University Hospitals of Morecambe Bay NHS Foundation Trust

Inspection report

Trust HQ, Westmorland General Hospital
Burton Road
Kendal
LA9 7RG
Tel: 01539732288
www.uhmb.nhs.uk

Date of inspection visit: 4 & 5 April 2023 and 15 - 18 May 2023
Date of publication: 23/08/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) provides hospital services across the Morecambe Bay area - an area covering a thousand square miles in south Cumbria and north Lancashire.

It operates from three main hospitals - Furness General Hospital (FGH) in Barrow, the Royal Lancaster Infirmary (RLI), and Westmorland General Hospital (WGH) in Kendal.

FGH and the RLI have a range of general hospital services, with full emergency departments, critical/coronary care units and various consultant-led services. WGH provides a range of general hospital services, together with an urgent treatment centre.

All three hospitals provide a range of planned care including outpatients, diagnostics, therapies, day case and inpatient surgery. In addition, a range of local outreach services and diagnostics are provided from community facilities across Morecambe Bay.

We carried out an unannounced inspection of the medical care core service at Royal Lancaster Infirmary and the maternity core services at Royal Lancaster Infirmary and Furness General Hospital.

Following our previous inspection, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activities of diagnostics and screening and treatment of disorder, disease and injury for both medical and maternity services.

The trust made an application for the conditions to be removed in March 2023. The trust was inspected to assess whether the required improvements, had been made and sustained.

As a result of the evidence submitted by the trust and gathered during our inspections of the core services, we agreed to remove the conditions in June 2023.

Our findings

Outstanding practice

Maternity – Royal Lancaster Infirmary

We found the following outstanding practice:

- The maternity services had developed and piloted "HOPE" boxes for those women who were separated from their babies either permanently or temporarily and had won an award for the work.
- The maternity services carefully planned in a multidisciplinary way, those complex births that may require input from safeguarding, children's services and mental health services and ensured that the possibility of a premature birth was taken into account.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must operate an effective complaints procedure which includes providing timely responses and updates to complainants. Regulation 16(2).

Maternity – Royal Lancaster Infirmary

- The trust must ensure that mandatory training completion rates are in line with trust targets. Regulation 18
- The service must ensure that there is a clear protocol for identifying women for prioritisation of induction of labour and that it is recorded in the care records. Regulation 12
- The service must ensure women receiving maternity care, who are assessed as at risk of sepsis, have their care and treatment recorded in line with national guidance. Regulation 12

Maternity – Furness General Hospital

- The service must ensure that there is a clear protocol for identifying women for prioritisation of induction of labour and that it is recorded in the care records. Regulation 12
- The service must ensure women receiving maternity care, who are assessed as at risk of sepsis, have their care and treatment recorded in line with national guidance. Regulation 12
- The service must ensure they remove equipment when out of service. Regulation 15
- The service must ensure medical staff are compliant with their mandatory training including safeguarding level 3.
- The service must ensure staff follow the most current evidence-based care and treatment for fetal monitoring, post-partum haemorrhage and shoulder dystocia proformas. Regulation 12

Our findings

- The service must ensure hand gel expiry dates are compliant and the environment is visibly clean with cleaning schedules appropriately completed. Regulation 12

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider continuing to pursue plans for development and investment in pharmacy workforce, to make sure medicines reconciliation rates and antimicrobial stewardship improves across the trust.

Maternity – Royal Lancaster Infirmary

- The trust should ensure that the plans to redesign the department are progressed in a timely way so that the bereavement suite can be reopened and oversight of patients waiting to be triaged can be always maintained. Regulation 15
- The service should consider employing a housekeeper for the ward area.
- The service should consider the improvement of internet connectivity in the department.

Medical Care - Royal Lancaster Infirmary

- The trust should continue to pursue plans for development and investment in pharmacy workforce to support continued improvement in medicines optimisation, medicines reconciliation rates and antimicrobial stewardship.
- The trust should ensure that all nurse appraisals are completed in a timely manner.
- The service should ensure staff complete mandatory training in accordance with the relevant schedule.

Maternity – Furness General Hospital

- The service should ensure there are sufficient blood pressure monitoring equipment Regulation 15
- The service should continue to monitor and review antimicrobial stewardship and prescribing in sepsis. Regulation 12
- The service should continue to ensure staff complete VTE risk assessments at appropriate times throughout pregnancy and following birth. Regulation 12
- The service should continue to develop a long term vision and strategy through engagement with staff, focused on sustainability and aligned to local plans within the wider health economy. Regulation 17

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Senior leaders demonstrated adequate experience, knowledge and capacity to lead effectively. They were aware as a collective that the leadership team was newly formed and that embedding of interpersonal relationships would require a degree of time. Since our last inspection, there had been an improvement in the view that all executives were visible and approachable.

Our findings

Challenges for the organisation to deliver and sustain improvements were well understood by the executive team. This included, being sighted on a historical cyclical nature of the trust demonstrating an improvement, only to then experience a drop in standards and outcomes.

The trust had a much-changed leadership team to that of our last inspection two years ago. We found that the leadership team worked cohesively; there was a self realisation from executive leaders, that embedded relationships were still within a formation period.

The chief executive (CEO) was appointed in 2018 and continued to be in post. They previously held the roles of director of finance and deputy chief executive for the trust from 2014.

The Chief Medical Officer (CMO) joined the Trust in November 2021, initially on an interim basis, which was later made substantive. The Chief Nursing Officer (CNO) joined the Trust in May 2023 two weeks before our inspection. The Deputy Chief Executive/Chief Financial Officer had been in post since February 2021 and undertook a wide portfolio. The Chief Operating Officer (COO) joined the trust in June 2022. The Chief People Officer (CPO) started in January 2023 and the Director of Governance in November 2021.

Several members of the executive team had experience at board level in a previous role, which complimented other executives who had worked in the trust in different roles prior to their executive appointments. Since our last inspection we noted that a breadth of executive leadership experience gained outside of the trust, had improved. As an example of this, the trust had recently appointed a public health consultant to develop how the trust addresses health inequalities within its service and the local communities.

As found at our last inspection, the trust chair was appointed in early 2020. They had a background in academia having worked in a variety of education and health roles. In 2022 they had been ratified as the new Chair of the Lancashire and South Cumbria Provider Collaborative Board (PCB).

The non-executive directors (NEDs) had a diverse range of leadership experience in the sectors of health and social care, finance and education. Most of the NEDs had been appointed in the time since our last inspection. The most recent appointments included bringing in expertise from a former chief executive officer of a large metropolitan borough council. The NEDs chaired the trust committees, which reported to the trust board.

Overall, staff we spoke with were complimentary about the visibility and accessibility of the executive team, which was a noted improvement since our last inspection.

Since our last inspection, board development activity had improved. An external organisation with specialism in leadership and management, coaching and training had been commissioned; this provided support and developmental opportunity to the executive team in identifying problematic issues and resolutive action. Audit findings from this were presented at trust board in March 2023.

Board development had been further supported by the new CPO with a programme of areas of focus over the forthcoming year; finance, quality and safety, performance and workforce wellbeing.

The Board showed awareness of the trust's difficult issues and challenges. There was a willingness to improve and deliver sustainable services for patients, with a crystalised attitude to ensure continuous sustained improvement. The board's professional curiosity had improved, however there remained a slight theme of accepting reassurance given, rather than seeking assurance.

Our findings

Pace and urgency of action had improved; most of the improvements required had been made since the last inspection. To deliver these improvements the trust was supported by NHSE. Following the last inspection, the trust was placed by NHSE into segment 4 of the national system oversight framework (SOF4). This meant it was in the NHSE Recovery Support Programme, and therefore received mandated support. This intensive support, including an improvement director, is intended to address the often complex, historical problems trusts face, and embed lasting solutions. Through this process an improvement plan was developed which was monitored through a System Improvement Board (SIB) on a monthly basis. The membership of the SIB included the trust, NHSE, the ICB, CQC, other system partners and key stakeholders. Where actions had not been completed, estimated dates and actions plans were in place.

Where areas of concern had previously been identified, work had been undertaken to achieve better outcomes. For example, an external review of the trust's leadership had been undertaken, with recommendations that were being implemented.

In addition, maternity services at the trust were placed in NHS England's Maternity Safety Support Programme (MSSP). The programme provides strategic support to maternity services previously rated requires improvement or inadequate.

A council of governors was in place, however we had concerns about the effectiveness of the body in working collaboratively as a Council and with the wider trust. This meant that, if the prevalent issues were not adequately addressed, the governing body could become a barrier to the overall effective governance of the trust. However, we noted that this had been identified by both the trust and an externally commissioned audit. A process was being implemented to address the issue.

The trust had 23 governors; this included 14 public governors, 5 staff governors and 3 appointed governors from 2 local universities and one local authority. During our inspection, the governors told us there was no structured induction or training in place to support them in this role.

We had concerns about the effectiveness of the trust's governing body. It was felt that this could, if not adequately addressed, become a barrier to the overall effective governance of the trust. We noted that this had been identified by the trust and an external report and that this was in the process of being addressed.

The trust operated through five care groups; medicine; surgery and critical care; women's and children's; core clinical services; and integrated community. Each care group was led by a triumvirate of a clinical director, an associate director of nursing or equivalent role and an associate director of operations. The care group triumvirates were supported by Obstetric Clinical Leads and service managers within the relevant groups.

Local leadership of the core services we inspected, had improved since the last inspection. For example, within leadership of the maternity services and the medicine care group (which covered both medicine and emergency care), we found positive evidence regarding improving outcomes and metrics. However, we also found that some staff felt local maternity leaders were not approachable and lacked visibility.

