North Cumbria University Hospitals NHS Trust

West Cumberland Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Surgery	
Services for children and young people	

Summary of findings

Letter from the Chief Inspector of Hospitals

North Cumbria University Hospitals NHS Trust provides acute hospital services in North Cumbria and services are based at the Cumberland Infirmary in Carlisle (CIC) and the West Cumberland Hospital (WCH) in Whitehaven and a birthing centre at Penrith Community Hospital. During this inspection we visited Cumberland Infirmary and West Cumberland Hospital.

This was a focussed unannounced inspection to review the safe and well-led domains within surgery and children and young people services across the trust. In surgery we carried out this inspection as a consequence of a series of 'never events' between June 2015 and February 2016. These had raised concerns about the lack of compliance in surgery with the completion of safety checks and procedures within theatres, particularly non-compliance with the 'Five Steps to Patient Safety', World Health Organisation Surgical Safety Checklist. We also reviewed progress in the implementation of the division's Perioperative Quality Improvement Plan which had been developed in response to these never events.

Within children and young people services (CYP), a shortage in medical staffing, particularly at consultant level, was highlighted at our previous inspection in 2015. During this inspection we reviewed medical and nursing staffing in line with the trust's workforce strategy as well as escalation and contingency plans in these areas. The service was under review with a number of models being considered and evaluated in order to better meet the needs of the CYP population. This formed part of the Success Regime agenda within North Cumbria (a national initiative designed to support local improvement programmes by bringing together wider healthcare economy partners).

Surgery key findings:

- At the time of inspection the Perioperative Quality Improvement Plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes from the plan.
- During interviews with staff, they told us that the division had strong leadership and most senior managers were highly visible and 'hands on'.
- Although staff acknowledged that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans, some staff said they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages.
- The ward cared for high numbers of medical 'outliers' with high acuity and different needs to surgical patients. This supported the view expressed by staff that they were working under pressure within the division.

Children and young people key findings:

- The wards planned staffing in accordance with recognised standards and were compliant with BAPM and RCN recommendations. There were escalation plans to address shortfalls or changing acuity.
- Medical staffing was heavily supported by locum appointments in senior positions however many of these posts were filled by unit known clinicians on extended contracts. Unit managers recognised the vulnerability of the situation and were taking steps to recruit to vacancies to reduce temporary engagements and stabilise turnover. The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). The standards covered areas such as consultant presence, time to consultant review and consultant led handovers.
- There was a clear strategy for the remodelling of the services provided by the Child Health Clinical Business Unit. Unit management had worked up a number of proposals which were now encompassed within the wider Success Regime looking at the improvement and sustainability of various provisions across the region. Staff confirmed their awareness of the proposals however were concerned about the implications for the service at WCH. Managers needed to ensure staff were kept up-to-date with Success Regime progression.

Summary of findings

- The unit had maintained a comprehensive governance and assurance structure to monitor and mitigate risk. The unit leadership team was visible and there was a real strength and 'team' culture with staff at ward level. Staff were proud to work for the trust and were passionate about delivering good care. Staff were supported locally and felt engaged with unit leaders.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).

In addition the trust should:

In surgical services:

- Ensure there are no inconsistencies with adhering to trust policy in signing for controlled drugs.
- Ensure robust recruitment and retention policies are adopted to cover staff and skill shortages identified on the divisional risk register.
- Identify appropriate mechanisms for supporting the wellbeing of staff during periods of additional pressures.

In children and young people services:

- Ensure staff provide an initial assessment and classification of harm for all submitted incidents in accordance with policy and national standards.
- Continue to monitor on-going medical staffing requirements to ensure safety and sustainability of service.
- Ensure all staff are kept up-to-date with Success Regime progression to reduce anxiety and uncertainty.
- Consider the designation of a clinical lead to reinforce the quality of the unit audit activity.

Professor Sir Mike Richards
Chief Inspector of Hospitals

West Cumberland Hospital

Detailed findings

Services we looked at
Surgery; Services for children and young people

Detailed findings

Contents

Our inspection team

The team included CQC inspectors and a variety of specialists including: a paediatrician, a paediatric nurse and a surgical nurse.

How we carried out this inspection

This was a focussed unannounced inspection to review the safe and well-led domains within surgery and children and young people services within North Cumbria University Hospitals NHS Trust. In surgery we carried out this inspection as a consequence of a series of 'never events' between June 2015 and February 2016. These had raised concerns about the lack of compliance in surgery with the completion of safety checks and procedures within theatres, particularly non-compliance with the 'Five Steps to Patient Safety', World Health Organisation Surgical Safety Checklist. We also reviewed progress in the implementation of the division's Perioperative Quality Improvement Plan which had been developed in response to these never events. As a consequence this inspection reviewed the safe and well-led domains within the surgical division.

Within children and young people services (CYP), a shortage in medical staffing, particularly at consultant level, was highlighted at our previous inspection in 2015. During this inspection we reviewed medical and nursing staffing in line with the trust's workforce strategy as well as escalation and contingency plans in these areas. The service was under review with a number of models being considered and evaluated in order to better meet the needs of the CYP population.

We asked the trust to provide information, which we analysed during and after the inspection. We spoke with nursing staff, medical staff and senior managers in surgical and children and young people services, as well as the executive team. We spoke with people who used the service.

Surgery

Safe	
Well-led	
Overall	

Information about the service

Surgical services provided at the West Cumberland Hospital included low risk breast, colorectal, ophthalmic, orthopaedic, urological, vascular, vascular and general surgery. Services had been moved back to the hospital following assessment by the divisional management team of staff levels, availability of appropriately trained staff, facilities and safety. The management team had detailed specific strategies that involved investment in theatres and anaesthetics at the hospital supporting the repatriation of urology, ENT and orthopaedic elective procedures.

In the last comprehensive inspection of the trust (2015) we rated surgical services as good. On this occasion we carried out a focussed and unannounced inspection as a consequence of a series of 'never events' between June 2015 and February 2016. These had raised concerns about the lack of compliance in surgery with the completion of safety checks and procedures within theatres, particularly non-compliance with the 'Five Steps to Patient Safety', World Health Organisation Surgical Safety Checklist.

We also reviewed progress in the implementation of the division's Perioperative Quality Improvement Plan which had been developed in response to these never events. As a consequence this inspection reviewed the safe and well-led domains within the surgical division.

During this inspection we visited the surgical Ward 1, Surgical Assessment Unit, Day Surgery Unit and we observed care being given and surgical procedures being undertaken in theatres.

We spoke with eight patients and relatives and five members of staff. We observed care and treatment and looked at 6 care records.

Summary of findings

This unannounced inspection focussed on the safe and well-led domains only.

Overall, surgery at WCH was safe :

The trust had good systems and processes in place to protect patients and maintain safety. Staff understood the process for reporting and investigating incidents.

The difficulties in the recruitment and retention of appropriate numbers and skills of staff had clearly been identified and responded to by the trust and the divisional management team. There were nurse vacancies at this hospital but staffing issues were being managed at a local level.

However, issues with medical cover had been identified (consultant paediatrician cover, the lack of a dedicated critical care resident on site, clinical capacity and the reliance on locum cover in ophthalmology). These were identified on the divisional risk register and were being addressed at the time of inspection.

Overall, surgery was being well-led:

Clear governance processes were in place across the division and the senior management team had identified the issues and challenges affecting performance within the division and responded to those challenges. This had led to the development of the Perioperative Quality Improvement Plan which was in the process of implementation during our inspection.

Surgery

Are surgery services safe?

We found surgery safe because:

- There were no never events reported within surgery at West Cumberland Hospital in the six months before inspection (March to August 2016). Previous never events had been fully investigated and changes to practice made where appropriate.
- The division held regular Emergency Surgery and Elective Care Business Unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- The surgical ward participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor and analyse patient 'harm free' care.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager.
- We looked at medical records on the ward and saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating the named nurse and clinician.
- A 'red flag' and Safer Staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron. Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.

However:

- During individual and group interviews some staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages.
- Although most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts.
- We reviewed staff rotas for the month before inspection and saw some shifts not staffed to establishment across most surgical wards at West Cumberland Hospital.
- The ward cared for large numbers of 'outlier' medical patients at times. Staff told us these patients had different needs to surgical patients and increased their workload.
- The Emergency Surgical and Elective Care Business Unit risk register (September 2016) identified issues with staffing across the trust. For example, consultant paediatrician cover provided from Cumberland Infirmary to West Cumberland Hospital, the lack of a dedicated critical care resident on site, clinical capacity and the reliance on locum cover in ophthalmology.

Incidents

- There were no never events reported within surgery in the six months before inspection (March to August 2016).
- There had been six never events between June 2015 and February 2016, one at West Cumberland Hospital. These had been subject to an early management report and had been fully investigated, root cause analyses undertaken and changes to practice made where appropriate.
- The trust had commissioned an external review of never events by the Royal College of Surgeons and been visited by the Clinical Commissioning Group. Learning from previous never events and changes to practice were clearly displayed within surgical areas at West Cumberland Hospital.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The division held regular Emergency Surgery and Elective Care Business Unit meetings where serious incidents were discussed, investigations analysed and changes to practice identified.
- Staff told us how they reported incidents through the electronic system and most said learning was shared through meetings, communication books and team briefings. However, some staff said they received no feedback on reported incidents.

