBLS) 90.9% and fire training 75%. The overall mandatory core skills training compliance for nursing staff was 92.9%. The paediatric medical staff mandatory training compliance was 79.8%. We were told staff had not been able to achieve the trust target of 95% due to staffing shortages.

Post inspection the trust provided overall compliance for women and children's care group as 94%. We were told it was not possible to split the care group into maternity services and paediatrics due to the technical parameters of the training management system.

Mandatory training included early onset sepsis and neonatal sepsis training. Staff we spoke to were knowledgeable about sepsis and how to escalate concerns to medical staff.

We reviewed three nursing staff electronic training records and saw there was evidence of local workplace induction and planned training dates where training was needed.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding level three compliance for nursing staff was 100% and medical staff was 85.7% for the children and young people service.

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. We saw evidence of this during our inspection. The service reported safeguarding incidents for information sharing.

Good

Services for children & young people

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was safeguarding information accessible by staff on the trust's intranet. This included information on female genital mutilation (FGM), child sexual exploitation, lessons learned from reviews, domestic violence services, contact details for staff if they had any concerns, a referral pathway and guidelines.

Staff and managers told us safeguarding concerns were reported and monitored. Staff described positive and supportive working with the safeguarding team.

Staff followed safe procedures for children visiting the ward. The wards had security measures such as locked doors with swipe access controlled by staff with CCTV surveillance. Access to the wards was via an intercom. This was used for people entering and leaving the wards, minimising any unauthorised access. Access to the units was monitored during the week by the ward administrative staff. These staff were not available 24 hours a day at which time doors and CCTV were monitored by nursing staff.

At the time of our inspection there was no children's or adult safeguarding lead for Furness General Hospital and support was provided from Royal Lancaster Hospital safeguarding lead.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, the service care pathway for 16 and 17-year-old patients was unclear and had resulted in delays in patients obtaining treatment.

At the time of inspection, the service did not have a clear pathway for 16 and 17-year-old patients' delivery of care. Nursing staff we spoke with expressed concerns that they had experienced challenges in obtaining support from medical staff due to conflicts within the trust's policies as to who had responsibility for these patients. There had been patient safety incidents reported regarding this issue prior to our inspection. However, this issue had not been adequately addressed at the time of our inspection. We raised this concern during the inspection and the trust made immediate changes to policies and procedures so there was a clear patient pathway.

Staff used a nationally recognised tool to identify children and young people at risk of deterioration. Comprehensive risk assessments were carried out and managed in line with national guidance.

Band six nursing staff were trained in advanced paediatric life support (APLS). This meant there was always a planned APLS trained member of staff on duty to maintain patient safety and respond appropriately in an emergency.

Children and young people were admitted to the children's ward for surgical procedures.

Children and young people requiring transfer to intensive care were stabilised on the ward where there was one high dependency cubicle. A regional paediatric transport service was used to transfer the children to other hospitals with paediatric intensive care facilities. There were clear pathways in place to support these transfers.

We reviewed transfers from Furness General hospital to other locations. For special baby care unit there were 20 transfers and there were 10 transfers from the children's ward within the last 12 months for clinical reasons.

The service had a sepsis lead and clear sepsis pathway from urgent and emergency care.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, a shortage of directly employed nurses was being covered by the ward manager working clinically full time, the matron working as part of the team when needed, and by bank staff.

Staffing levels were planned in accordance with national guidance. Managers reviewed the number and grade of nurses and support staff for each shift. We saw there was always a planned minimum of two registered children's nurses in inpatient and outpatient areas.

At the time of inspection there were six nursing staff absences on the children's ward.. To assist with nurse staffing levels two additional posts had been approved for

advertisement at the time of our inspection. The ward manager was working clinically full-time to support the staffing needs. The ward matron worked clinically as required when the ward was busy.

During the year before the inspection, fill rates were consistently above a 94% fill rate in the children's ward. During the same time period, they were 83% (or above) compliant with British Association of Perinatal Medicine (BAPM) standards in the special care baby unit. There were two regular agency staff used on the special care baby unit which provided more consistency.

Nursing staff had been increased on the ward since our last inspection and staff told us they had no concerns regarding the number of nursing staff.