Increased pharmacy support to the emergency department and medical admissions, had successfully delivered a sustained improvement in rates of medicines reconciliation from ~35% December 2021 to currently maintaining ~60% overall trust performance following a step change in August 2022. To support further improvement, a business case for expansion of clinical pharmacy services focused on non-elective admissions for example, at weekends was being revisited.

Our findings

Pharmacy workforce health and wellbeing was acknowledged as a risk (rated 12). Occupational health support sessions had been booked to support pharmacist pressure. For example, pharmacist capacity to support clinical audit and multidisciplinary team meetings in ED was limited.

However, extended hours pharmacist support to the emergency department was being piloted to assess the benefits of increased deployment. Similarly, there was only limited capacity within the pharmacy team to attend medical speciality 'Get it Right First Time' meetings to support cost improvement work. Skill mix within the pharmacy team meant that wards generally had dedicated technician support with pharmacist support provided through a blended model remote and face-to-face ward presence.

The trust had a designated mental health and safeguarding lead within one role. This role had an aligned portfolio of mental capacity, mental health, safeguarding and oversight of the deprivation of liberty safeguards. The lead was supported by a deputy who undertook responsibility for operational aspects, allowing the lead to focus on strategic goals and aims. We found that the mental health and safeguarding function had good insight and overview of the risks and challenges pertinent to their remit.

The trust had also implemented a programme of trained learning disability champions. At the time of our inspection there were 63 staff carrying out this role who were overseen and supported by the safeguarding lead.

Fit and Proper Persons Regulation (FPPR)

The provider's fit and proper person procedure was fit for purpose and the files were in line with the requirements of the regulation.

During our well led inspection, we undertook checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

This regulation ensures that directors of NHS providers who have responsibility for the quality and safety of care, and for meeting the fundamental standards, are fit and proper to carry out this important role.

We reviewed 8 director personnel files in total. Our review included checks for executive and non-executive appointments.

We found that appropriate FPPR checks had been completed within all personnel folders we reviewed. The trust completed the required checks initially and on an ongoing basis, to evidence compliance with the requirements of the regulation.

The trust's employment checks policy required two employment references for all newly employed directors. Each of the 8 files we reviewed included two employment references for the appointed director.

All files included records of interviews and checks with professional bodies, where applicable, and national registers including the insolvency register.

The trust used a mixture of paper and electronic staff files to store information for the fit and proper persons requirements.

Our findings

Vision and Strategy

The trust had a refreshed vision for what it wanted to achieve and a strategy, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply and implement plans and monitor progress effectively.

Following our last inspection, the trust had refreshed its vision and strategy. The trust's purpose was to 'deliver compassionate care and the best results for the people of Morecambe Bay' and had a vision to do this by 'creating a great place to be cared for and a great place to work'.

The trust's values had also been remodelled to incorporate the following statements:

- We are Compassionate
- We are Respectful and Inclusive
- We are Ambitious
- We are Open, Honest and Transparent

Each value had an underlying set of driving principles to be able to achieve what was needed. This evidences that the trust had considered what type of organisation it wanted to be and how to put this into practice.

The current trust strategy 'Putting Patients First - Our Strategy 2022 – 2027' was approved by the Board in April 2022 and covered four priorities:

- Deliver outstanding care and experience
- Create the culture and conditions for our colleagues to be the very best they can be
- Making the best use of our physical and financial resources
- Working in Partnership

The strategy focused on the changes to health and care systems, the challenges that will be faced and the benefits of a healthier living population within the Morecambe Bay locality.

We reviewed the trust's 'plan on a page' document for each core service or team, for the financial year of 2023/24. For each core service or team, departmental-specific tasks and actions were mapped to the above four key priorities. The plans also documented the service or team triumvirate leads and a section which detailed key risks. This evidenced that the trust's strategy had a good level of local embedding.

From our interviews, we noted that trust executives and senior managers could coherently articulate organisational priorities.

Our findings

The trust recognised that the strategy was ambitious and would be a significant undertaking. The implementation of the strategy was underpinned by two aspects. Firstly, by means of 'enabling strategies'. This considered specific areas or themes which included quality, finance, inclusion and people. Secondly, the trust had focussed on how the strategy could develop and remain relevant in increasingly challenging times for healthcare providers and wider systems. The trust hoped to articulate this aspiration by way of the following:

- Clinical strategy and delivery plan
- Business planning, team and personal objectives; and
- Five year delivery plans e.g. people, digital, capital

We also noted that the trust had the following the enabling strategies, which were either approved or in development, to support delivery of the overarching Trust Strategy:

- Clinical Strategy
- Finance Strategy (approved at Trust Board in June 2023)
- Quality Strategy (awaiting PSIRF Trust priorities)
- People Strategy
- Leadership Strategy (under development following revision of People Strategy)
- Continuous Improvement Strategy
- Patient Experience Strategy
- Estates Strategy
- Equality, Diversity and Inclusion Strategy
- Digital Strategy

The trust was also part of longer term and system wide strategies such as the new hospitals programme. Immediately after our inspection, it was announced that a new hospital would be built to replace the Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030. This was also stated to include investment in improvements to Furness General Hospital.

The trust's five-year pharmacy and medicines optimisation strategy was being refreshed to align with the trust's clinical service delivery plan 2023-28. Additionally, there was a focus on working with providers across the ICB to support delivery of a system-wide approach to medicines optimisation priorities including workforce transformation, the discharge medicines scheme and pharmacy support to virtual wards.

Our findings

In recognition of the NHS England vision for pharmacy technicians, there was a focus on investment in clinical training to support extension of their roles for example in antimicrobial stewardship and medicines reconciliation. There was a similar focus on continued development of pharmacist prescribing in advance of pharmacist graduates having prescribing rights from 2026.

Culture

Culture within the trust had mostly improved, however in some services, issues remained. Services where culture had been poor in the past, represented key areas where improvements were still required.

The trust was committed to further developing an open culture where patients, their families and staff could raise concerns without fear, with executives expressing a genuine willingness in treating concerns as potential learning opportunities.

The trust recognised that challenges regarding its organisational culture continued and had not been fully resolved since the last inspection. The trust had designed a cultural transformation programme which had been in delivery phase since July 2022, with a recognition that any change in culture can take three to five years to embed.

This was further developed, following the results of the trust's national NHS staff survey feedback in early 2023, the work of the programme was ongoing, with the trust having identified the overall goal of improving psychological safety remaining a high priority.

In the national staff survey 2022, levels of bullying and harassment of colleagues had increased slightly from the previous year.

Some improvements to culture had been affected by ongoing high profile media attention from historical cultural concerns in some areas of the trust. This coverage was a reflection of the lengths of time that any investigations and reports require to conclude and the associated interest that generates. The trust recognised the areas for improvement that were highlighted by external reports and were actioning these.

In the staff survey (2022) 54.3% of respondents agreed or strongly agreed that they would recommend the trust as place to work. This was slightly under the England average of 57.4%. This had decreased from 56.3% in 2021 and maintained an overall downward trend since 2018.

There were 55.0% of respondents who would be happy for a friend or relative to receive the standard of care at the trust. This had decreased from 59.2% in 2021. This was lower than the England average which was 62.9%. Again, this continued an overall downward trend since 2018.

When asked about wellbeing, the 2022 survey results showed that 59.9% of respondents said they felt the organisation took positive action on health and wellbeing. This was higher than a national average of 56.5%. There were 67.6% of respondents who felt that their immediate manager took a positive interest in their health and wellbeing. This was against the national average of 67.4%.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had an occupational health and well-being team. Between February 2022 and February 2023 trust sickness rates fluctuated between 5.00% and 7.05% with a mean monthly sickness rate of 6.07%.

Our findings

The trust worked appropriately with trade unions. Trade union representatives were positive about relationships with the trust and told us that senior managers engaged well with unions. The trust recognised staff success by staff awards and through feedback. The trust supported staff to achieve national recognition and awards.

Following Sir Robert Francis' Freedom to Speak Up (FTSU) review in 2015, NHS England and NHS Improvement expected all NHS organisations in England to adopt the Freedom to Speak Up: Raising Concerns policy for the NHS (April 2016), as a minimum standard.

The trust had 3 Freedom to Speak Up Guardians (FTSUGs) who provided an independent staff liaison service. The FTSUGs provided a service by which staff could raise concerns, worries or risks in their workplace. They worked closely with the National Guardian Office (NGO) and attended FTSU workshops, regional network meetings and FTSU conferences.

The FTSUGs were supported by approximately 22 respect and civility champions; these were staff who were employed across the care groups and the hospital sites. The respect and civility champions were part of a broader team of 130 champions who had FTSU training. Their role was to signposted staff accordingly and extend the influence of FTSU in the Trust. In addition, the service had support from the board with a named non-executive director (NED) and executive director.

The FTSUGs attended trust induction to speak to new staff and saw this as an opportunity to promote the service and change the culture at the trust. A new FTSUG had recently been appointed; they were an international recruit who provided support and understanding to other international staff. The team liaised with the international recruitment team to encourage international staff to speak up; they were provided with a welcome pack ensuring they knew their rights as an employee of the trust.

We reviewed the trust's freedom to speak up policy. It was in date, detailed the roles and responsibilities of colleagues of all seniorities and provided a structured process. The policy also detailed the system in place for senior leadership oversight. The FTSUGs reported a good working relationship with the executive leadership team and the assigned NED.

Freedom to speak up training had been implemented at the trust and all staff were expected to complete this. Each member of the board completed the training which, the team felt, set a precedent within the trust.