- Matrons had an overview of every incident, complaint and concern and operated a system of response and feedback to patients and staff.
- The trust held regular mortality and morbidity case review meetings within all specialities to discuss case descriptions and summaries, classification, outcome and key lessons.
- These were attended by multi-disciplinary teams and lessons learnt were identified and used to inform service development through: audit (for example,implant compliance, Warfarin reversal protocol, wrong site surgery), safety huddles, ward meetings, newsletters and on a one to one basis as necessary.
- Duty of candour requirements were explicitly stated within trust policies, the trust intranet, training and trust incident policies.

Safety thermometer

- The surgical ward participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information. This tool was used to measure, monitor and analyse patient 'harm free' care.
- Trust information identified that 87% of patients received harm free care whilst receiving treatment throughout the surgical division. A total of 30 pressure ulcers, 17 falls and four catheter acquired urinary tract infections were reported from June 2015 to June 2016.
- This information was displayed in the entrance to the ward and was easy to understand; staff had knowledge of the displayed information and ward performance.
- Information for the month before inspection (August 2016) showed there were no incidences of hospital acquired pressure ulcers, no incidences of patient falls, two incidences of urine infections associated with catheter insertion and no incidences of blood clots in those patients assessed as being at risk.
- Audits showed 97% of patients received an assessment of venous thromboembolism (VTE) and bleeding risk using the clinical risk assessment criteria described in the national tool. We saw patients were re-assessed within 24 hours of admission.
- Patient safety was monitored through the completion of moving and handling assessments; falls risk assessments, the national early warning score (NEWS) and malnutrition (MUST) assessments and by following infection, prevention and control measures.

Cleanliness, infection control and hygiene

- The trust had an infection surveillance programme and an infection control matron in place. An annual infection and prevention and control report was presented to the board and there were monthly reports to the Safety and Quality Committee.
- The trust had policies in place, amongst others, to cover aseptic techniques, patient transfers, hand hygiene, outbreaks, norovirus and Methicillin resistant Staphylococcus Aureus (MRSA). These were available as paper copies and on the Trust intranet.
- The trust reported no incidences of MRSA between April 2015 and March 2016. Two cases of C. Difficile were reported between April and June 2016, which met trust targets.
- The trust carried out monthly audits of hand hygiene compliance, commode, cannulas, urinary catheters, personal protective equipment, ventilated patients, ultra violet spray and glow cleanliness.
- We saw that the standard of environmental cleanliness was good across the ward and surgical areas inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- The ward had daily, weekly and monthly cleaning schedules for domestic staff, housekeepers and nursing staff. Cleaning and environmental audits were completed on a monthly basis and these showed results between 94% over the last twelve months.
- A Healthcare Associated Infection Delivery Plan had been developed across the division to ensure compliance with, for example, urinary catheter insertion techniques, hand hygiene, surgical scrub uniform policy, SSI national standards, cleaning standards and learning from SSI root cause analyses.
- Surgical Site Infection (SSI) Group meetings were held to reduce the incidence of infections through for example, temperature monitoring, patient education, inter-operative practices, treatment rooms, pre-admission screening, SSI rates and day zero practice.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to the ward and all surgical areas. These showed 100% compliance with clean commodes, hand hygiene, cannula and catheter audits.

- We observed staff washing their hands and all patients we spoke with told us that this was done, hand gel was available throughout the hospital, at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- Trust environmental cleanliness audits (20 July 2016) showed divisional compliance with hand hygiene techniques varied between 89% and 94% (below trust standard).
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules. Wards had appropriately equipped treatment rooms, used for aseptic technique and dressing changes.
- Clinical and domestic waste disposal and signage was good, and staff observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed Trust policy.

Environment and equipment

- The ward and surgical areas were uncluttered and in excellent state of repair. The ward had a spacious design, large floor plan and storeroom capacity was available.
- We inspected resuscitation trolleys and suction equipment on the ward and found all appropriately tested, clean, stocked and checked weekly as determined by policy.
- Managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips and falls. Risk assessments included: types of hazard and likelihood of occurrence, quality and condition of flooring, maintenance and cleaning procedures.
- The arrangements for managing domestic and clinical waste kept people safe. All staff were aware of the clinical and domestic waste disposal procedures, the use of specific bags and special ties to seal clinical waste.
- Specific rooms and equipment had been designed for the use of bariatric patients to ensure safety for both staff and patients. Requests were made to the moving and handling team when further equipment was required.

Medicines

- On the ward and surgical areas, medicines were stored, prescribed and administered in line with trust policy and procedures. We saw the trust had introduced an electronic dispensing system which staff had been trained to use.
- However, there were inconsistencies with adhering to trust policy in signing for controlled drugs. We found records where a second check had not been done; this was not the same procedure as Cumberland Infirmary. We reported this to the trust and action was taken to ensure a common process across the trust.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Pharmacists liaised with and supported the ward team regularly to ensure adherence to trust policy.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs and newly qualified staff were required to attend training and complete the e-learning safe medications training.
- Temperature checks were recorded for the safe storage of medication in refrigerated units on a daily basis.

Records

- We looked at six sets of medical records across wards at West Cumberland Hospital. We saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating the named nurse and clinician.
- Daily entries of care and treatment plans were clearly documented and care plans and charts reviewed had completed patient assessment, observation charts and evaluations, food and fluid balance sheets, consent forms with mental capacity assessments where necessary, and diabetes and wound care charts as applicable.
- Records included a pain score and allergies were documented.
- We reviewed handover sheets used by ward staff and the escalation documentation which was effective in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in those patient notes seen.

Surgery

Safeguarding

- The Trust had a clear safeguarding strategy and safeguarding board meetings. Minutes and action plans were clear and these meetings were well attended by senior staff from across the Trust. Learning from serious case reviews was monitored and safeguarding showed good attendance and compliance of staff at safeguarding training.
- Safeguarding training plans and schedules were displayed in the ward office and held centrally by the training department.
- Trust data (August 2016) showed 57% of staff had attended adult basic life support, 73% infection, prevention and control training, and 70% safeguarding adults - level one and 73% safeguarding adults - level two.
- On wards, staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.

Mandatory training

- The surgical division had an action plan in place to achieve compliance with mandatory training targets by April 2017 and attendance at mandatory training programmes for all staff was monitored locally and also by the Learning & Development Department. At the time of inspection the overall training rate within surgery was 34%.
- Training audits showed 55% of staff had completed an annual appraisal (consultants 95%, trust doctors 91%, surgery staff 51%), higher than the trust average. Trust wide audits showed 100% of staff attended the trust induction, 94% completed equality and diversity training and 90% of staff had completed moving and handling training.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks and key trainer delivered sessions. Staff said they were supported with professional development through education.
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- Clinical educators were in post and supported staff with all training, their continued professional development and professional revalidation.
- Additionally, the division had commissioned a programme of 'Human Factors' awareness training designed to increase awareness of the individual's role and impact in procedures. The programme was part completed at the time of inspection.

Assessing and responding to patient risk

- The trust used an early warning score risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient in surgery was embedded. Staff recorded observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- We saw full completion of early warning score risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- Comprehensive risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patient nutritional needs. Pain scores and diaries for patients were available.
- Trust audits showed compliance with pressure area care documentation (100%), slips, trips and falls documentation (100%), MRSA screening (96%), and NEWS documentation (100%).
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- A trust audit (May 2016) measured compliance with the 'Five Steps to Patient Safety' procedure. This showed 100% compliance with undertaking the team brief before surgery.
- The audit also showed 96% sign-in by the surgeon prior to anaesthesia at West Cumberland Hospital. Regional block side checks were documented in 81% of procedures audited at West Cumberland Hospital.
- Time out was taken for all patients at the hospital with all members of the team listening and stopping and 100% responding as required at West Cumberland Hospital.

- Debrief was not always undertaken at the hospital (19% at West Cumberland Hospital). However, when debrief was undertaken all staff were present. The audit recommended further work on encouraging the team debrief through business unit governance meetings and dissemination of learning by governance leads.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in those patient notes seen.
- Daily audits of the 'Swab, Needle and Instrument record' had been undertaken. The latest figures provided by the trust (16 August to 26 August 2016) showed 95% compliance.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours 24 hours per day, seven days per week by a team of senior nurses with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances.
- Trust information (July 2016) showed actual staffing levels were less than planned staffing levels on some shifts but appropriate as surgical activity and patient acuity had been assessed.
- Staffing levels for qualified nursing staff varied from 85% and 100% during the day and between 75% and 102% at night. Figures provided showed non-qualified staff was 98% to 99% during the day and was 100% at night.
- Matrons told us shortfalls in nursing cover were managed day to day through regular senior nurse team meetings and cross-site conference calls as a business unit working together to meet demands in ward activity.
- Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis.
- The trust had established a staff 'bank', which provided cover for short notice requests, agency staff were not used. Trust data (September 2016) showed May 2015had high bank usage, for example 206 hours were filled by bank staff in the three months to August 2016 on Ward 1.
- Trust data (September 2016) showed there were 19 qualified and 0.8 healthcare assistant whole time equivalent vacancies across the division.
- To address this, the division had developed recruitment plans, sickness monitoring was reported quarterly to the Safety and Quality Board and used bank staff and overtime. Additionally daily board rounds were undertaken to prioritise care, monitor rotas and inform patients and family of actions taken.
- A 'red flag' and Safer Staffing system had been introduced to identify when lower than optimal staff numbers may impact upon patient care and to initiate mitigation. Escalation processes were in place through the matron, service manager and chief matron.
- We were told that critical care for patients was provided within recovery on occasions while waiting for critical care beds to become available. When this was necessary recovery staff were supported by anaesthetic and intensive care medical staff.
- During individual and group interviews staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages leading to staff feeling exhausted and potential harm to patients.
- However, we did not find increases in the incidences of falls, pressure ulcers or urinary tract infections.
- Although most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts.
- We reviewed staff rotas for the month before inspection and saw some shifts not staffed to establishment. There were processes in place to 'flex' staff from other wards when possible to ensure safe care.
- For example, the ward had been unable to fully cover four night shifts with qualified staff and also four night shifts with non-qualified staff during August 2016.
- The ward cared for numbers of 'outlier' medical patients. Staff told us these patients had different needs to surgical patients and increased their workload.
- For example, we were told the ward had had 26 out of 29 beds occupied by medical outliers on one occasion; on the day of inspection there were six outliers on the ward.