Each shift was planned to have a competent band six nurse for advanced paediatric life support (APLS). We reviewed the staffing rota and saw this was planned for December 2019. We saw there was one occasion for a Saturday late shift where this did not happen due to sickness on the day. We were told the medical staff had APLS training and provided cover for the ward as well.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to be compliant with national guidance. However, due to consultants working overtime and flexibility of other grades of medical staff, patients were kept safe from avoidable harm and there were sufficient staff to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

At the time of our inspection medical cover was provided by consultants, middle grades and junior grades. The consultant whole time equivalent establishment was ten. At the time of inspection there were six whole time equivalent consultants. Five consultants were permanent staff and one locum consultant.

To fill the consultant vacancies, consultants were working additional shifts and had been required to cancel outpatient appointments based on risk to ensure cover was provided on the paediatric ward. At the time of inspection there was a shortfall of 4.9 whole time equivalent paediatric consultants.

Medical staff told us there was a shortage of paediatric consultants and recruitment had not been successful to fill the vacant roles. In response to this an options appraisal had been performed. This had resulted in additional middle grade doctor posts which had been recruited. A new three tier rota system was due to start January 2020. At the time of our inspection senior leaders and staff told us different dates for the implementation of the new rota systems. They also described delays in the implementation of this rota. We escalated this at the time of our inspection and were assured that the rota would be implemented on 13 January 2020.

Senior leaders recognised the requirement for the service to be compliant with national standards and guidelines for medical staffing. However, at the time of the inspection the service was not compliant with the requirements of the Facing the Future Standards.

Staff told us there had been concerns with medical handovers and shift changes not starting on time. The concerns about the medical handovers included disrespectful behaviour, staff talking over each other and the time the handovers were taking. At inspection we discussed this with a senior manager who told us they were aware of this and action had been taken to begin to improve the handovers. Staff told us there had been improvement in medical handovers over the last few weeks.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and available to all staff providing care.

The service used electronic and paper records. Records were stored securely. Electronic records required individual password access and paper records were kept securely in locked trolleys.

The electronic patient administration system used a flag system to indicate if a child was subject to a child protection plan or had learning disabilities. Other flags on the system were used such as allergies.

We reviewed seven patient records and saw notes were in order and that the information needed to deliver safe care and treatment was available to relevant staff and accessible.

Good

Services for children & young people

Nursing care plans were present for core care areas and we saw evidence these were reviewed each shift.

Where children and young people had surgery, we saw the appropriate documentation such as anaesthetic, consent and observations forms were completed and stored in the patient records.

Incidents

The service did not manage patient safety incidents well. Staff recognised but did not always report incidents and near misses. Managers investigated incidents and shared some lessons learned with the whole team and the wider service. When things went wrong, it was not always clear that the appropriate duty of candour actions had been completed within the recommended timescales.

Incidents were reported on the trust electronic system. Staff we spoke to knew how and when to report incidents. All incidents were reviewed initially by the ward manager and matron and escalated if needed.

We found there was a reduction in the number of incidents reported for quarter three in 2019/2020. Following our inspection, the trust told us this was a natural fluctuation. We also noted that the number of incidents closed within target for this period reduced to 75%.

Staff spoken with understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation when things went wrong. It was not always clear in the 27 incident records viewed, where an incident was graded as moderate or above, that the appropriate duty of candour letter in some cases had been sent within the recommended timescale.

From December 2018 to December 2019 across the women and children's care group there were 27 incidents where it was identified that duty of candour was applicable. This was completed within ten working days in 23 incidents, completed outside the ten working days in two incidents and not completed in two incidents. We addressed this with the trust and are aware that they have acted to start to address this.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

We reviewed 12 incidents from the women's and children directorate and saw the records relating to the incidents included incident notification reports and rapid reviews where were in line with the trust incident reporting policy.

We requested a 72-hour review for a recent incident of concern, however this had not been completed at the time of the inspection. We requested a copy of the 72 hour review post inspection and this has not been received.

Are services for children & young people effective?

Good

We did not rate effective at this inspection as this inspection was a focused inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure staff received specialist training for their role. Nursing staff were supernumerary for a minimum of two months whilst completing induction training. The training period could be extended if needed. Staff had access to clinical educators to support learning and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children and young people. Staff had the opportunity to discuss training needs with their line manager and were supported and given time to develop their skills and knowledge. For example, staff told us about the paediatric and neonate development away day (PANDA) they had been able to attend.