The FTSUGs were aware that their visibility increased contact from staff within the trust; they had implemented different ways of reaching staff and marketing their services. An example of this was the use of QR codes displayed in community settings, making the service more easily accessible.

The FTSUGs were required to provide an annual report to the board of directors. The reports set out the number of concerns raised to the service and the themes and trends identified. The trust had developed action plans to address the concerns.

We reviewed the latest freedom to speak up update, which had been provided to the board in January 2023. This provided the board with an overview of training, the launch of a new electronic app and case management system, an executive summary and key metrics about the initiative.

Our findings

In the staff survey 2022, 56.5% of respondents felt safe to speak up about something that would concern them in the organisation. This was worse than the England average of 60.3%. This figure increased for respondents who would feel secure raising concerns about unsafe clinical practice to 66.7%, however this was again worse than the England average of 70.8%.

Although policies and procedures were in place and there were suitable mechanisms for board oversight of freedom to speak up, the trust continued to recognise that it was required to improve psychological safety in staff being confident to speak up.

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.

Staff in frontline services knew about the Duty of Candour and how to apply it in practice. As part of our inspection, we reviewed 7 serious incident investigations completed by the trust. The trust appeared to apply the Duty of Candour correctly in each of the records.

Inclusion and Diversity

The trust promoted equality and diversity in daily work and provided opportunities for career development, although there was still work to do in this regard.

The Workforce Race Equality Standard (WRES) is a requirement for NHS healthcare providers through the NHS standard contract. WRES aims to provide measurable and meaningful indicators of equality performance within an organisation, from which they can develop and improve, including ensuring employees from ethnic minority groups have equal access to career opportunities and receive fair treatment in the workplace. It can be an important metric to evidence how inclusive and diverse an organisation is.

The WRES and Workforce Disability Equality Standards (WDES) reports for the trust demonstrated there was a lack of diversity in senior leadership posts. The trust was addressing this with the aim of improving the diversity of the board. At the time of our inspection, we saw proactive measures in place to encourage and support board level applications from people from ethnic minority groups.

Data from WRES, was presented to the board of directors and governors in September 2022. Data showed that 29.1% of staff from a black and ethnic minority background had experienced harassment, bullying or abuse in the previous 12 months from other staff. This was a 27% improvement on the figures, for the same, in the previous year. We were told that this year each executive has had an EDI objective.

There were 18% of respondents from ethnic minority staff who felt they had personally experienced discrimination from a colleague or team leader in the last 12 months. This compared slightly worse than the England average of 17%.

The WRES action plan used SMART objectives and clearly outlined a range of initiatives to address these results which included the following themes: to recruit and develop inclusive leaders, improve routes to speak up, support and empower staff, and deliver targeted support.

Our findings

During our inspection of the maternity core service, some staff at the Furness General Hospital site continued to report their experiences of racism, despite work being undertaken by the trust to tackle this. This had been added to the hospital's risk register, with actions and mitigations monitored at the monthly risk meeting.

Again, whilst policies and procedures were in place and there were suitable mechanisms for board oversight of reducing racial discrimination, the trust continued to recognise that improvements were required, to improve attitudes and behaviours toward diversity.

We found an example of a Director who was participating in a regional reverse mentoring scheme, which demonstrated the Trust's commitment to recognise the risk of bias within the Trust.

In the NHS staff survey, 2022, 85.5% of respondents said that the trust encouraged staff to report errors, near misses or incidents. The latest result was similar to the England average of 86.1%. There were 53.7% of respondents who felt that the organisation treated staff who are involved in an error, near miss or incident fairly, compared to the England average of 58.2%.

The five-year inclusion and diversity strategy, that included both patients and staff, had been updated and covered the period from 2021 - 2026. The strategy was comprehensive in its vision. Board oversight was maintained via a Positive Difference Action Plan Annual Report which had been presented to the executive team, most recently, in July 2022.

At our previous inspection in 2021, we found the trust had a positive accessibility and inclusion offering for patients who used the service. At this inspection. we found that this continued to be an accurate reflection.

Staff networks were in place to support staff from a range of backgrounds. The trust had established a staff network for people from ethnic minority groups, the women leaders' network, the Armed Forces network, the LGBT network, the carers network and the disability equality network. Each network had a chair and an executive lead who attended network meetings and events; the network chairs told us that the executive leads supported them well.

The staff network leads sat on the trust's Equality, Diversity and Inclusion group which reported to the board of directors via the people committee.

The trust is one of only 24 NHS trusts in England to have achieved the Defence Employer Recognition Scheme (ERS) Gold Award in recognition for their commitment to the Armed Forces community through the Armed Forces network.

With the support of the disability equality network, the trust was awarded Disability Confident Leader (level 3) status. This scheme helps disabled people into work and ensures employers using the scheme take a positive approach to disability during recruitment of new staff. Level 3 is the highest level of the disability confident initiative, and the trust was one of only 40 NHS trusts to achieve this.

Governance

The arrangements for governance were mostly clear and demonstrated improvement. External support continued to develop governance processes throughout the trust and with partner organisations. Staff were broadly clear about their roles and accountabilities. Processes were effective; however, timely completion could be a challenge.

Our findings

A lot of work had clearly been undertaken in improving governance, performance and risk management since the last inspection. The trust was now at the point of devolving these areas, where appropriate, to the care groups and services. These systems and processes were not yet embedded.

The Trust has a Director of Governance who is responsible for Patient Safety, Health & Safety, Risk Management, Clinical Audit and Effectiveness, Library & Knowledge Services, Compliance & Assurance, PALS & Complaints, and Claims and Litigation.

Each executive director held their own portfolio for management responsibilities.

The trust had a number of board level committees which were chaired by a non-executive director. These committees included audit, people, quality, finance and also specifically in relation to maternity services, an Ockenden action plan.

The trust continued to receive support from external stakeholders and system partners to improve governance areas. We found promising evidence that the board could further develop capacity and processes to ensure that any changes made, were maintained once the support ended. This had been reflected in the system improvement board (SIB) and the proposal to support the trust moving to SOF3 in the NHSE's single oversight framework.

The trust had been the subject of various independent reports, which had been commissioned by the trust and NHS England. The reports considered historically problematic areas within the trust. The latest report was published in November 2021, which was after our last inspection. The assurance review of the trust was published in June 2023, shortly after our on-site inspection. The report states, "Progress has been made in relation to all recommendations, but particularly in key clinical areas that presented patient safety risks."

The trust had commissioned an external audit of the trust's leadership, which had been published in March 2023. Recommendations of this audit, with regard to governance included reducing duplication. This indicated that not all required improvements had been embedded fully.

There was a scheme of accountability and delegation, which set out the executive responsibilities with clear delegated limits. The trust had an accountability framework which enabled ward to board performance reviews of the following:

- Quality
- Safety
- Operations
- Finance
- Workforce/OD/People/Culture

There were clear committee reporting structures in place to support improving governance. The governance processes in place ensured there were opportunities for the senior leadership team to discuss and learn from the performance of services, including reviewing actions taken to mitigate risk.

Our findings

As part of the SIB, improvement plan actions/updates had been provided on a monthly basis. These updates, which tracked recommendations of varying reports, provided information on target dates of completion. A red, amber or green (RAG) rated colour system indicated if it was on target.

In May 2023 the trust reported that all 61 of the 'must do' requirements from the previous CQC inspection have been completed and 47 of the 51 'should do' recommendations were complete. There were five actions linked to the four remaining 'should do' recommendations outstanding, which were being monitored for completion by the quality assurance committee.

The external well led audit of March 2023, highlighted that the format of the Board Assurance Framework was in line with good practice, however there were areas suggested where the trust could consider evolving to improve the effectiveness of the BAF. This was with an aim of providing greater connection to performance reporting, and clarity on gaps in controls and assurances.

Assurance committees monitored and reviewed the board assurance framework (BAF) to ensure it was effective and reported to the board on the assurances. The BAF detailed the trust's four key strategic aims.

At the time of the inspection, the processes of identifying and managing patient safety issues had improved. An example of this was the improved outcomes of the stroke pathway within the trust. During the inspection of the core services and when considering national audit data, we identified a trend of improvement.

Following our last inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to take urgent enforcement action and placed conditions on the provider's registration. The trust made an application for the conditions to be removed in March 2023. As a result of the evidence submitted by the trust and gathered during our inspections of the core services, we agreed to remove the conditions in June 2023.

During our inspection of the medical care and maternity core services, we found evidence which demonstrated an improvement in both; governance and oversight of risks and long-term sustainability. For further information please refer to the well led sections of the maternity and medical care core service reports.

We reviewed a copy of the trust's audit plan for 2023 – 2024. It included varying types of required audit, for example National, National Institute for Health and Care Excellence, Commissioning for Quality and Innovation and Royal Colleges. The scheduled audits were RAG rated for priority and clearly detailed both the time period covered and the colleague who would be auditor and supervisor.

Oversight of the audit schedule and compliance was described within the plan as "Any audit activity which is not progressing in accordance with the plan will be detailed through the reporting processes so that appropriate action can be taken by the care group. If this is not resolved, it will then be escalated and reported as an exception to the Clinical Audit & NICE Steering Group (CA&NSG)".

We reviewed the April 2023 report for internal audit. This reported "Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently." The audit considered this assurance in "the context of organisations across the NHS is facing a number of challenging issues and wider organisational factors particularly with regards to the ongoing pandemic recovery response, financial challenges and increasing collaboration across organisations and systems."