- Capacity bed meetings were held twice daily to monitor bed availability, review planned discharges and assess bed availability throughout the trust.

Surgical staffing

- Medical staffing skill mix across the hospital varied across grades compared to the England average at 39% consultant (national average 43%), 16% middle career (national average 10%), 26% Registrar group (national average 35%) and 20% junior doctors (national average 11%).
- At the time of inspection there was an 8% consultant vacancy rate within the division – four anaesthetists, one urology consultant and three ophthalmology consultants.
- The role of nurse practitioners had been developed to mitigate risks associated with vacancies in cover of junior doctors.
- The Emergency Surgical and Elective Care Business Unit risk register (September 2016) identified issues with staffing across the trust. The division had developed recruitment and retention policies to address these issues.
- The inability to recruit permanent anaesthetic staff and the reliance of locums across the trust and particularly at West Cumberland Hospital was identified as a risk.
- Risks with consultant paediatrician cover provided from Cumberland Infirmary to West Cumberland Hospital were identified. National standards indicate '..on-site clinicians must have access to senior colleagues...within ten minutes when required.' This cover was provided on an informal and 'goodwill' basis.
- The lack of a dedicated critical care resident on site at West Cumberland Hospital was identified as a risk. Advanced critical care practitioners had been recruited and were undergoing training to perform the role.
- Further risks were identified around clinical capacity and the reliance on locum cover in ophthalmology. Concerns had been raised about the quality of cover, changes to appointments and lack of continuity.
- We saw that surgical handovers took place daily and were primarily consultant led and took place in private areas to maintain confidentiality.

Are surgery services well-led?

We found surgical services well-led at West Cumberland Hospital:

- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The divisional leadership team detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The trust had developed a Quality Improvement Plan (QIP) to ensure implementation of its Clinical Strategy, Nursing, Midwifery and Allied Health Professionals (AHP) Strategy.
- The division had also developed a Perioperative Quality Improvement Plan in response to recent issues identified within surgery.
- Regular Divisional, Emergency Surgery and Elective Care Business Unit, Safety and Quality Group and the Clinical Leads for National Safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- The Friends and Family test showed 95% of respondents would recommend care within the trust (June 2016) and the 'Two minutes of your time' survey was used to elicit patient feedback on how likely patients are to recommend, resulted in overall scores (maximum 10) of 9.77 for the ward.
- These results were supported through discussions with patients during our inspection. Patients were complimentary about the care and treatment received at the hospital and were very supportive of the services provided.

However:

- At the time of inspection the Perioperative Quality Improvement Plan was in the early stages of implementation, impacting upon some areas but not yet fully embedded within the division. Although most staff were aware of the plan, they could not articulate specific outcomes from the plan.
- Although staff acknowledged that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans, some staff said they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages.

- The ward cared for high numbers of medical 'outliers' with high acuity and different needs to surgical patients. This supported the view expressed by staff that they were working under pressure within the division.
- Results from the 2015 NHS Staff Survey showed the trust had improved in overall staff engagement. Staff also responded that most problems were: in putting themselves under pressure to come to work despite not feeling well enough, senior managers did not try to involve staff in important decisions and there are not enough staff to support them to do their job properly.

Vision and strategy for this service

- We met with senior trust and divisional managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgical division.
- Staff demonstrated the values of the trust during the inspection and were clear about the trust vision and understood their role in contributing to achieving the trust wide and directorate goals.
- The trust had developed a Quality Improvement Plan (QIP) to ensure implementation of its Clinical Strategy and its Nursing, Midwifery and Allied Health Professionals (AHP) Strategy.
- Within the QIP the trust had identified specific objectives to improve the management of the deteriorating patient, the recognition and initiation of treatment for patients with sepsis and ongoing development of the Mortality and Morbidity Framework.
- The division had also developed a Perioperative Quality Improvement Plan in response to recent issues identified within surgery. This aimed to enhance governance through learning from events and incidents, develop the workforce through a positive learning environment and initiate external assessment and compliance.
- The plan also identified initiatives for improvements in booking and scheduling, performance, information and reporting, reductions in sickness absence, patient and public involvement and the implementation and monitoring of National Safety Standards for Invasive Procedures (NatSSIPS).
- The management team detailed specific strategies for the repatriation of services to West Cumberland Hospital. These involved investment in theatres and anaesthetics at the hospital supporting the repatriation of urology, ENT and orthopaedic elective procedures.
- Emergency low risk surgery and minor trauma were planned to be repatriated to the hospital with associated investment from the Clinical Commissioning Group.

Governance, risk management and quality measurement

- An Integrated Performance Report which gave progress updates on the Emergency Surgery and Elective Care Improvement Plan was presented to the trust board at each meeting. An example of actions identified was additional clinical sessions to improve compliance against national standards for referral to treatment.
- Regular Divisional, Emergency Surgery and Elective Care Business Unit, Safety and Quality Group and the Clinical Leads for National Safety Standards for Invasive Procedures (NatSSIPS) meetings were held.
- We reviewed agendas and minutes and these showed that serious and clinical incidents, guidelines and standard operating procedures, audits, complaints and compliments were discussed. We saw evidence of audit activity and learning from complaints and clinical risk management issues.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly.
- The division's risk register was updated following these meetings and when needed. Risks were described, controls identified, and progress against mitigation, risk grading, assurance sources, gaps in control and assurance and dates of review were documented.
- Risks identified included, for example, theatre overruns, staffing, compliance with national targets and guidelines; cost improvement plans and ward capacity. Action plans were monitored across the division and sub-groups were tasked with implementation.

Leadership of service

Surgery

- We held meetings with the divisional leadership team who detailed their understanding of the challenges associated with providing good quality care and identified actions needed.
- The team had identified specific strategies and initiatives to meet the challenges within the division and had developed the Perioperative Quality Improvement Plan to facilitate improvements.
- However, at the time of inspection the plan was in the early stages of implementation. Although most staff were aware of the plan, they could not articulate specific outcomes from the plan.
- Senior staff were motivated, enthusiastic about their role and had clear direction with plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, skills and experience to lead effectively.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good. Clinical management meetings were held and involved service leads and speciality managers. Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- The team explained that there were particular difficulties within the division and these were being tackled. Specific issues identified were:
  - the referral to treatment rate within 18 weeks for admitted patients was worse (89%) than the England average (July 2016) and was not meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment;
  - the percentage of patients whose operations were cancelled and not treated within 28 days was worse (11%) than the England average(6%) for most quarters from April 2014 to March 2016;
  - trust figures (June 2016) showed two patients operations were cancelled and not treated within 28 days at West Cumberland Hospital;
  - cancelled operations as a percentage of all elective admissions were consistently worse than the England average from April 2014 to March 2016.

Culture within the service

- During interviews with staff, they told us the division had strong leadership and most senior managers were highly visible and 'hands on'. This reflected the vision and values of the division and the trust. We interviewed staff on an individual and group basis throughout the ward, theatres and surgical areas.
- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority.
- Nursing staff stated that they were supported by their managers and they could access one-to-one meetings which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.
- There was an acknowledgement that the trust had plans in place to increase staffing levels and develop effective recruitment and retention plans.
- However, some staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages resulting in exhaustion which increased the potential for harm to patients.
- The numbers of shifts not staffed to establishment across most surgical wards and areas, caring for medical 'outliers' and the high acuity and needs of patients supported the view expressed by staff that they were working under pressure within the division.
- Staff explained that morale had been difficult to maintain despite recognised leadership support and effective team working. Staff described good teamwork within the division and we saw staff worked well together; there was respect between specialities and across disciplines.
- Staff told us they had been uncertain about the future of surgical services at the hospital and the impact upon their roles, skills and development. However, staff were aware of plans to repatriate services to the hospital when appropriate to do so.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, PALS and 'Two Minutes of Your Time', and 'Tell us what you think' questionnaires were available on all ward and the reception area. Internet feedback was gathered along with complaint trends and outcomes.

Surgery

- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.
- All staff were clear about their roles and responsibilities, patient focused and worked well together.
- The Friends and Family test showed a response rate of 48% at West Cumberland Hospital (England average, 27%). From these responses 95% of respondents would recommend care within the trust (June 2016).
- The 'Two minutes of your time' survey was used to elicit patient feedback on: how likely patients are to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, and kindness and compassion received. These indicators (August 2016) gave overall scores (maximum 10) of 9.77 for the ward.
- These results were supported through discussions with patients during our inspection. Patients were, without exception, complimentary about the care and treatment received and were very supportive of the services provided.