Managers gave all new staff a full induction tailored to their role before they started work. There was a trust wide induction and local induction. These were recorded on the electronic training system.

Good

Services for children & young people

We were told the overall appraisal rate within the last 12 months for women's and children directorate was 86.8% which included staff for children and young people services. The appraisal data for children and young people was: paediatric medical staff 100%; paediatric outpatient staff 100%; children and young people senior nurses 100%; Furness General Hospital children and young people staff 96.7%; children and young people diabetes staff 83.3%; and, special care baby unit nursing staff 75%.

Managers identified poor staff performance and supported staff to improve. We saw evidence of this on inspection for medical and nursing staff conduct.

Are services for children & young people caring?

Good

We did not inspect caring at this inspection as this inspection was a focused inspection.

Are services for children & young people responsive?

Good

We did not inspect responsive at this inspection as this inspection was a focused inspection.

Are services for children & young people well-led?

Good

We did not rate well-led at this inspection as this inspection was a focused inspection.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, the senior leadership team were based at another location in the trust and as such they were not visible to most of the staff that we spoke with.

The children's and young people service leaders were led by a consultant paediatrician and matron. Staff told us they were visible and approachable. The service sat within the women's and children's care group which was led by a clinical director, associate director of operations and an associate director of nursing for children and young people. Staff told us they had not seen senior leaders at the hospital and were unaware if they had visited.

The leaders were aware of the challenges to the quality of the service, but action to address them had not taken place in a timely manner. The actions to address the culture within the children's and young people staff group had not been sustained since our last inspection.

The sustainability of the service had been considered by the trust due to the consultant staffing vacancies. Plans were in place to make improvements to the medical staffing rota.

The priorities of the service had been focused on ensuring there was adequate nursing and medical staffing.

Culture

There had been a deterioration in culture since our last inspection. Staff morale was low and there were strained relationships between clinicians and nursing staff. Staff raised concerns to us about the culture. Most staff were focused on the needs of patients receiving care.

Staff told us the culture had not supported openness and honesty at all levels within the organisation. Medical staff told us they were not confident in raising incidents for fear of repercussions.

At the time of the inspection we noted that the guardian of safe working and freedom to speak up executive lead was the trust medical director. Arrangements were in place for the chief executive to meet with the freedom to speak up guardian on a quarterly basis. The trust freedom to speak up presentation to the board highlighted 127 concerns raised 2018-2019 across the trust. Of these concerns 95 linked to unacceptable behaviour. From 1 April 2019 to 23

December 2019, 104 concerns had been raised across the trust. Two concerns related to behaviour of paediatric medical staff and were escalated to the deputy medical director.

Staff we spoke with were concerned about working relationships between clinicians affecting patient care. We were told some patient care plans had been changed by consultants following another consultant review without a clinical indication. Nursing staff told us that they were expected to explain the change to the patient and their parents. The reason for change in care plans was unclear and nursing staff told us it was difficult to explain the change. Nursing staff had raised these concerns to senior staff. We discussed these concerns with board level staff during our inspection. Following the inspection, the trust told us that they had introduced an audit programme to identify whether children's care plans were changed without clinical need. The medical director was leading this piece of work.

Staff told us there were disagreements between medical and nursing staff in front of patients and their families. This had been between consultants, from consultants to junior medical staff and from consultants to nursing staff. There had been six complaints within the last 12 months for paediatrics and neonatology of which two related to the attitude of doctors.

Staff told us they witnessed bullying and harassment of other staff and raised concerns with senior staff. Medical staff told us they did not feel supported or had not had enough supervision depending on which paediatric consultant was working on the ward or on call. We escalated this to the trust and requested assurance that nursing and medical staff would be supported and supervised going forward.

Post inspection we requested a copy of the junior doctors' survey and evidence of action to address the findings. We reviewed the junior doctors survey for 2016, 2017 and 2018. The results from 2018 highlighted improvement work was needed for overall satisfaction, clinical supervision, reporting systems, supportive environment, adequate experience, curriculum coverage, educational governance and rota design. The trust had an action plan from September 2019 to support all staff with break times, taking annual leave, 'are you ok' campaign, effective and inclusive handovers and raising awareness of stress risk assessments.