Our findings

The trust Medicines Safety Group provided scrutiny and oversight of all incidents and risks involving medicines. 3 A's (Alert, Advice, Assure) reporting had been implemented to provide updates from reporting committees to the trust's Medicines Management Drugs and Therapeutics Group (MMDTG) and ultimately to the board, via the Quality Governance Group.

Separately, the Pharmacy Quality & Business meeting provided assurance to the Core Clinical Services Care Group Quality meeting that pharmacy issues and risks were managed effectively. The trust's Controlled Drugs Accountable Officer ensured that the required controlled drugs quarterly reports were submitted to the Local Intelligence Network.

The Chief pharmacist was focussed on strengthening connections with clinical leads and engagement with the care group reporting structure. Care Group representation at MMDTC and pharmacy representation at Care Group governance meetings helped to ensure that information for example, changes to policy, and learning from medicines audit was shared at ward level.

Appropriate governance arrangements were in place in relation to the administration and compliance with the Mental Health Act. The chief nurse and the head of safeguarding and professional lead were responsible for oversight and monitoring of the use of Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act (MCA) and the Mental Health Act (MHA) across the trust.

Management of risk, issues and performance

Risks, issues and poor performance were adequately sighted on and mitigated at board level. Systems to manage performance had improved and the risk management approach reflected the trust's overall commitment to sustainability of quality outcomes.

Mechanisms were in place for services to escalate, prioritise and manage risk up to and with senior leaders.

Whilst there continued to be some reliance on external parties to support the identification of key risks, there had been improvement with internal management, appetite and mitigation. The trust had plans to cope with unexpected events.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions.

In interviews with executives and senior leaders, they were clear about the trust's top risks and articulated a coherent consistent narrative. These included the health and wellbeing of staff, trust finances and embedding quality improvements to ensure safe care. This mirrored the risks identified in the BAF.

The trust completed risk registers at care group and corporate level. We found these mostly reflected the key risks and requisite urgency of actions to assure safe service provision. Risk appetite was documented for key areas and aligned to an ethos of accepting a higher tolerance for risks and opportunities, which had the potential to deliver transformation.

We found evidence that risks identified were relevant and monitored effectively to provide assurance that actions had been taken. For example, the corporate risk register specifically considered the prevalent risk of BAME colleagues having a poorer experience at work. We noted that all risks had a named assessor, manager and the dates of last review and next due.

Our findings

We were told how the trust proactively worked to tackle health inequalities in the community. Patient engagement was increased to seek the views of people in the local area regarding accessibility of the trust and their experiences with the trust.

The trust was working with a public health consultant who reviewed population health management. This link with public health enabled the trust to proactively target specific health issues within the community. An example of this was the support offered to local GP services to facilitate home visits for patients who did not want to visit the hospital for some treatment plans.

We reviewed evidence that training was provided to leaders so that they could approach, appraise and mitigate risks at varying levels. A review of the risk assessment training matrix had been presented to the risk management group in February 2023. This recommended acknowledging a proposed training matrix which would 'clarify expectations in order to embed consistency and a culture of good risk management'.

The estates function sat within the portfolio of the Chief Operating Officer, who was supported by a Head of Estates and Facilities. We reviewed information which evidenced a backlog in maintenance tasks which were required to achieve the relevant Category B hospital status. The cost of completing the tasks was estimated to be in the region of £130 million. The Trust had registered the risks of the Royal Lancaster Infirmary site with the new hospitals programme.

There was a focus on improved oversight of antimicrobial stewardship (AMS). The pharmacy AMS team was working collaboratively with trust Infection Prevention and Control (IPC) on C. difficile, a priority for the ICB. The number of antimicrobial C. difficile risk reviews had increased from less than 50 in September 2022 to 350 in March 2023 (trust data). Additionally, empirical guidelines were being developed for oral and maxillofacial surgery to reduce the risk of infection and to optimise choice of antimicrobials, minimising the use of medicines most associated with increased risk of infection with Clostridium difficile.

Baseline antimicrobials audits were underway focussed on antimicrobial choice and review. Progress was shared with trust IPC but feedback was not yet provided at ward level due to a lack of capacity in the AMS team. However, a user-friendly format for sharing audit outcomes with wards and prescribers was in development to help drive improvement. The trust performance was in line with the regional average for the sepsis measure, antibiotics within 1h (March 2022 to Feb 2023). The clinical lead for Sepsis had recently re-introduced monthly Sepsis, AKI and VTE steering group meetings for all care groups with the aim to improve all aspects of Sepsis care.

The trust monitored performance by way of dashboards and key metrics. Regular updates had been provided, as part of the trust's participation within the system oversight framework. The trust continued to experience the impact of the COVID-19 pandemic regarding performance and outcomes for patients.

In March 2023, the 18-week consultant led referral to treatment times had shown a small decreasing trend for the previous eighteen months and was reported as 67.5%. Also as of March 2023 there were 1,089 patients who had waited more than 52 weeks. Alternate patient pathways had been explored including virtual wards and clinics and the operation of a same day emergency care provision (SDEC).

Cancer waiting metrics, as of March 2023 included the following. The proportion of patients seen by a specialist within two weeks of GP referral were 93.89% against a target of 93%. The 62-day wait for patients referred with suspected cancer was 64.93% against a standard of 85% and 31-day treatment performance for patients was 89.66% against as standard of 96%.

Our findings

Leaders were sighted on infection prevention and control by way of an annual IPC report to the board. This included an overview of the trust performance against measurables and associated actions and planning.

During our inspection of the core services, we noted evidence of variance in IPC standards at Care Group level. For example, within the medical care service we found no evidence of IPC issues at recorded high percentages of audit. However, as part our maternity core service inspection, we did find IPC issues which required escalation. We subsequently received the trust's assurance both; on the day and following the inspection.

The trust was aware of the financial challenges it had as well as those of the wider system. There were clear plans in place to monitor and manage these financial challenges; this included developing Quality Impact Assessments and Equality Impact Assessments to ensure patients and the local community received equitable services.

The trust had managed and prioritised cost improvement programme plans and finished the financial year 2022/23 with over 70% recurrent savings.

At the time of the inspection, the trust planned to spend £515 million in 2023-24 delivering services to its population and to achieve its financial targets. £42.4 million of this total expenditure was classed as capital.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had developed into a much improved data driven organisation, which was demonstrated in the Integrated Performance Report (IPR) and use of statistical process control (SPC) charts. There was a self realisation that significant challenges would lie ahead for the development and implementation of a new electronic patient record system which was planned over the coming year.

The board received information to review performance and delivery of care. The leadership team were committed to using data including SPCs.

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Systems were in place to collect data from wards and teams.

Feedback surveys were sent to people accessing the services of the trust; this captured information relating to the local population, including protected characteristics, enabling the trust to make improvements. An example of this was where the trust updated complaint response letters to use more inclusive language.

Information technology systems were secure, to prevent unauthorised access to information. The trust had an information and digital management governance group which fed into the quality committee to ensure risks, concerns and issues were escalated accordingly.

The trust acknowledged the need for a new electronic patient record (EPR) system and recognised the importance of its compatibility and ability to interface with other systems used within the integrated care system. Risks associated with the new system implementation had been identified and a task list assigned to a working group for action.

Our findings

Patient passports were utilised for people with additional needs such as learning disabilities, autism or dementia. These were accessible to staff within patient electronic notes. There were forms available for both adults and children. The trust acknowledged however that progress for this continued to be required as a number of patients were still without such.

There were effective arrangements in place to ensure data and notifications were submitted to external bodies as required.

An outline business case had been drafted in preparation for replacement of the trust's current ePMA (electronic prescribing and medicines administration) in Q3 2025.

The Caldicott Guardian worked with the senior information risk owner (SIRO) and processes were in place to ensure data was protected.

The SIRO was a member of the executive team and had completed SIRO training in 2022. They were supported by a number of clinical system safety officers and information asset owners. We were told audits were completed which provided the SIRO with assurance.

Cyber security training had been arranged for the board.

There had been only one incident reported to the Information Commissioner's Office (ICO) in 2022/23. There were no adverse findings from this incident.

The trust had an Information Security Policy; this was due for renewal in 2022, but this date was extended due to ongoing "Office of SIRO" concept development. The policy review date was extended to September 2023.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

During our inspection, positive stories were shared with us about staff and patient engagement. These included ethnically diverse patients and those with protected characteristics and pointed towards improvement in addressing health inequalities. There were areas still to be developed to effectively use all the information gained from this engagement for improvement.

The trust had a patient experience strategy which was signed off in May 2023; this identified four strategic priorities:

- Enhance patient experience
- Carer and public involvement
- Volunteering
- Patient Safety Incident Response Framework (PSIRF)

Our findings

At the time of our inspection, we were told that the trust had approximately 160 active volunteers. The patient experience team were working to maximise the contributions made by volunteers and were actively recruiting more voluntary staff at the trust.

A handbook detailing the PSIRF process was being developed for patients and their relatives. The trust engaged a patient focus group to ensure the content of the document was right for the target audience.

Each board meeting began with a patient story; this was provided by the patient experience team.

The executive team recognised not all staff felt valued and respected. This had also been raised though the staff survey. The executive team acknowledged more work was required in this area. They also recognised that staff engagement was an area for further development and were planning on reinstating visits to clinical areas.

Opportunities to engage with patients was being sought. For example, as part of the initiative at WGH for next day discharge for patients following some hip and knee surgery. The pharmacy team planned to deliver a medicine session as part of 'Joint School' prior to admission and was planning to trial supporting written medicines information with patients in July 2023.