Staff engagement

- Results from the 2015 NHS Staff Survey showed the trust had improved in overall staff engagement (3.60) although still less than the national average (3.79).
- The trust also commissioned a staff survey conducted by an external organisation (2015). Results showed staff felt improved satisfaction with pay, managers taking an interest in health and wellbeing, incident reporting, acting on concerns and prioritising the care of patients.
- However, staff also responded that most problems were: in putting themselves under pressure to come to work despite not feeling well enough, senior managers did not try to involve staff in important decisions and there are not enough staff to support them to do their job properly.
- We saw senior managers communicated to staff through the trust intranet, e-bulletins, team briefs and internal campaigns. The ward held staff meetings, which discussed key issues for continuous service development.
- All staff were invited to attend regular forums with the chief executive where they were able to voice their opinions, listen to updates and discuss concerns.

Services for children and young people

Safe	
Well-led	
Overall	

Information about the service

Services for children and young people (CYP) were provided on both hospital sites within North Cumbria University Hospital NHS Trust and managed by a single management team under the Child Health Business Unit. There were 6,568 admissions into the CYP service between March 2015 to February 2016. West Cumberland Hospital (WCH) accounted for 2,058 (31.5%) of these with 90% classified as emergency admissions.

At WCH, the CYP service comprised a 14-bedded children's ward and a Special Care Baby Unit (SCBU) accommodating up to 9 babies.

From April to June 2016, the SCBU reported 314 live births and 30 admissions to the unit. The unit recorded five intensive care (IC) bed days, 21 high dependency (HD) bed days and 387 special care (SC) bed days in this period. Cot occupancy rates were 50%. (Northern Neonatal Network Quarterly report, Q1 2016).

The CYP service at WCH was last inspected between 31 March 2015 and 2 April 2015. The service was rated 'good' in all domains. It was noted there had been improvements in the prevention of avoidable harm and exposure to risk and nurse staffing. There was a visible, child centred culture within the service and staff provided good care. A shortage in medical staffing was highlighted. During this inspection we reviewed medical and nursing staffing in line with the trust's workforce strategy as well as escalation and contingency plans in these areas. The service was under review with a number of models being considered and evaluated in order to better meet the needs of the CYP population. This inspection focussed on the safe and well-led domain.

During our inspection, we visited the children's ward and SCBU at WCH. We observed care, staff working, ward rounds and ward meetings. We spoke with 15 members of staff, including consultants, specialist doctors, trainee doctors, managers, nursing staff and pharmacists. We introduced ourselves to two parents. We reviewed eight sets of care records including prescription charts.

Services for children and young people

Summary of findings

This unannounced inspection focussed on the safe and well-led domains only.

Overall, safety for children and young people at WCH :

The wards planned staffing in accordance with recognised standards and were compliant with BAPM and RCN recommendations. There were escalation plans to address shortfalls or changing acuity. Medical staffing was heavily supported by locum appointments in senior positions however many of these posts were filled by unit known clinicians on extended contracts. Unit managers recognised the vulnerability of the situation and were taking steps to recruit to vacancies to reduce temporary engagements and stabilise turnover. The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). The standards covered areas such as consultant presence, time to consultant review and consultant led handovers.

The unit had maintained good incident reporting processes, safeguarding procedures and nurse staffing levels at WCH. Staff were confident and comfortable in reporting incidents of harm or concern however a number of reported incidents lacked a classification of harm. Staff explained procedures for sharing learning from such incidents was good and we were told of changes to practice following lessons learnt. Staff were aware of the importance of ensuring their practices kept children and young people free from harm. Ward environments and clinical areas were 'child-friendly', secure, clean and well maintained.

Documentation and record keeping was very good. Safeguarding policy was embedded across the unit and staff were knowledgeable about safeguarding procedure for vulnerable children. The service had good local processes to monitor changes in a child's condition. There were robust arrangements with neonatal network colleagues if a higher intensity of care was required to a deteriorating baby.

Staff followed trust mandatory training requirements and additional core training relevant to their specific clinical area. Managers were working to ensure all staff completed necessary training and to meet trust target in all elements.

Overall, the children and young people service was being well-led.

There was a clear strategy for the remodelling of the services provided by the Child Health Clinical Business Unit. Unit management had worked up a number of proposals which were now encompassed within the wider Success Regime looking at the improvement and sustainability of various provisions across the region. Staff confirmed their awareness of the proposals however were concerned about the implications for the service at WCH. Managers needed to ensure staff were kept up-to-date with Success Regime progression.

The unit had maintained a comprehensive governance and assurance structure to monitor and mitigate risk. The unit leadership team was visible and there was a real strength and 'team' culture with staff at ward level. Staff were proud to work for the trust and were passionate about delivering good care.

Staff were supported locally and felt engaged with unit leaders.

Staff sought opportunities to improve the service they delivered. Feedback from numerous local, regional and national public engagement surveys and satisfaction questionnaires was consistently very good across the unit at WCH.

Services for children and young people

Are services for children and young people safe?

- Staff understood the incident reporting processes and were confident in using the trust's risk management reporting system and we were told of some learning that flowed from incident investigations.
- There was a thorough audit process looking at key safety related indicators. Staff implemented, monitored and took immediate steps to complete action plans to address non-compliance. For patient ease of reference, staff published and displayed findings..
- Documentation, including completion of care plans, risk assessments, reviews, medication charts, observations and patient involvement, was good.
- The trust safeguarding team was well established and procedures were embedded across the unit. There was thorough audit of safeguarding policy in line with best practice and recognised standards. The safeguarding team had forged constructive working relationships with wider partners and agencies involved in protecting children.
- Nurse staffing was compliant with BAPM and RCN recommendations.

However:

- Medical staffing was heavily supported by locum appointments in senior positions. Unit managers recognised the vulnerability of the current situation and the potential sustainability implications in the medium to long term. Managers had secured locum agreement to longer term contracts however were actively looking to recruit to permanent posts.
- The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). The standards covered areas such as consultant presence, time to consultant review and consultant led handovers.
- There was a number of submitted incidents which did not have harm level categorised which may lead to missed themes, inappropriate late classification or delayed investigations.
- The unit audit results against National Institute for Health and Care Excellence (NICE) guidelines for Neonatal Infection (CG149) was poor. The unit auditors however produced recommendations to unify first line antibiotic prescribing, increase NICE guidance awareness and to re-audit to review lessons learnt.
- Mandatory training compliance across the unit was variable. Whilst a number of specific core areas met the trust target of 80%, there were areas that fell well below the benchmark. Managers worked with staff to address shortfalls.
- Unit managers needed to implement processes to ensure safeguarding alerts were transcribed from the patient administration system (PAS) onto the symphony system to ensure all vulnerable children receiving care at WCH were highlighted.

Incidents

- The unit followed the trust incident reporting policy.
- Staff reported incidents of harm and concerns using the trust web-based risk management reporting system. Staff we spoke with told us they felt confident reporting incidents and matters of concern.
- The trust reported over 9,037 incidents in 2015/16 (NRLS notifications and STEIS incidents). The Child Health Business Unit accounted for 124 (1.4%) of those recorded. Of those reported, 88% were classified as no or low harm, 6.5% were rated as minor harm, 5% as moderate harm and less than 1% was deemed severe.
- The service reported no never events between July 2015 and June 2016. Never events are incidents defined by the Department of Health as serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly. There were two serious incidents (SIs) relating to treatment delays. From April to July 2016, children's services at WCH reported 55 incidents (31 from the ward and 24 from SCBU). These were categorised as no injuries (87%), minor (4%) and moderate (2%). There were no near miss or severe incidents recorded however 4 incidents (7%) were not classified.
- Seniors staff reviewed submitted incidents at the weekly risk meetings where the unit had representation from the ward and SCBU. Incidents were also discussed at the monthly unit governance group. The reports provided a very detailed background and chronology to the incidents. Investigators reported findings, contributory and mitigating factors. Areas of good practice were highlighted, risks identified and root cause analysis

completed. The report concluded with recommendations, audit and served as a tool for embedinged learning opportunities. Investigators compiled a serious incident action plan detailing persons with designated responsibility for the actions, timescales for completion and expected evidence to confirm compliance. The reports also provided a change analysis reviewing normal/accepted practice, what occurred at the time of the incident and if procedures needed changing thereafter.

- Staff confirmed they received individual feedback from incident submission by email and face to face with the ward manager. Ward managers tended to share outputs from incidents in ward meetings, in the ward communications book, and by displaying meeting minutes and during appraisals. The trust also cascaded learning from incidents on the 'safety messages of the week' bulletin.
- We heard how the unit had learnt lessons from incidents, for example, staff identified issues with the plastic protective sheath on intubation stylus coming dislodged with potential risk to the children. The unit changed the equipment immediately and now carry out a double check post-intubation to ensure the coating is intact prior to disposal.
- Staff confirmed an understanding of the duty of candour (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).
- The SCBU shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aimed to improve outcomes for babies born and cared for across the network region, providing trusts with an opportunity to share good practice.
- The service monitored perinatal mortality and morbidity through the child death overview panel (CDOP) meetings. Doctors, nurses and other healthcare practitioners involved in the care of the deceased from paediatric, neonatal and maternity services attended. Attendees shared information and learning from the panel at ward team meetings.