We were told that four weeks prior to our inspection the trust's medical director had met with staff in paediatrics to talk about the cultural issues. Whilst staff noted that there were some improvements since the meeting, at the time of our inspection concerns were still expressed around ongoing cultural issues with medical and nursing staff. Senior staff told us about some actions that were in the process of being taken to address the behaviour and performance that was not consistent with the trust's behaviour standards framework. However, the pace to address this behaviour was slow.

The care group leads told us culture had been part of the organisational development work from February 2017. They had not seen any culture concerns from incident reporting and behaviour had been put onto the trust wide risk register in the last few months with no apparent themes. There were inconsistencies in the patient experience as a result of differing practices of the medical staff. For example, we were told some clinicians had not seen patients if they were late for an appointment and a new appointment had to be made. The location of the hospital was difficult for patients to get to from some geographical areas and other clinicians understood this and would be flexible and see patients when possible.

Governance

The governance processes and procedures for the care group had not identified the further deterioration in culture for the children and young people's service, or taken effective action to improve it. However, staff at all levels were clear about their roles and accountabilities but there were not regular opportunities to meet, discuss and learn from the performance of the service.

The children and young people's service sat within the women's and children care group directorate within the trust. There was a governance structure in place to ensure information was escalated and cascaded between the frontline staff and senior management team.

Whilst the trust governance processes and procedures for the division has identified the deterioration in culture within the children and young people's services, action to address this was not at a sufficient pace. Staff told us that culture had deteriorated significantly over the summer months.

Good

Services for children & young people

The ward manager in the children's and young people's service was working clinically100% of their time and the matron was working clinically as required whilst they were waiting for the additional nursing staff to be recruited. This did not allow any time for their administrative governance tasks which included incident investigation review and mitigating actions for the risk register. This had been escalated to the care group leads. Two additional nursing posts had been approved, but at the time of our inspection they were not out to advert.

The women's and children's service had ward meetings planned for the year, however; some had needed to be cancelled. The children's outpatient area had the most missed meetings due to capacity.

We were concerned regarding the pace to address issues within the service. On inspection we found there were 38 policies out of 140 outside of their review date.

Post inspection we reviewed the women's and children's care group performance report. The report stated there had been a big improvement in the outstanding actions and there were no long-term outstanding actions. However, we noted 23.5% of actions were beyond their review date.

We reviewed 12 patient group directions. Four were due for review November 2019 and six were due for review December 2019. We were told these had been reviewed but were waiting for pharmacy to sign them off.

Care group governance meetings were held monthly. Discussions included incidents, audits, complaints and risks. Care group performance reports were presented to the trust board. The reports were an overview for the care group and the information was collated from the maternity and children's service performance report. Post inspection the trust told us each performance report was discussed at length and areas of concern or good practice were shared by service.

At inspection we established that within the trust the mortality leads were no longer in post. The medical director was covering these roles and was reviewing approximately 35% of deaths trust wide. We also noted that different mortality review processes were being undertaken in the trust's two main hospitals.

The Quality Committee minutes from October 2019 noted the levels of mortality reviews that had taken place at Furness General Hospital were unacceptable. We reviewed the morbidity and mortality meeting minutes from March, June and September 2019 and saw the minutes did not consistently show who had attended. It is important to identify who attends the meetings to show the appropriate people are in attendance.

A rota had been developed to have weekly review meetings which started in November 2019. However, board members confirmed the new morbidity and mortality process would be in place from May 2020 when new mortality leads would be in post.

The service had a governance newsletter to keep staff informed about governance issues.

Managing risks, issues and performance

Leaders and teams used systems to manage performance. The systems did not always evidence actions or controls taken to mitigate risks. Some risks had not been actioned in a timely manner.

The service had systems in place to identify learning from incidents, complaints and safeguarding alerts to make improvements. The care group team reviewed the systems in meetings with the local leaders. We reviewed these systems during our inspection and requested further information following the inspection. This information identified some risks had been on the risk register since 2014.

Risk management systems were in place to identify issues and manage risks but were not effective. The service had a risk register. We reviewed the risk register performance data as of November 2019. We saw 23.2% of mitigating actions were beyond their target completion date, 11.1% of risks required action and input from a commissioner for effective mitigation and 91.7% of risks had a mitigating action plan in place.