Patient feedback was collected and used to target future engagement to ensure all patient groups were reached. We heard that approximately 80,000 patients gave feedback on the trust in 2022/23. On review, the patient experience team realised that under-18's and older people's views were not strongly represented.

The trust have implemented the use of live QR codes to seek feedback from people on wards. It has also re-introduced paper feedback to ensure all people accessing trust services have the opportunity to give feedback.

The trust introduced a new process where all discharged patients would be contacted the following day. Data goes down to ward level and is validated every day. There is a minimum 15% response rate target.

The Friends and Family Test (FFT) gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment. The trust had a response target of 15%, but at the time of our inspection were receiving responses from 14% of patients contacted.

Friends and Family Test results were grouped into three areas: outpatients, inpatients, and A&E. Results were presented in the trust's Integrated Performance Report. Results in February 2023 showed that 93.3% of the patients who responded rated the trust overall as good or very good.

People rating their experience as positive whilst receiving care as an inpatient equated to 92.4% of respondents. There were 12 comments logged against inpatient services where respondents rated their experience as very poor or poor. The 12 comments were broken down to 11 for the Royal Lancaster Infirmary site and 1 for the Furness General Hospital site. There were no themes identified in the comments.

Patients receiving care in the trust's accident and emergency departments were less positive with eight of the 12 patients who responded to the Friends and Family Test rating their experience as poor or very poor. The Royal Lancaster Infirmary site received 41 comments relating to long wait times. A total of 86.8% of respondents rated their experience as good or very good.

Our findings

The trust monitored both formal complaints and informal complaints received for each directorate. Between April 2022 and December 2022, the trust received a total of 283 complaints. The Medicine and the Surgery and Critical Care groups consistently received the most complaints, having received 53% and 25% of complaints, respectively.

As part of our inspection, we reviewed the records of 5 randomly selected complaints. Three of the 5 records had been completed in line with the trust's policy and within timescales set by the policy. Two of the records had been actioned in line with policy and timeframes required. Themes and trends were identified from complaints and lessons learned were noted and shared with staff.

A quarterly complaints report was presented at Quality Assurance Committee and provided an overview of complaints, compliments, comments and concerns handled in the previous quarter.

The information was broken down into care groups and site. The report also detailed any Parliamentary and Health Service Ombudsman (PHSO) information requests received.

From our inspection findings and our ongoing monitoring of the trust, we found evidence that there could be significant time lapses in responding to concerns to individual complaints. The trust were aware of this and had implemented a system recently to mitigate the timeliness of complaint response issues.

Trust pharmacy leaders were working collaboratively with the ICB (Integrated Care Board) as part of workstreams focused on system-wide approaches to aseptic service provision, workforce, virtual ward, and medicines formulary.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The inspection team noted a high level of learning over the previous two years, with a culture of being open and accepting to identified areas of improvement. The trust acknowledged that this area continued to be a work in progress, and the journey to improve areas such as timely incident reviews and complaints was still being undertaken.

The reporting and management of incidents, including Serious Incidents Policy, was reviewed as part of our inspection process. The policy clearly identified the escalation and reporting process for staff. It set out roles and responsibilities for all staff in the organisation. The committee structure for reporting and assurance was clearly set out and was appropriate.

The policy referred to an open, fair and just culture and achieved one of the four aims of Patient Safety Incident Response Framework (PSIRF), which was incoming.

The trust told us that a policy launched in May 2023 would cover the time until implementation of PSIRF proper and correctly referred to the SI Framework principles.

There was a daily triage meeting that reviewed reported incidents. Incidents of concern were reviewed by the executive review group and a 72-hour review undertaken if required.

Our findings

During our time on site, we reviewed a sample of 7 randomly selected serious incident reviews. We found detailed 72-hour reviews were completed on all incidents; these included an initial action plan.

Root cause analysis (RCA) investigations were not completed within the trust 60-day timeframe, although more recent incidents, from 2023, were investigated in a timelier manner. The RCAs were detailed and comprehensive. The trust had rolled out specific training to staff responsible for working on RCAs and planned to roll this training out to more staff. Further work would be beneficial to make the reports more concise. There was no documented discussion as to how the learning would be audited to ensure it was embedded. We found some inconsistencies in the date incidents were reported and their target dates in line with the requirements of the trust policy. Overall, the investigations were of a reasonable standard.

During our inspection, we reviewed a sample of Structured Judgement reviews (SJRs). SJRs allow trained clinicians to review, identify and describe the quality of care received by patients and assign a score of that quality. We reviewed 10 randomly selected SJRs; we looked at the structure of the report and whether there was sufficient evidence to justify the NCEPOD (National Confidential Enquiry into Patient Outcome and Death) classification and the Hogan grading of the conclusion of the report.

Of the 10 records reviewed, the narrative text detailed the reason for admission to the trust to a sufficient standard for the review to be conducted. Identified learning points were clear, explicit and well documented to assist the dissemination of lessons learned. We found this to be a well-structured and timely process with appropriate learning and scoring for each death reviewed. We found that learning from deaths was shared throughout the organisation.

The trust had a fortnightly Mortality Triangulation Group meeting where incidents, litigation and coroner referrals were reviewed and triangulated with input from PALS and the safeguarding lead. There was also a Mortality Steering Group where all care groups met to review lessons learned and the dissemination of this information across the trust. There was a focus on ward to board working and the trust had implemented a reporting structure to facilitate this.

Medicines incidents were reported on Learning from Patient Safety Events (LFPSE) Service to support local safety improvement work. Following analysis of incidents and themes recent work focused on the timely administration of medicines in Parkinson's disease and separately on the use of Fentanyl patches in the management of postoperative pain.

A pilot using patient wristbands and monitoring sheets was underway at across the Trust aiming to improve patch checks and monitoring for side-effects. The trust was also engaged with the ICB opioid safety improvement programme. Audits of opioid initiation and use on discharge supported the local system approach to reducing opioid prescribing in primary care.

The trust had a proactive quality improvement team actively working and promoting continuous improvement throughout the trust. The team have held quality improvement workshops with members of the executive team and developed a new strategy called The Hive. They aligned projects to meet trust priorities and objectives. During our time on site the quality improvement team held a celebratory event for a Fundamentals of care programme completed with ward managers.

The trust displayed a QR code link in staff areas of the Trust to a reporting and information app for speaking up. The App explained the principles and expectations of speaking up using a varied format of narrative policy links and video presentations. The app encouraged direct reporting through its platform and allowed staff to escalate concerns anonymously should this be considered necessary.

Our findings

The trust participated in both local and national clinical audits. The clinical audit and effectiveness group sat under the quality governance group with oversight from the director of governance.

In 2022/23 the Trust participated in 48 national audits and seven confidential enquiries, equating to 94% of eligible national audits and 100% of confidential enquiries. There were three national audits that the Trust did not participate in during 2022/23.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023	Good →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement →← Aug 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Lancaster Infirmary	Requires Improvement → ← Aug 2023	Good ↑ Aug 2023	Good → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023
Furness General Hospital	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023	Good → ← Aug 2023	Good → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023
Westmorland General Hospital	Requires improvement Aug 2021	Good Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021
Overall trust	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023	Good → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement → ← Aug 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Royal Lancaster Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Aug 2023	Good ↑ Aug 2023	Good ↑ Aug 2023	Good ↑↑ Aug 2023	Good ↑↑ Aug 2023	Good ↑↑ Aug 2023
Services for children & young people	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good Aug 2021	Good Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Good Aug 2021	Good Aug 2021
Urgent and emergency services	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Inadequate Aug 2021	Requires improvement Aug 2021
Maternity	Requires Improvement ↓ Aug 2023	Good ↑ Aug 2023	Good →← Aug 2023	Good →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023
Overall	Requires Improvement →← Aug 2023	Good ↑ Aug 2023	Good →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023

Rating for Furness General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires improvement Jul 2022	Good Jul 2022	Good Jul 2022	Requires improvement Jul 2022	Good Jul 2022	Requires improvement Jul 2022
Services for children & young people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Critical care	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
End of life care	Good Feb 2017	Good Feb 2017	Outstanding Feb 2017	Good Feb 2017	Outstanding Feb 2017	Outstanding Feb 2017
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good Aug 2021	Good Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Good Aug 2021	Good Aug 2021
Urgent and emergency services	Requires improvement Aug 2021	Requires improvement Aug 2021	Good Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021
Maternity	Requires Improvement → ← Aug 2023	Requires Improvement ↑ Aug 2023	Good → ← Aug 2023	Good → ← Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement ↑ Aug 2023
Overall	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023	Good → ← Aug 2023	Good → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023

Rating for Westmorland General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Feb 2017	Not rated	Good Feb 2017	Good Feb 2017	Good Feb 2017	Good Feb 2017
Surgery	Good May 2019	Good May 2019	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Medical care (including older people's care)	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Outstanding May 2019	Good May 2019
Urgent and emergency services	Good Aug 2021	Good Aug 2021	Good Aug 2021	Good Aug 2021	Good Aug 2021	Good Aug 2021
Maternity	Inadequate Aug 2021	Requires improvement Aug 2021	Not rated	Requires improvement Aug 2021	Inadequate Aug 2021	Inadequate Aug 2021
Overall	Requires improvement Aug 2021	Good Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021

Royal Lancaster Infirmary

Ashton Road
Lancaster
LA1 5AZ
Tel: 0152465944
www.uhmb.nhs.uk

Description of this hospital

The Royal Lancaster Infirmary is a part of the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT). It provides acute hospital services including urgent and emergency care, medical care, surgery, maternity, critical care, paediatrics, and out-patients for people in the North Lancashire and South Cumbria areas.