Safety Thermometer

- The service had adapted and developed a safety thermometer type audit tool called 'paediatric clinical indicators' for use across the business unit to monitor and measure harm free care.
- Senior staff audited compliance against the tool in 12 key clinical indicators (communication, elimination, manual handling, food and nutrition, infection control, medicines management, pain management, patient observation, privacy and dignity, tissue viability, record keeping and discharge standards) on a monthly basis.
- Staff used the tool in conjunction with clinical audit measures and patient satisfaction surveys to obtain a holistic view of safety issues and performance.
- On the paediatric ward between June to August 2016, clinical indicator compliance averaged 89% (against trust 'green' rating of 95%). The minor discrepancy was noted in the completion of a property disclaimer which was omitted from paediatric documentation. SCBU compliance from January to June 2016 was 100%.
- The trust scored better than other trusts in three out of five questions relating to safety and the same as other trusts in the remaining two within the Children's Survey 2014.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean.
- The unit recorded no cases of clostridium difficile (C. diff), methicillin resistant staphylococcus aureus (MRSA) and methicillin sensitive staphylococcus aureus (MSSA) in the previous 12 months prior to the inspection.
- There were cleaning schedules and cleaning logs for each ward. These were well maintained and all staff spoken with confirmed it was their responsibility to ensure the wards were clean.
- Handwashing signage and handwashing facilities were situated at the entrance and throughout the clinical areas. Antibacterial hand gel dispensers were also available at various locations within each unit. There were various IPC posters and information on display. We observed staff and visitors washing their hands and using hand gel.
- Ward staff were involved in monthly hand hygiene audits. Staff displayed monthly audit compliance results on ward information boards. Throughout 2016, hand hygiene compliance results remained consistently in excess of 90% on the paediatric ward and SCBU.
- Staff were also involved in 'spray and glow' audits (where auditors confidentially sprayed ward surfaces

with UV solution with the area revisited the following day to ensure the area had been disinfected and decontaminated). At WCH, the paediatric ward and SCBU recorded 100% compliance against cleanliness standards.

- Ward information boards displayed ward performance data. On the paediatric ward, in August 2016 this was reported as: cleaning score 100%, infection prevention and control (IPC) 100%, cannula 100% and hand hygiene 100%.
- On SCBU, the unit shared outputs from various audits covering various safety indicators. Overall, compliance was very good against hand hygiene, cleaning schedules and patient experience surveys with results all in excess of 90%.
- The unit was involved in trust-wide IPC quality improvement audits. These audits combined a detailed review of IPC care pathways, standard precautions, risk assessment and management, environmental factors, decontamination issues, waste disposal, equipment cleanliness and personal protective equipment. Overall, auditors reported the cleanliness of the paediatric ward and SCBU as good. Compliance scores remained consistently above 90%. IPC staff highlighted a number of minor issues which were duly put into a log where action plans followed for improvement and learning. We reviewed 17 action plans, which showed immediate actions taken, (for example mattress cover integrity, immediately replaced), and highlighted areas for follow-up (for example, requisitions for work repairs where IPC was compromised).
- IPC training was mandatory with a trust target of 80%. Staff compliance across the unit was recorded at 85%.
- We saw personal protective equipment (PPE) was readily available for staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice.
- Toys and play areas within the units were clean and staff informed us they followed guidance from the IPC team when purchasing and cleaning such items.
- We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance and risks involved in handling of sharps. We observed staff safely disposing of needles in appropriate sharp bins and arranging disposal when full.

Environment and equipment

- The hospital ensured access/egress from the clinical areas was safe for the children by securing entrance/exit routes by way of a camera monitored buzzer entry system. Staff monitored visitors entering and leaving the ward.
- Staff completed environmental and equipment checks as part of their daily work and formally through the audit process. Checks included equipment cleanliness (such as commode, drug fridges and mattresses), accessibility, storage and integrity. The trust environmental report showed the paediatric ward and SCBU compliance averaged in excess of 95% between April to June 2016. Staff displayed audits findings on ward noticeboards.
- Ward areas consisted of bays and individual rooms. Individual cot spaces in SCBU were spacious to allow for necessary equipment, staff and family access and unhindered movement however the ward manager informed us the newly furbished unit lacked storage capacity and a designated staff room. Staff on the paediatric ward reiterated a lack of storage on their unit and had escalated this to the project development team.
- We saw evidence of processes to ensure equipment was safe and we saw documentation for checking and cleaning equipment. Medical and nursing staff worked in partnership with the trust medical devices, electronics and supplies teams to maintain equipment and devices. All equipment we checked was tested and labelled accordingly.
- Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.
- Resuscitation and emergency equipment was suitable for the needs of the children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. We reviewed the logs and found no omissions. Staff were trained to use equipment and their competency recorded.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed this policy.
- Staff completed medicines management audits on a monthly basis. The paediatric ward and SCBU were found to be fully compliant against key indicators. Ward staff displayed audit findings on display boards.

- Staff received training on medicines management as part of their local induction into the clinical areas. Managers had introduced a number of local medicines based competencies, for example, in administering intravenous medications. Ward managers assessed and monitored competencies against agreed best practice standards.
- Medicines were stored securely and always in a locked cupboard. The nurse in charge for the respective units held the keys to access the medications.
- Staff checked controlled drugs stock on a daily basis in accordance with local policy. We viewed stock review checks showing completion.
- Staff checked refrigerator temperatures on a daily basis to ensure those medications requiring storage within specific temperature ranges were safe for use. We reviewed daily logs, which were complete. Staff informed us of the procedure they followed if the temperature fell below the lower range or exceeded the upper range. There were two refrigerators in SCBU which were clearly labelled confirming which was for medicine storage and which was for the storage of milk.
- Staff we spoke with told us they had 24-hour access to a member of pharmacy for information and advice.
- In August 2016, the SCBU completed an audit of 17 case notes reviewing compliance against sepsis policies and National Institute for Health and Care Excellence (NICE) guidance (CG149 – Neonatal Infection). The results confirmed 69% of children were given antibiotic treatment within one hour of the decision to treat being made. The audit concluded first line antibiotics for presumed neonatal sepsis was not in keeping with NICE guidelines and differed between CIC and WCH. The audit produced recommendations to unify first line antibiotic prescribing, increase NICE guidance awareness and to re-audit to review lessons learnt.
- We reviewed eight paper prescription charts on the paediatric ward and SCBU. Staff completed charts legibly and all entries were signed and dated. Staff recorded the child's weight at regular intervals throughout the duration of the admission along with a date of birth. No medications were omitted however on one chart we noted the antibiotics had not been prescribed in accordance with local guidelines. Here the prescriber had failed to annotate the dose timing and had replaced this with a note confirming "12h" (12 hourly). The ward manager confirmed this was not recognised practice and had this immediately rectified. Allergy checks were completed in all cases.

Records

- Staff managed, handled and secured records safely on the unit. There were no records left unattended during our inspection. The ward manager on SCBU explained her notes cupboard lock was broken however a works requisition had been generated to get a replacement.
- We reviewed eight sets of paper based care records. Staff completed records accurately and in a timely way. There was evidence of consultant review however all reviews were not completed within the 14 hour window. Diagnosis and management plans were well documented and there was evidence of multidisciplinary input. The records included appropriate clinical history, review, risk assessments and noted discussions with family members.
- Nursing documentation was also paper based. This included family history, an age specific assessment of activities of daily living and individualised care plans. Staff kept various documents bedside for ease of reference such as observation and nutritional charts.
- Ward managers completed a monthly clinical indicators documentation audit of clinical records on their respective units. The audit, covering nine key criteria, recorded compliance against record keeping indicators such as legibility, treatment plans and information sharing, patient involvement and policy awareness. During June to August 2016, the paediatric unit at WCH was fully compliant against all nine criteria.
- The SCBU completed case note reviews as part of the NHS Litigation Authority (NHSLA) audit 2015. Managers audited 10 case notes each month against 30 key indicators ranging from demographics to examination findings and treatment plans. Overall compliance was very good with only four criteria not achieving 100%. The shortfalls concerned entries not being fully timed/dated with the writer's bleep and grade entered for later contact or reference.
- Ward managers also completed monthly paediatric early warning score (PEWS) audits ensuring key clinical observations (blood pressure, heart rate, respirations, pain score, oxygen saturations) were completed and

recorded in accordance with clinical need and best practice. Between March and June 2016, we found the paediatric unit at WCH to be fully compliant with a minimum of 10 of 12 criteria.