For example, the child and adolescent mental health services had been on the risk register from August 2014 and was linked to the corporate risk provision and access of mental health services. The open action to discuss and agree a single pathway had a target date of July 2020.

The care group leads told us that the risk they were most concerned about was staffing. Actions in place to mitigate the risk with the use of agency and bank staff with staff working overtime to cover the staffing shortages were not sustainable for the long term. A new medical on call rota

was due to start in January 2020. We were told the staffing shortages risk had been ongoing for several years. The paediatric consultant recruitment risk had been on the risk register since 2015. However, action to fully address this risk had been slow and a decision was made in July 2019 to change the rota .

There was a general risk added to the risk register May 2019 for staff members not submitting patient safety incidents due to fear of repercussions and peer pressure. We requested evidence of the action taken to mitigate and address this risk post inspection. Post inspection we saw evidence some action had been taken, but this had not been effective as some staff told us they were not confident to report incidents because they were still scared of the repercussions..

Assurance systems and performance for wards were monitored using an audit system overseen by the matron. This looked at patient safety documentation checks, for example, handover, medicines management and safe environment. Any issues or concerns were escalated to the care group leads. We reviewed the children and young people's service audit from November 2019 report and saw the children's ward, children's outpatient area and special care baby unit overall status was compliant (green) at Furness General Hospital.

Managing information

The service collected data and analysed it. Validated data was not easily accessible to all staff to allow them to understand performance, make decisions and improvements.

The care group leads were responsible for cascading information up to the senior management team.

Performance measures for the service were reported using key performance indicators and other metrics. This was reported as the women's and children service dashboard each month. The report included financial information, staff training, staff appraisals, risk register performance and a quarterly review of outstanding actions. Post inspection we received copies of the CYP and therapies clinical business unit performance report for November and December 2019. We were told this monthly report was presented to the care group management board by the service manager, matron and clinical lead.

During the inspection we questioned the number of patient safety incidents reported to the national reporting and learning system (NRLS) for the women and children's care group. Post inspection we asked for further information about the trust internal decision making and reporting process. The trust clarified that all patient's safety incidents were reported to NRLS in line with requirements. However, where incidents were not required to be reported to NRLS, they were not.

The service was in the process of moving neonatal patient records to the electronic format to be in line with the rest of the care group.

Staff told us they had access to all necessary information and had access to IT equipment and systems needed to do their work.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that there is a clear pathway for 16 and 17 year old patients that all staff are aware of. (Regulation 12)
- The trust must ensure all risks are assessed, monitored and actions taken to mitigate them are effective and timely. (Regulation 17)
- The trust must ensure that systems to collect and analyse data are effective. Such as the maternity dashboard accurately reflects current data or performance . That validated data is easily accessible to staff to allow them to understand performance, make decisions and improvements. (Regulation 17)
- The trust must ensure that there are sufficient numbers of suitably qualified medical staff on the rota. (Regulation 18)
- The trust must ensure that it has appropriate arrangements in place to assure itself around staff competencies regarding equipment. (Regulation 18)

Action the provider SHOULD take to improve

- The service should ensure that incident records clearly evidence duty of candour has been completed. (Regulation 20)
- The trust should ensure leads for mortality and safeguarding are in place within the service. (Regulation 17)
- The trust should ensure that all appropriate incidents go to the serious incidents requiring investigation (SIRI) panel. (Regulation 12)
- The trust should ensure morbidity and mortality processes are consistent across both sites. (Regulation 17)
- The trust should ensure that medical and nursing staff receive appropriate supervision and support. (Regulation 18)
- The service should ensure staff have access to child abduction and awareness training. (Regulation 18)
- The trust should consider increasing the visibility of senior leaders across maternity and the children and young people's service areas.
- The trust should take timely action to improve culture within the service and continue to monitor and sustain improvement.
- The trust should consider auditing in line with the WHO maternity safety checklist procedures carried out in birthing rooms.
- The service should continue to audit care plans to ensure they are not changed unless there is a clinical reason.
- The trust should consider ensuring data to monitor training compliance can be viewed at service level.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Providers must assess, monitor and mitigate the risks relating the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Providers must ensure that systems to collect and analyse data are effective.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Providers must provide care and treatment in a safe way.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure they can meet people's care and treatment needs.