We carried out an unannounced inspection of the maternity and medical care core services at Royal Lancaster Infirmary following the trust making applications to have conditions from their registration removed.

Following our previous inspection in April 2021, under Section 31 of the Health and Social Care Act 2008, we imposed urgent conditions on the registration of the provider in respect to the regulated activities of diagnostics and screening and treatment of disorder, disease and injury in relation to the trusts stroke pathway.

The trust was inspected to assess whether the required improvements, had been made and sustained.

Our rating of this location stayed the same. We rated it as requires improvement because:

Maternity

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff did not all have training in key skills.
- Senior leadership still needed to address some important areas.

However:

- The service had enough staff to care for women and keep them safe. Staff understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

Our findings

- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Medical Care

Our rating of this service improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service provided mandatory training but not all staff completed it on time.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but the targets for completion rates had not been met for some training courses.

The mandatory training was comprehensive and met the needs of women and staff.

Staff had access to training specific to their role, for example, they received mandatory training on a Symptom Specific Obstetric Triage System that had recently been introduced to the service.

The service provided a mandatory core competency framework multidisciplinary training (MDT) for nursing staff, midwives, obstetricians and anaesthetists. This was delivered by an interactive e-learning tool which offered certification for fetal monitoring and maternity crisis management with a cardiotocograph (CTG) training simulator. All CTG's followed a nationally recognised criterion. Fresh Eyes duration audits had been completed indicating a compliance rate of 95%.

Four multidisciplinary training days were offered to staff in a year. The training days included scenario training in haemorrhages and anaphylaxis and bereavement training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff were emailed when mandatory training needed to be completed, however, core competency framework training courses were often completed with a face-to-face session and the trust being in operational escalation level 4 had impacted on completion of training as staff were sometimes pulled from a training course to work clinically.

Regarding the core competency framework multidisciplinary training (MDT), midwifery staff at Royal Lancaster Infirmary had met the 90% completion target in 4 out of the 7 courses (newborn life support; maternity emergencies and multi-professional training; care during labour and the immediate postnatal period and the growth assessment protocol (GAP/GROWTH) which had a 75% compliance target). Medical staff had met the target in 2 out of the 7 courses (newborn life support and maternity emergencies and multi-professional training).

The courses where compliance targets had not been met were: fetal surveillance in labour (midwives 73.9% and medical staff 76.4%); care during labour and the immediate postnatal period (medical staff 88%); personalised care (midwives 87% and medical staff 86.7%); saving babies lives care bundle (midwives 80% and medical staff 59%) and GAP/GROW training (medical staff 66.7%).

Staff also received mandatory training in trust core skills.

Maternity

Excluding level 3 safeguarding training and appraisals, which are detailed in sections below, midwifery staff had met the 90% completion target in 5 out of 8 courses (infant and child abduction; fire e-learning; infection control; equality and diversity and conflict resolution). Medical staff had met the target in 3 out of the 8 courses (infection control (100%); equality and diversity and conflict resolution).

The courses where compliance targets had not been met were: basic life support (midwives 85.4% and medical staff 66.7%); infant and child abduction (medical staff 83.3%); manual handling (midwives 88.3% and medical staff 85.7%); fire departmental (midwives 78.8% and medical staff 57.1%) and fire e-learning (medical staff 78.6%)

Safeguarding

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

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. Staff were trained to level 3 for safeguarding children and adults. Safeguarding training covered prevent duty training (the governments counter terrorism strategy) and female genital mutilation (FGM). Data showed, that, in April 2023, 92.1% of midwives had received level 3 safeguarding for children and adults.

Medical staff received training specific for their role on how to recognise and report abuse, however, the compliance rate for level 3 safeguarding training for medical staff was at 76.9% in April 2023 and had not met the trust target compliance rate of 90%.

Community midwives received one to one monthly supervision for safeguarding. This included discussion and learning from real cases.

There was a Band 7 and Band 8A full time equivalent safeguarding midwives in the service to support staff on the wards and in the community. They had regular meetings with the Director of Midwifery.

Staff told us that safeguarding concerns were normally identified by the community midwives in the women's antenatal appointments. Women were specifically asked about domestic abuse by community midwives.

The electronic patient record system had an indicator alert if there was any safeguarding information about the patient on file.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff had good working relationships with the local safeguarding authorities and were confident of what information would need to be shared.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff provided examples of how they had received support from the safeguarding midwives.

Maternity

We spoke to a patient who told us that staff had supported them whilst on the maternity ward with a safeguarding issue. She felt supported and understood by staff and felt their approach had been considered and proportionate.

Access to the ward and delivery suite was granted only by staff. Whilst on inspection, we observed safe practice by the domestic staff who did not allow us on to the maternity ward but instead awaited clinical staff to query who we were on the intercom.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills.

The safeguarding team for maternity undertook audits to ensure that women were appropriately safeguarded. In a review of 60 sets of notes, they found that 100% of women were asked about domestic violence at least twice during their child birth continuum.

Safeguarding training was kept dynamic and there were changing focus courses every year, for example, domestic violence, updates on female genital mutilation; safer sleep in cold homes and poverty; professional curiosity to avoid missed opportunities and good safeguarding documentation training. Training was also delivered on the Hope boxes that was an initiative developed by the service for women whose babies were removed either temporarily or permanently after birth.

Midwives and support workers were trained in ICON (Infant Crying Is Normal). ICON was discussed with families before discharge and support was offered. This helped to safeguard babies from abusive head trauma. Personal coping with crying plans were available to families.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

All the areas that we visited were visibly clean and had suitable furnishings which were clean and well maintained.

The service's last Patient-Led Assessment of the Care Environment (PLACE) scores for 2022 at Royal Lancaster Infirmary showed the service had generally performed well for cleanliness. For example, the cleanliness score was 99.84%. The condition, appearance & maintenance score was 98.66% The national average benchmark was 98.01% & 95.79% respectively.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service had procedures for isolating women in side rooms when they had contagious or infectious illnesses including COVID – 19 and Clostridium difficile.

Taps were flushed daily to minimise the risk of legionella in the water system.

Maternity

The midwifery support workers told us that the antenatal and postnatal ward did not have a housekeeper which they felt impacted upon their roles as they were having to take on more domestic tasks.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. Call bells were available at the side of every bed.

Staff carried out daily safety checks of specialist equipment. Daily and weekly charts were completed and signed. We reviewed the adult resuscitation trolleys on the maternity ward and delivery suite and saw they were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag.

The triage unit consisted of two single rooms on the labour ward area. We were told by the clinical director that there were plans to move triage unit so that it was not impacting on the delivery ward. Staff from the day assessment unit raised concerns with us that the triage unit being based on the delivery ward was resulting in bed blocks.

The day assessment unit consisted of a three bedded assessment area that was based close to the labour ward and Antenatal clinics.

The maternity ward had four 4-bedded bays with a mixture of antenatal and postnatal patients.

The service had enough suitable equipment to help them to safely care for women and babies. All equipment had an individual asset number placed upon it and all had been serviced and calibrated accordingly.

The day assessment unit did not have a resuscitaire in it, but they had an emergency anaphylaxis kit and a neonatal resus grab box. They also had a call bell which went through to the delivery suite. Resuscitaires were available in all the labour rooms.

Maternity staff had been trained on all the relevant equipment including phototherapy monitors. We saw training records for equipment.

Staff disposed of clinical waste safely. We saw bins for disposal of sharps were labelled, had a temporary closure and a fill line.

The bereavement suite was not in use as it had been identified by staff that it was not situated close enough to the wards for staff to support women whose health may deteriorate. The clinical director told us that there was a business case to move the bereavement suite to a more suitable location.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Maternity

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the Maternity Obstetric Early Warning Score (MOEWS) chart to alert them to a deteriorating patient. Audits provided showed a 100% compliance for MOEWS for all 13 standards including women requiring review had a clear management plan documented.

Staff knew about and dealt with any specific risk issues. We saw evidence of venous thromboembolism (VTE) assessments being completed on admission, up to 6 hours after birth and a review being completed prior to the patient being discharged. Staff told us they complete VTE risk assessments at every opportunity, on admission to the hospital and post birth. However, the trust had identified VTE assessments were not always being completed at appropriate times throughout pregnancy and following birth which placed women at risk of not having appropriate thromboprophylaxis which could lead to a pulmonary embolism. The trust had issued a briefing to staff in February 2023

Staff had specific training for sepsis. A comprehensive policy and protocol for sepsis had been implemented in 2022 and staff had specific training. Sepsis management was included in skills & drills training. The service had a target of 100% for compliance to the policy. However, audits showed that staff did not always adhere to the policy and were not achieving 100% in most of the 15 benchmark standards.

An action plan had been implemented to improve recording of sepsis management and adherence to national guidelines. Where better reporting could be addressed mandatory fields have been added to e-records. Sepsis was discussed at unit and ward meetings to raise awareness of poor compliance and recording. Other actions included, all women commenced on the sepsis care bundle to be discussed with a consultant obstetrician regardless of time of day and updating antibiotic choice in guidelines with microbiology. The full action plan was due for review May 2023 and added to the risk register.

Antenatal cardiotocography results were checked by two midwives.

Over 90% of babies had a physical examination within 72 hours. The babies that did not had been transferred directly to the neonatal ward for enhanced care.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The electronic system that staff used provided them with access to two psychological measures, the Patient Health Questionnaire (PHQ9) and the generalised anxiety disorder (GAD 7) scale. With results from these outcome measures, staff would then decide what referrals would be necessary for the patient, including referrals to the mental health liaison service.