Safeguarding

- The trust had a safeguarding children (including unborns) policy ratified in 2015 following the publication of NICE guidance. In January 2016, the named nurse for safeguarding children drafted safeguarding children and young people operational guidance and notes for staff working in specific areas such as accident and emergency, outpatients and paediatric in-patient areas.
- The trust had a designated safeguarding team which comprised a named doctor (part-time), a named nurse, lead midwife, an executive lead and a management lead for safeguarding. Staff confirmed the safeguarding team to be accessible and supportive in dealing with queries and concerns. The named doctor worked flexibly within her job plan to meet the needs of the service and provided on-call advice and support. Supervision was provided by the designated doctor on a twice yearly basis. The safeguarding team and the named doctor provided training to clinicians outside paediatrics, for example, gynaecology and orthopaedic staff. The named doctor had no formal acute community workload however attended the Local Safeguarding Children's Board (LSCB) and the Child Death Overview panel (CDOP) on behalf of the trust.
- In the Safeguarding Children – Internal Audit Report published in February 2016, the trust reviewed their governance, guidance and staffing framework. The team identified five areas of potential impact on the safeguarding function namely, safeguarding board terms of reference, guidance sharing, 'Interserve' staff pre-employment checks and training and the review of the named doctor role. The audit team implemented action plans for each of the items referred to.
- In the trust Safeguarding Children Audit findings published in August 2016, a review of 40 clinical records highlighted all reviewed documentation showed a safeguarding assessment. At WCH, staff complied with the child protection policy in 95% of cases reviewed. All safeguarding concerns and decisions made were assessed to be appropriate. Staff completed the CWILTED tool (which stands for condition, witness, incident, location, time, escort, disability to assist staff in assessing safeguarding concerns – which was attached to the safeguarding assessment tool referred to in Children First, the National Guidelines for the Protection and Welfare of Children (1999)) in 72% of cases. The audit identified some recommendations for future action, namely improved discharge communications and a reinforcement that the child should be given the opportunity to talk to staff alone. Action plans were on-going at the time of the inspection.
- The named doctor for safeguarding completed a child protection audit in 2016, reviewing over 70 case files dating back to 2014. The audit purpose was to ensure reports met with Royal College (RCPCH) child protection standards. Improvements were noted in specific documentation areas (people present, reference to child's emotional state, improved summaries, detail of evidence for basis of opinion and follow-up plans). Areas for improvement and recommendation suggested more detail around timings of events for example examination, interview with child and recording the child's statement in full. The named doctor planned to share findings in peer review sessions to share best practice, to devise a template for report preparation and to complete a re-audit in the coming year.
- All staff we spoke with had a clear understanding of the processes involved if they had any concerns in and out of hours. The safeguarding team had developed a very thorough on-line intranet resource for staff access which provided contact details, operational guidance, training and information on external safeguarding stakeholders and support agencies. Staff also accessed the trust safeguarding newsletter which detailed case conference minutes, child death review learning outcomes, training and other useful resources.
- Trust mandatory training on safeguarding included signs and symptoms of child sexual exploitation (CSE), female genital mutilation (FGM) and learning from serious case reviews (SCR).
- In 2015/16, mandatory safeguarding training records across the trust showed deteriorating compliance, averaging 84% for level one safeguard training, 81% for level two and 79% for level three in quarter 4 (January to March 2016). Level two and level three safeguarding training was delivered by way of initial core training, an annual refresher and a three yearly core update. Senior staff and managers identified an unacceptable level of completion and arranged further training dates to

ensure all relevant staff completed their designated mandatory training to the right level in the coming recording period. Staff also attended joint external regional training events on safeguarding topics.

- Staff confirmed they had good relationships with the Local Safeguarding, Looked After Children Boards and Child Death Review Group along with other community based staff involved in the safeguarding process. Designated trust staff attended the meetings on a regular basis.
- There were systems to ensure children and young people subject to safeguarding concerns were safe. For example, the local safeguarding team would share updates with relevant hospital personnel. Children who attended the hospital from other areas were tracked using their NHS number however staff at WCH were reviewing processes to ensure such alerts were transcribed from the patient administration system (PAS) onto the symphony system.
- The safeguarding team were involved with Cumbria Clinical Commissioning Group Designated Leads Group. In this forum, staff shared best practice, audit and assurance processes and system improvements to improve practices to support vulnerable children in the region.

Mandatory training

- The target for mandatory training compliance was 80%. The trust employed a dual responsibility strategy for the management of mandatory training involving ward managers and personal staff accountability.
- Mandatory training included topics such as health and safety, equality and diversity, infection prevention and control, fire safety, information governance, and safeguarding. Role specific training included paediatric life support, essence of care, blood safety and medicines management.
- Overall, generic mandatory training figures in the unit for all grades at WCH was 80%. Trust induction and speciality induction rates were recorded at 100% whereas some health and safety modules were as low as 61%. Managers worked continuously to ensure all staff completed mandatory training topics in the requisite timeframes.
- Role specific training compliance varied across the unit. Paediatric essence of care modules reported in excess of 95% compliance; blood safety training and competency reviews were between 88% to 36% compliance, medicines management reported 81% completion, and paediatric life support training averaged 53% compliance across basic, immediate and advanced levels. Managers had identified the variability in compliance and recognised the need to ensure better compliance across the unit. Further training dates to address the variance in uptake in some core training were planned to meet the trust target.
- By August 2016 end (rolling mandatory training year – April to March), the paediatric ward reported 90% completion and SCBU 85% completion against all mandatory training requirements. Managers were continuing to capture those staff members who were not yet fully compliant to ensure completion by year end.

Assessing and responding to patient risk

- Staff promptly assessed the children and consultants reviewed all children. In the records we reviewed, all children had a current treatment and management plan in accordance with their needs.
- Consultants completed ward rounds each morning. Evening ward rounds were flexible to prioritise new admissions and/or poorly children. Staff informed us all children had an immediate paediatric nurse assessment, were reviewed by the attending doctor within four hours and all were reviewed by a consultant within 24 hours (including at weekends). We found evidence of consultant reviews documented in the medical records.
- Staff completed all relevant observations and risk assessments on admission such as nutritional status, skin integrity and, where appropriate body maps were completed. Staff reviewed risk assessments regularly.
- Staff discussed the child's progress at handovers and during safety huddles. This allowed nursing and medical staff to reinforce plans to monitor deteriorating patients such as increasing observations, or 1:1 nursing or care escalation. Senior medical (consultants, anaesthetists, middle grade doctors) and nursing staff responded immediately to any urgent change in a child's condition.
- The service used evidence-based documentation to monitor observations and the child's condition when receiving care. The paediatric unit used age specific paediatric early warning scores (PEWS) to monitor condition stability and escalation triggers. This included a clinical observation chart, coma scale and pain score

tools. Staff used the assessment table to assist in determining what action taken in the event of deterioration, such as increasing the level of care or considering external transfer.
- The service secured funds to develop PEWS action cards for all staff. Staff used the cards as a useful referral guide and check list when considering care escalation.
- In the event of a child deteriorating and requiring intubation for example, the child would be managed on the intensive care unit (with or without paediatric nurse support) prior to retrieval and transfer to a tertiary centre.
- The trust had a transfer of patient policy (including intra and inter hospital transfers) with a designated section for the care and management of paediatric and neonatal patients. The SCBU was part of the NNN, which provided specific transfer guidelines for the movement of babies to more intensive therapy areas. This included detail for baby retrieval, preparation for transfer and transport requirements.
- The unit had adopted NICE guidelines (CG149) for the assessment, treatment and management of babies and children with risk factors for infection or clinical indicators of possible infection. The unit had audited compliance against the said guidelines and the unit used The UK Sepsis Trust screening and action tool to record sepsis assessment.
- Staff at WCH expressed concerns in the care and management of children requiring assessment by an approved mental health practitioner (AMHP) from the child and adolescent mental health service (CAMHS). Staff identified these children to be an additional risk factor on the ward where they required additional support by way of 1:1 nursing. Staff reported delays in securing CAMHS assessment (provided by another trust) leading to pressure on the ward. Staff confirmed they escalated this concern to unit managers.

Nurse staffing

- The paediatric ward accommodated 14 children (comprising seven in-patient beds and seven assessment beds).
- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels for the children.
- Senior staff referred to guidance provided by Royal College of Nursing, considered nurse to patient ratios, used professional judgment to assess staffing requirements on general paediatric areas and utilised data from the e-rostering system. Managers forward planned nurse rotas to allow for early identification of staffing shortfall and completed a twice daily acuity review to manage changing patient need.
- Where there were identified staffing shortfalls, there was a clear escalation process in place. Ward managers advised they obtained support from the wider unit, requested existing staff extend or work additional shifts or requested staff from the nurse bank.
- The ward planned for three registered nurses on shift during day shifts and two registered nurses overnight. Staffing was further supported by a healthcare assistant (HCA) on all shifts and a play specialist working weekdays. The ward manager acknowledged where a third registered nurse could not be rostered to cover the full duration of the day shift, they rostered shorter shifts to cover the ward at busier periods (10am – 6pm). We reviewed staffing rotas from July to September 2016 and noted actual staffing met establishment. This broadly correlated with fill rates for the same period which averaged 82% for registered nurses during the day and 100% at night. HCA fill rate figures were 102% and 82% respectively.
- The paediatric ward displayed planned and actual staffing numbers on whiteboards. At the time of the inspection, planned staffing numbers were advertised as three registered nurses during the day with support from a HCA and a play specialist. Actual staffing figures correlated with those advertised. There were three children on the ward providing a registered nurse to child ratio of 1:1.
- The standard for bedside deliverable hands-on care (as defined by Royal College of Nursing defining staffing levels for children and young people's services, 2013) recommends 1:3 registered nurse:child staffing for children under 2 years and 1:4 registered nurse:child for children over 2 years.
- Based on the paediatric ward staffing figures, registered nurse to child staffing ratios would be at a maximum of 1:4.6 during the day and 1:7 overnight based on 100% occupancy. Ward occupancy figures for June to August 2016 showed an average of 60% bed usage which equated to 8 children therefore adjusting registered nurse to child staffing ratios to be 1:2.6 during the day and 1:4 at other times.
- Managers confirmed during periods of increased pressure, such as the winter months, extra registered

nurses were recruited or accessed via the nurse bank to support the unit. Additionally, the unit was currently training up two nurse practitioners into post to support staff at WCH.

- Managers confirmed retention was good on the ward at WCH. At the time of the inspection, the paediatric ward showed a 0.6 whole time equivalent (WTE) deficit in band 5 registered nurse staffing. Sickness absence rates averaged less than 5% between August 2015 to July 2016.

Special Care Baby Unit (SCBU)

- The SCBU service at WCH was a 9 bedded facility. There were six babies on the unit at the time of our inspection.
- From April to June 2016, the unit reported 30 admissions. The unit recorded five intensive care (IC) bed days, 21 high dependency (HD) bed days and 387 special care (SC) bed days in this period. Cot occupancy rates were 50%. (Northern Neonatal Network Quarterly report, Q1 2016).
- Managers in the neonatal unit followed service standards for hospitals providing neonatal care produced by British Association of Perinatal Medicine (BAPM, 2010). The BAPM standards provided guidance on staffing governance and staffing levels in neonatal units.
- BAPM recommends staffing ratios of neonatal nurse qualified in speciality (QIS) to babies. In intensive care a ratio of 1:1, in high dependency care a ratio of 1:2 and in special care a ratio of 1:4. The unit at WCH did not provide any routine intensive care or high dependency care however in the event of a baby deteriorating, SCBU staff instigated continuous positive airway pressure (CPAP – which would see the baby reclassified into a high dependency or intensive care category) during transfer and retrieval discussions. All qualified staff on the unit had achieved QIS.
- The unit used the trust e-rostering system and managers ensured the unit was staffed in accordance with recommended standards. The unit planned staffing was two registered nurses (a minimum of one of which would be QIS) and one HCA during the day and two registered nurses overnight. The unit was deficient of a HCA on the day of our visit. We reviewed off-duty rotas from May to July 2016 and based on a three shifts per day system (early, late and night), the unit met or exceeded BAPM standards in 98.5% of rostered shifts. Fill rates for SCBU coincided with our review of the off-duty rotas, reporting 100% for registered nurses during the day and 105% during the night with HCA staffing being recorded at 50%.
- Managers recorded nurse staffing levels twice daily on Badgernet (a single record of care for all babies within neonatal services) and replicated this data onto the trust 'safe care' tool which allowed managers to see live staffing levels, acuity and patient numbers.
- Managers worked with their team to cover staffing shortfall. Existing staff worked additional hours and flexed rostered working patterns to cover. The unit reported minimal nurse bank use however had a pool of specialist staff to draw upon when required.
- The unit managers had recently appointed two nurses and continued to monitor turnover, attrition and long-term sickness to ensure safe staffing was maintained on the unit. Staff stated the unit was safely manned however made it clear when the unit reached capacity, staff felt the increase in pressure and stress to maintain adequate care. Unit managers considered workforce assurance and succession planning as an on-going concern and this formed part of the Success Regime agenda (a national initiative designed to support local improvement programmes by bringing together wider healthcare economy partners).

Medical staffing

- According to the Health and Social Care Information Centre, medical staffing skill mix varied in comparison to the England average. Overall, the service had a significantly lower proportion of consultant grades (23% compared to 39% average) and a lower number of registrar grades (42% compared to 47%) than the England average. The service had a significantly greater number of middle career grades (doctors with at least three years' experience as senior house officer or at a higher grade) and junior doctors than the England average. The total whole time equivalent (WTE) for medical staffing was 14.
- The unit at WCH had one substantive consultant in post however employed five senior locum staff (four consultants and a middle grade doctor), many of whom were on long term contracts or had worked at the trust for over six months. Unit managers acknowledged the vulnerability of the service at WCH in view of high senior position locum use and the potential for professional isolation for the substantive consultant in post. They

were working up contingency plans with NHS England and NHS Improvement to support the medical staffing arrangements. In the interim, unit managers increased operational support, clinical visits and reinforced cross-site communications. Unit managers continued with recruitment and were interviewing two consultant candidates in the autumn.

- The majority of the consultant's job plans provided for 10-programmed activities (PAs) a week however in reality most were working in excess of this, in the region of 11-12.5. The unit did not meet all Royal College of Paediatric and Child Health (RCPCH) – Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). The standards covered areas such as consultant presence, time to consultant review and consultant led handovers.
- The unit provided consultant presence until 10pm with on call arrangements thereafter. All staff confirmed on call cover to be effective with support easily accessible when required.
- The service operated a consultant of the week (COW) rota from 9am to 5pm and a hot week where cover was provided out-of-hours from 5pm to 9am the following day. We reviewed paediatric rotas from June to August 2016 showing consultant cover, staff and middle grade attendees, COW and on-call staffing arrangements (consultant on call from home overnight and at weekends with a combination of speciality doctor/ foundation year doctor/advanced paediatric nurse practitioner (APNP) on site). There were no rota gaps.
- The unit at WCH was further staffed by three speciality doctors, one specialist trainee, 1 GP trainee and two foundation year doctors.
- Notes reviewed confirmed a consultant reviewed all children admitted to the paediatric unit with an acute medical problem within 14 hours of admission. There was one set of notes on SCBU which recorded a number of reviews by a specialist grade doctor but the baby did not have a consultant review until approximately 48 hours after admission.
- Formal consultant led medical handovers occurred each morning. There were less formal evening rounds to review admissions or children of concern. All children were discussed and this combined a detailed review of the child, an update on progress, on-going treatment plans and an opportunity for junior medical staff to learn and ask questions.
- Junior medical staff told us their senior colleagues including all senior locum staff were accessible and approachable. Consultants and senior paediatric doctors welcomed contact out of hours in the event of concern about a child or for treatment advice and were happy to attend the unit when required.
- Sickness rates for medical staff and locum use across the paediatric and neonatal unit was less than 2% in 2016.

Major Incident Awareness and Training

- The unit had a paediatric service escalation plan and a staffing contingency plan to provide guidance and support to staff in the event of a major incident.
- The unit took part in a multi-agency table top exercises in July 2016 to test the resilience of such plans. The exercise primarily focussed on services at WCH site however the impacts at CIC formed a key part of the exercise discussions. The exercise identified a number of areas for future consideration and improvement such as the need for more depth and detail for long term loss of staff, more training and awareness across the unit to fully embed the plans and to fully integrate the paediatric policies into the wider trust framework.
- Staff on the paediatric wards confirmed an awareness of the escalation plans.

Are services for children and young people well-led?

- There was a clear strategy for the unit consistent with the trust vision which was interconnected to the Success Regime agenda to review proposals for the improvement and sustainability of the service.
- The unit had an embedded governance and assurance structure which had patient safety, risk management and quality measurement at its core. Senior staff recognised the key priorities within the unit and had worked up proposals and action plans to mitigate risk.
- Unit managers were visible and there was a real passion and resilience within ward based staff to deliver quality care to the children and their families. Staff were supported by senior colleagues and there was a real strong team culture at all levels. Staff were proud to work for the trust.

- The unit reported improvements in the NHS Staff Survey and local staff engagement survey. There was consistently very positive feedback from patients and their families in a variety of local, regional and national satisfaction reviews.

However:

- Whilst staff were fully aware of the strategy for the future of the service, they were increasingly concerned about what the future held for them, the wards at WCH, and they described this uncertainty as being detrimental to morale.
- There was an active audit programme coordinated by the governance group however this lacked a responsible and accountable clinical lead.

Vision and strategy for this service

- The Child Health Clinical Business Unit strategy aligned with the trust vision to provide patient centred, quality healthcare services underpinned by the values of patient's first, safe and high quality care, recognition of the importance of wider contribution, responsibility, accountability and respect.
- The unit had advanced a strategy for children's services based around remodelling services to create a one-team sustainable integrated children's service across the acute sites.
- It was acknowledged by the unit management team to develop such an integrated model of care that was better able to respond to the demands upon it, namely the needs of its population, geography, local infrastructure and recruitment issues, the evaluation of any reconfigured services would need to involve a 'whole-system' model across multi-agencies. The unit management team worked up various proposals and options to achieve this model however these have now been encompassed within the work of the Success Regime.
- The unit is currently working in partnership with the Cumbria Clinical Commissioning Group (CCG), the West North and East Cumbria Success Regime, Cumbria Partnership NHS Foundation Trust, Cumbria County Council, North West Ambulance Service, NHS England and neighbouring NHS Foundation Trusts to develop a business case to support the strategy.
- The unit management, in conjunction with trust executive, developed an internal success regime implementation plan in which they highlighted eight objectives to support the changes being considered. These priorities focussed on developing self-care pathways, clarifying routes to access services, development of an integrated approach to the management of the sick child, plans for the management of long term conditions, complex needs and vulnerable children, improving mental health services, improving multi-disciplinary working and optimising the use of telecommunication technology.
- Current considerations had looked at new ways of working, consolidating in full or in part, consultant led paediatric in-patient services at CIC with a short stay paediatric assessment unit (SSPAUs) and access to nurse led low acuity beds at WCH. SCBU would also be consolidated at CIC however this option required detailed clinical analysis and further consideration of provision of wider maternity services. Consultation on these proposals would be put out to the public in the autumn 2016.
- The leadership team from the unit were clear about the strategic options being considered and staff on the wards at WCH appeared fully informed about the proposals for the future of children's services in the trust. They acknowledged the change was necessary however were concerned about the implications this had on their role, job security and the future of the service at WCH.
- Staff we spoke with were all clear in their understanding of the overarching trust vision and values. We saw posters displaying the values in areas around the hospital. Staff at all levels also understood the priorities of their own service.
- Managers reviewed the progress of the business plan at regular unit level governance and operational meetings, involving medical, nursing and managerial staff groups.

Governance, risk management and quality measurement

- The Child Health Business Unit held cross-site monthly governance and operation board meetings chaired by the governance lead and clinical director accordingly. Each group was well attended.
- The governance group considered compliance, safety, standards, experience, risk, audits, education, safeguarding and exception reports. Attendees

compiled action plans following each meeting which were discussed at the next. Minutes from these meetings were accessed on the trust intranet, displayed on wards and discussed at ward level gatherings.