Staff arranged psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep women and babies safe. We observed the maternity and delivery teams completing their handover from the night shift to the morning shift. The handover was focused, undisturbed and followed the Situation-Background-Assessment-Recommendation (SBAR) technique which provides a framework for communication between staff members.

Patients that attended as "walk ins" for maternity triage and initially attended urgent and emergency care were redirected to triage in the maternity unit.

Maternity

Midwives assessed and treated using a recognised prioritisation system for triage and were meeting timeframes within a target of 15 minutes.

The service had opened a triage unit for women who were suspected of experiencing an obstetric emergency. The triage unit was located in two of the delivery rooms in the delivery unit. There were plans in place to relocate the triage area to a different part of the department, as the current layout could be problematic because there was no waiting area for the triage area within the delivery suite and no clinical oversight of patients awaiting their initial assessment. Staff told us that, more often than not, women would be seen straight away and if this could not be facilitated there would generally be a delivery room free on the unit where the woman could wait with access to midwifery staff immediately should their condition worsen.

There was a dedicated phone line for the triage service and a midwife carried the phone with them. The triage midwife had access to a triage algorithm in the obstetric triage system to triage women over the phone. Staff were assured that the new system was safer than what was in place previously.

The service had introduced a Symptom Specific Obstetric Triage System. This system aimed to see and triage women within 15 minutes of arrival at the triage unit. Patients were risk assessed into four categories that determined when they would be seen by medical staff: a risk assessment of red meant that the emergency buzzer was pressed and women were seen immediately; orange meant up to a 15 minute wait; yellow meant up to an hour wait and green meant up to a four hour wait.

Women triaged as lower risk (yellow and green) were referred to the day assessment unit during opening hours.

There were weekly audits of the triage system, and these showed 90% compliance for 5 out of 6 weeks for those patients who were assessed as orange. However, the triage system had only been in place for a few weeks at the time of our inspection so there was no long-term data on waiting times.

Records showed that 16.76% of inductions of labour were delayed in the service. This equated to 101 out of 607 induced labours. Staff told us that this was mainly due to staffing issues.

Leaders said women scheduled for IOL were reviewed at daily triage and discussed at handovers and safety huddles. Medical staff made the decision who had priority. Delayed induction of labour was on the risk register. Leaders said they were developing a standardised pathway to ensure women were receiving timely care.

However, there was no documented process or prioritisation of order for women needing induction of labour. Individual risk assessments were recorded in the records of women waiting for induction, but staff could not articulate which induction was a priority.

There was evidence that delayed induction of labour had been reported up to the Women's Health Quality Board Meeting and themes were identified with challenge offered to ensure women are getting face to face reviews by consultants and middle grade doctors.

A rise in the delayed induction of labour numbers was said to be due to the capturing of the information more clearly and these being reported. The trust had recently been flagged as an outlier for induction of labour for reduced fetal movements. A thematic review was completed, and the service said they were assured good clinical practice was taking place across the Bay.

Maternity

The number of third and fourth-degree tears were comparative to other trusts.

Staff shared key information to keep women safe when handing over their care to others.

Maternity staffing

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

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. Managers used the Birth Rate Plus tool to calculate the number of staff needed.

The service provided one to one care in labour.

The ward manager could adjust staffing levels daily according to the needs of women. Staff from the maternity ward and delivery suite were on the same roster and as such moved from wards if required.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

The service had designated midwives for triage who were trained in the use of the obstetric symptom triage system.

Midwives and HCAs on maternity triage did not feel that they had the appropriate number of staff when the service was busy. They explained that when they were busy certain tasks such as observations and demonstrating to new mothers how to complete tasks such as feeding, winding or changing a nappy would be reduced. Staff felt that they were unable to provide the emotional support and care that they would have liked to due to staffing issues. They told us that they often worked through their breaks due to how busy they were.

Staff on the day assessment ward felt that staffing was an issue. They were allocated 1 midwife who worked 8am to 9pm and 1 support worker who worked 10am to 6pm but often there were difficulties getting this shift filled and it was normally filled by bank staff.

The ward manager on the antenatal and postnatal ward and staff on that ward told us that staffing was an issue.

On the day of inspection, the antenatal and postnatal ward was 1 midwife short on the morning shift and 2 midwives short on the afternoon shift but remained within safe staffing levels because the number of patients on the ward was not at capacity.

However, the staffing fill rates provided by the trust showed that target fill rates of more than 85% for maternity were consistently met over the six months from October 2022 to March 2023. During this period an average of 88.3% of shifts met acuity; an average of 11% of shifts were up to 1.5 midwives short and an average of 0.5% of shifts were more than 1.5 midwives short. The overall average fill rate for this period was 86.25% and the trust was able to maintain 1:1 care in labour at 100%.

The service used bank staff and minimal agency staff to ensure that shift fill rates were maintained and the ward manager for the antenatal and postnatal ward sometimes worked clinically to cover for staff. The trust was aware when staffing rates were likely to be lower due to school holidays and the festive season and planned bank and agency staffing accordingly.

Managers made sure all bank and agency staff had a full induction and understood the service.

The number of midwives and healthcare assistants did not match the planned numbers. Royal Lancaster Infirmary had a total of 105.84 whole time equivalent budgeted staff, including maternity support workers and midwives with 15.02 vacancies in total. There were 21.83 vacancies for midwives but the overall maternity vacancy figures were reduced due to an overstaffing of 7.6WTE band 3 maternity support workers. Broken down by department, the antenatal clinic was fully staffed; there were 11.94 vacancies on the delivery suite and ward 17 and there were 3.1 overall vacancies in community midwifery.

The service had plans in place to recruit more midwives although acknowledged that there were shortages of qualified midwives nationally.

At the time of our inspection a full midwifery workforce review was at the quality assurance stage. This had been written with the support of the deputy regional chief midwife. The funded establishment was above the Birthrate Plus recommended levels due to the complexities of the multi-sites.

The service had low turnover rates. The overall turnover rates for midwives was 3.29% from March 2022 to February 2023. The antenatal clinic and delivery suite and ward 17 had zero turnover rates during this period.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience. However, managers regularly reviewed and adjusted staffing levels using locum and substantive staff.

The service had enough medical staff and had actions in place to manage vacancy shortfalls. There was a shortfall in middle grade doctor posts with less than optimum deanery trainee posts due to rota changes.

Information provided in the March 2023 ‘Safe Today’ papers indicated there were 13 consultants in post out of an establishment of 12.23 and 4 middle grade doctors out of an establishment of 6. There were 3 locums covering 1 of the vacant posts and 2 other middle grade doctors who were on maternity leave so there was only 1 vacant post in medical staffing without locum cover. There were 7 intermediate grade doctors out of an establishment of 7. The service had planned for above the required establishment posts.

The service always had a consultant on call during evenings and weekends. From Monday to Thursday there was an out of hours resident consultant on site and an on-call consultant off site who could get to the hospital within 30 minutes in addition to a middle grade doctor and intermediate grade doctor. The trust was not required to have a resident on-call consultant because of the birth rate but had nevertheless put this enhanced service in place. In the event of an emergency, the service had the ability to bring in a third consultant on call.

On day shifts there was a consultant, middle grade doctor and intermediate grade doctor on call for the labour ward. There was also a floating middle grade doctor for the wards. There was no designated doctor for the triage unit at the time of our inspection. The middle grade doctor or consultant on the labour ward would examine the patients within the required time frame.

The service did have 4 speciality trainees but 3 had left the programme for differing reasons.

Locum doctors were used to fill middle-grade gaps and rotas were adequately covered. Managers made sure locums had a full induction to the service before they started work.

Records

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

The service had an electronic record system that was fairly recently introduced but was embedded and staff were confident in using it. Records were stored securely.

We reviewed 10 patient records including paper and electronic and found them to be comprehensive and all staff could access them easily. Staff could access diagnostic results in a timely manner.

When women were transferred to a new team, there were no delays in staff accessing their records as they were stored securely on the electronic system used by the care organisation and other local care organisations that used the same system.

The neonatal transitional care notes were still in paper format but the service was hopeful that these could be incorporated into the electronic system in the near future.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff stored and managed all medicines and prescribing documents in line with the trust's policy.

Pharmacy staff supported ward staff with the supply of medicines. We found medicines were stored safely and securely. There was a process in place to monitor the temperature of medicines storage including medicines that need to be stored in a refrigerator. There was a process in place to ensure medicines were not used passed their expiry date. Emergency medicines were available with systems to ensure they were checked daily and were within the expiry date.

Audits were completed to demonstrate the safe and secure storage of medicines. Overall, the audits found medicines were managed safely and securely; however, an audit had highlighted an issue with the appropriate security measures applied to the storage of flammable liquids and medical gases. We found this to be an issue for community midwives, however it was rectified on the day. Information provided by the trust confirmed all actions from audits in 2022 had been completed.

Staff completed medicines management training. The training records showed more than 85% of midwives in the maternity department had completed their training and 96% of community based midwives were compliant with their training.

We found the community midwives had a process in place for management of medicines when attending home births. At the time of the inspection the community midwives did not have access to pain relief for women who were planning a home birth. The service had recently stopped providing the pain relief gas, Entonox, due to concerns around over

exposure to midwives. However, the service had not removed the Entonox cylinders from the department and were storing Oxygen cylinders in transportation bags marked for Entonox. There was a risk community midwives could mistake the Entonox for Oxygen and put people at unnecessary risk of harm due to delays in Oxygen treatment in a medical emergency. Once highlighted to the Trust, they took swift and appropriate action to rectify the concern.