- The operational board held cross-site monthly meetings. Rolling agenda items covered action logs, finance, performance dashboards, human resource matters, site specific issues and team brief cascades.
- The unit had representation on the patient safety panel where incidents, incident themes, complaints and serious incident investigations were discussed.
- The service received good exposure at Board meetings and in view of its positioning within the Success Regime.
- There was a comprehensive risk register across the business unit comprising some 36 identified risks, seven of which were rated 'red'. These included service resilience, a lack of community paediatric clinicians increasing out-patient attendances, transfer of HD babies, lack of 24 hour senior medical cover, infusion pumps with risk of overfeeding, unavailability of clinical records for review at clinics and adherence to 'Safer Children (2007) guidelines regarding on-site senior cover.
- Staff regularly reviewed identified risks at governance meetings in accordance with allocated timeframes. Staff recorded progress made against the risks along with risk controls, gaps in controls and assurance measures within the risk register. There was evidence of re-evaluation of risk grading and on-going review.
- We saw evidence of an on-going programme of internal quality audits and NICE guideline reviews undertaken routinely across children's service to ensure safe and effective care. Clinical leads told us they felt the governance and level of audit activity across the service and the trust was very robust. The unit did not have a dedicated consultant to lead on clinical audit however the unit governance group allocated audit activity and monitored progress.
- Following previous inspection activity, the unit developed a strategic performance improvement plan, identifying key priorities aligned to the domains of safe, effective, caring, responsive and well-led. These plans provided very detailed improvement projects, for example, ward level compliance with PEWS to more strategic plans such as integrated working with community based services. The plans used SMART principles (specific, measureable, action, results and timing), outcomes/metrics and considered financial implications of each priority. The unit also extended the reach of the plan to address financial, strategic and partnership working aims.
- There was evidence of good working relationships with other trusts and organisations across the region, for example, community partners, specialist service providers and neighbouring NHS trusts.
- The SCBU worked closely with their colleagues at CIC and the Northern Neonatal Network. The team submitted data from the service to Badgernet, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.
- Unit managers captured quality measurements and key performance indicators on the governance dashboard such as admission data, staffing, incidents, and risks.
- Staff told us they were encouraged to report incidents and near misses, concerns from patients and identify risks to the organisation. Patient Safety issues were cascaded into daily handovers and ward meetings.
- The paediatric service received 45 Patient Advice and Liaison Service enquires between August 2015 and July 2016. The unit at WCH received four complaints in the same period, two of which were concluded in a 30 day window. Overall, complaints received by the unit were low.

Leadership of service

- Staff informed us the executive team were visible and often visited the wards. We were provided with sight of various walk around observations and a detailed '15 Steps' (safety and quality assessment tool) analysis compiled in July 2016 which were completed by the executive team, senior clinicians and unit personnel.
- Staff commented about communications with management sometimes become disconnected with a lot of meetings cancelled due to time and staffing pressures.
- Staff considered unit managers, clinical leads and locum staff to be supportive and part of the team. Senior staff were clear about their responsibilities toward their staff. They spoke about the importance of listening to staff concerns, being open and honest about the reality of issues impacting on their wellbeing such as recruitment difficulties, service changes and supporting the ward in the delivery of safe care.

- Ward staff commented they felt supported by Matron and their service manager. They found both to be receptive, approachable and proactive.
- Unit management recognised the strength and resilience of their ward based teams and their commitment to the service, especially during difficult periods. They acknowledged a real strong 'team' ethos and togetherness.
- Staff told us they felt well supported by their colleagues and ward manager. They felt there was a clear management structure across the unit. If there was any conflict within the service, they would go to their ward manager and seek support.
- Overall appraisal rates across the unit at WCH were good and exceeded 80%. Managers had appraisal dates booked for all outstanding members of staff to ensure completion within the requisite timeframe.

Culture within the service

- Medical and nursing staff were proud to work for the trust.
- Staff described everyone working toward a common goal, to do the best for every child and their family. We received positive comments, "I wouldn't work anywhere else", "I'm loving being here" and "Everyone works together".
- Staff spoke positively about their role, their team and the care provided. Staff agreed the trust and the unit put patients first. Staff we spoke with recommended the trust as a place to work. Medical and nursing staff reported no bullying, intimidation or harassment behaviour from managers or colleagues.
- Staff described the culture at WCH to be positive, supportive and respectful. Staff referred to positive engagement with unit managers and clinical leads at WCH.
- Ward based staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children. Staff also told us they felt safe to ask for help, seek support, question, enquire and challenge their peers on the ward.
- Staff at all levels were committed and passionate about caring for the children and their families.

Public engagement

- Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of truly caring interactions between staff of all grades with the children and their families.
- Staff invited formal and informal feedback from the children and their carers by way of the ward satisfaction survey, patient experience surveys, local and national data capture such as NNN satisfaction questionnaires and NHS Friends and Family.
- A number of the surveys could be completed by the child, the parent or both with feedback from the surveys being displayed on accessible notice boards in a user friendly format.
- Recognising that some children were too poorly to put their thoughts in writing, staff also engaged with them face-to-face to capture their views.
- The paediatric ward published real-time patient feedback survey findings. Between January to July 2016, patient satisfaction levels had consistently improved from 8.33 to 10.00 (out of 10.00), averaging 9.85 across the period. On SCBU, the unit displayed patient satisfaction survey results, SCBU specific patient questionnaire results and recorded NNN feedback. Comments received were consistently positive with overall satisfaction scoring recorded in excess of 95% across the majority of key indicators.
- The unit engaged in obtaining feedback from the NHS Friends and Family Test (FFT). At WCH, 100% of respondents on the paediatric ward confirmed they would be extremely likely or likely to recommend the ward for care. 100% of respondents would be extremely likely to recommend SCBU as a place to receive care.

Staff engagement

- Staff in the unit had taken part in the trust staff survey in 2015, published in January 2016. The trust had significantly improved in six of the 60 questions rated and no question responses were significantly worse from 2014
- Staff in the unit had also participated in the national NHS Staff Survey 2015. The trust had improved its overall staff engagement score from 3.50 in 2014 to 3.60 in 2015 however the same remained below national average scores of 3.79. The top five ranking scores related to equal opportunities for career progression, staff reporting incidents, discrimination at work, flexible working and working extra hours. The bottom five

ranking scores related to staff agreeing their role made a difference, staff witnessing incidents, effective team working, recommendations as a place to work and good communication between senior management and staff. The trust executive directors reviewed findings and agreed to focus on three areas namely staff well-being, staff engagement in the sharing of ideas to improve services and improvements in communications between managers and staff. A task and finish group staff survey action group was created to progress these recommendations. This work was on-going at the time of our inspection.

- The unit provided GMC Survey findings for 2016 (trainee responses regarding training programmes under four categories of learning environment and culture, governance, support to learners and developing and implementing curriculum and assessment). There were varying results across the domains. In 11 of the 15 sub-sections, the unit were the same as other trusts. In the remaining four, the unit were below outcome in two (clinical supervision) and above outcome in two (local and regional training).
- The trust communications team distributed regular bulletins, newsletters and uploaded trust information onto the intranet for staff to access.
- A locum consultant described feeling actively involved and integrated into the team at WCH.

Innovation, improvement and sustainability

- The unit was actively involved and engaged in the trust quality improvement plans 2016/17 (QIPs) which identified 17 work streams which required a more detailed improvement focus. In children's services, the unit concentrated on improving the management of the deteriorating child (use of PEWS and sepsis policy), workforce planning and recruitment, reporting incidents and in supporting a safe and learning culture.
- The unit was involved in some limited cost improvement projects (CIPs) around a review of administrative functions however continually monitored and reviewed financial spend.
- A locum consultant implemented a rapid access clinic and a triage system for new appointments.
- Staff on SCBU worked with parents and a local charity to secure funds to improve privacy and dignity on the unit with the purchase of new partition screens.
- The Chief Matron for Children was recognised for outstanding safeguarding practice.
- The unit secured funding to develop PEWS/SBAR cards for all paediatric staff as a personal reference source to improve patient safety and effective communications.
- The unit was working closely with partners under the Success Regime to review children's services to ensure an improved and sustainable model of care for the local people.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure children and young people services meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended).

Action the hospital SHOULD take to improve

In surgical services:

- Ensure there are no inconsistencies with adhering to trust policy in signing for controlled drugs.
- Ensure robust recruitment and retention policies are adopted to cover staff and skill shortages identified on the divisional risk register.
- Identify appropriate mechanisms for supporting the wellbeing of staff during periods of additional pressures.

In children and young people services:

- Ensure staff provide an initial assessment and classification of harm for all submitted incidents in accordance with policy and national standards.
- Continue to monitor on-going medical staffing requirements to ensure safety and sustainability of service.
- Ensure all staff are kept up-to-date with Success Regime progression to reduce anxiety and uncertainty.
- Consider the designation of a clinical lead to reinforce the quality of the unit audit activity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.** How the regulation was not being met: • Children and young people services did not meet all Royal College of Paediatrics and Child Health (RCPCH) - Facing the Future: Standards for Acute General Paediatric Services (2015 as amended). Specifically, the unit did not meet: ▪ Standard 1 – A consultant paediatrician is present and readily available in the hospital during times of peak activity, seven days a week; ▪ Standard 3 – Every child who is admitted to a paediatric department with an acute medical problem is seen by a consultant paediatrician within 14 hours of admission, with more immediate review as required according to illness severity or if a member of staff is concerned; ▪ Standard 4 – At least two medical handovers every 24 hours are led by a consultant paediatrician.