Medicines prescribed for discharge were obtained from the hospital site prior to going home. There was a system in place if women left without their medicines.

The pharmacy team had supported the service with the development and implementation of guidelines to support midwives with administration of certain medicines, (midwives' exemptions) without the need to wait for a doctor to prescribe the medicine, allowing for the swift treatment of a number of conditions. There was a patient group directive in place to allow midwives to issue medicine to women who were at risk of pre-eclampsia, a condition that affects some pregnant women. We found guidelines were in place to support staff with the swift identification and treatment of sepsis, this included the most appropriate antibiotics to give depending on the source of infection. However, an audit completed by the trust for treatment of sepsis January to April 2023 showed not all staff were following the guidance. Areas for improvement identified in the audit included adherence to the guidelines for choice of antibiotic prescribed, poor documentation in patient notes and not all women having the correct blood samples taken. The trust had already worked to address some of the actions with suitable timelines in place for the remaining actions to be completed.

The pharmacy team did not routinely support the maternity department with the reconciliation of medicines; however, they were available to support on request. There was a process in place for the ward staff to complete a medicines reconciliation when women were admitted to the birthing centre.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had clear reporting responsibilities for incidents and reporting mechanisms in place. Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust/provider policy. They reported serious incidents clearly and in line with trust policy.

New incidents were reviewed every morning in a meeting chaired by the quality, safety and assurance lead midwife with all of them being graded and reviewed. This was a multidisciplinary meeting and ensured that incidents were managed appropriately and within expected timescales.

The executive review group met three times per week to review more serious incidents so any 72-hour reviews were completed within this timescale. Reviews were completed by the ward manager or clinical governance team.

The trust had invested in additional training on root cause analysis, including for doctors and additional support was offered for those staff investigating incidents.

The service had no never events on any wards.

Managers investigated incidents thoroughly. Women and their families were involved in investigations where this was appropriate.

Maternity

Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Feedback was delivered to staff in a 3 minute brief email every week, in a monthly bulletin and incidents were shared in safety huddles and monthly perinatal mortality review meetings.

At the time of our inspection, there were 17 incident investigations ongoing into delayed induction of labour and rejected blood tests where handwriting was illegible and samples had been disposed of. None of the incident investigations were overdue.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

There was evidence that changes had been made as a result of feedback, for example, any delays in induction of labour of more than four hours were reviewed by a senior clinician. There had also been increased training on postpartum haemorrhages for which the trust was an outlier.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

We reviewed all the policies held electronically and staff could demonstrate that all policies specific to maternity services were in date and had been reviewed and updated appropriately. There were systems in place to ensure that policies were reviewed and updated in a timely manner and the governance team had good oversight of policy management.

We found that policies examined in more detail were comprehensive and based on national guidance.

Policies were easily searchable and accessible to all staff on the Sharepoint system.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives, and carers.

Maternity

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs.

Patients told us that staff made sure women had enough to eat and drink. One patient described the food as "surprisingly good".

The service provided infant formula for women that were bottle feeding, if they needed it. We saw supplies of infant formula on the ward.

Breast milk was stored securely in a breast milk fridge with keypad access on the postnatal ward.

Babies were weighed on day 3 and day 5.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition.

Specialist support from staff such as dietitians was available for women who needed it.

Midwives assessed and made onward referrals where women required dietary advice for conditions such as diabetes, or a high body mass index. Breastfeeding advice and support was available for women and further development of roles for breastfeeding champions were being identified in the service to promote this.

The service had achieved stage 1 accredited Baby Friendly Initiative status with a full range of support and advice on the maternity app and website.

Pain Relief

Staff assessed and monitored women regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

At the time of inspection community midwives did not have access to pain relief from Entonox for women who were planning a home birth. The service had recently stopped providing the pain relief gas, due to concerns around over exposure to midwives. Women were informed about this prior to choosing to birth at home. Several maternity services have had to withdraw analgesia gas as an analgesic option due to excess occupational exposure to gases. This was an ongoing Health and Safety Executive investigation nationally.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. The MOEWS was used to measure pain and we observed staff asking women about pain when they completed their observations.

An audit shared by the service showed 100% of women requiring an epidural were provided with one within 30 minutes of being requested.

Women mainly received pain relief soon after requesting it. From 5 women that we spoke with on the antenatal and postnatal ward, 4 said that they had received pain relief soon after requesting it and one said that she had except on one occasion which they waited over an hour due to a mix up between staff which they believed was due to how busy the ward was.

The trust had sent a survey to all women who had given birth in the previous 6 months. The survey results showed 15% of women stated they felt they did not get pain relief in a timely manner. The trust was working to improve this.

If women were still in pain, further investigations were offered.

The ward manager on the antenatal and postnatal ward told us that a standard list of pain relief drugs were provided following a caesarean section.

Staff had access to ice packs that they offered women who had back pain.

The service offered Transcutaneous electrical nerve stimulation (TENS) machines to women in labour to reduce pain.

Staff prescribed, administered, and recorded pain relief accurately.

Patient Outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for women at location level.

The service participated in relevant national clinical audits such as MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). We asked the service to provide any reports or action plans against MBRRACE outcomes. The information supplied was specific to across Bay maternity service action plans to reflect shortcomings identified in the MBRRACE audit and related directly to the standards. However, it did not reference any local learning or action plans.

The national benchmark against the MBRRACE report published in October 2022 showed an average of perinatal deaths of 4.85 per 1000 total births, (In 2020 this was 4.20 per 1,000 total births). Comparator trusts and health boards were sitting at around 5% when adjusted for other contributing risk factors. Information in trust surveillance reports said, 'since maternity services had reverted to pre-pandemic pathways of care the live data monitoring tool showed a decrease in perinatal mortality rate at 3.7 per 1000 births, which was within 5% of the group average at UHMBT'. From January 2022 to 31 March 2023 of 11 incidents that related to deaths, 5 were eligible in 2023 and all had been notified within 7 working days. The service was not an outlier nationally.

All perinatal deaths were reviewed using the perinatal mortality review tool (PMRT) to identify themes and trends. There was an increase nationally in perinatal mortality during the pandemic said to be due to women contracting covid and reduced access to services.

Trends and themes were monitored at PMRT and there was an action plan to address any areas for improvement. We saw evidence the trust had oversight and action plans to address and monitor progress against the national maternity and perinatal audit 2018-2019. The service had worked hard to address previous PMRT backlogs and had completed all 26 historical reports. Much thought had been given to the sensitivity around this approach due to the time lapse using the support of the bereavement midwife who had continued contact with families. Updates were included in the Women's Health Quality Board. This was an improvement from our last inspection.

Maternity

The Maternity Incentive Scheme rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is through an incentive element to trust contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 3 (results published February 2022), the trust had not met 7 (out of 10) safety actions. However more recent governance reports provided by the trust indicated this had improved to 7 out of 10. Senior leaders also confirmed this and explained how they were working towards meeting all 10 safety actions. It was acknowledged that there was still work to do to achieve and maintain the 10 safety actions.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There were engagement meetings and follow-up of audit outliers.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. We saw evidence in meetings that these were discussed and reported to the Women's Health Quality Board and learning taken forward into actions. For example, partograms (graphical record of key data during labour) and growth charts are now included in the bereavement notes and audits of assurance to be undertaken.

The percentage of 3rd and 4th degree tears were higher than expected at 4.5% for the period August 2021 to July 2022 than the national average of 3%. The service had oversight of this and had implemented an OASI training bundle which was being monitored and reported on. (OASI is an obstetric anal sphincter injury which can occur during vaginal birth, sometimes referred to as severe perineal tearing). Data reviewed on the maternity dashboard for February 2023 showed this figure was decreasing and was no longer an outlier.

The service had policies and procedures for Major Obstetric Haemorrhage (MOH) including Antepartum and Postpartum Haemorrhage.

An audit was undertaken by the service of 18 electronic patient records of women experiencing a postpartum haemorrhage (PPH) of more than 1500ml between, January and February 2023 to understand any repeat themes in management of PPH's across the Bay. There were 11 at the Royal Lancaster Infirmary of the 18 records reviewed. Actions had been taken to improve outcomes such as skills and drills training for PPH with doctors and theatre teams. Blood loss was now recorded on theatre white boards, so all staff had oversight of blood loss volumes. Theatre staff could also instigate the major obstetric haemorrhage emergency procedure and request blood from blood banks. A 'whole team' responsibility approach has been implemented.

All reported PPH over 1500 millilitres (mls) had to undergo a 72hour review and be classified as moderate harm or above. The governance lead had oversight of all major obstetric haemorrhages and communicated with the ward manager to review investigations progress. The service relied on a multi-disciplinary team review off risk factors for women at increased risk of a PPH and a plan put in place to mitigate risks. New PPH risk assessments were being implemented that trigger specific pathways and protocols depending on blood loss to improve outcomes for women experiencing a PPH.

Staff said incident and governance reporting and feedback to staff had improved.

Managers said they could now monitor performance and benchmark against other services for PPH through the improved maternity dashboard. Information from the maternity dashboard for February 2023 showed an increasing trend of PPH across the trust over the last six months, which was in the upper 25% when compared to other trusts but not an outlier.

Managers shared and made sure staff understood information from the audits and implemented actions to improve outcomes for women and babies.

Competent staff

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

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

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

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection 87% of staff on the antenatal and postnatal ward and delivery suite had received an appraisal.

A fetal monitoring lead midwife had been appointed to work 15 hours per week to ensure midwives had access to training and competencies which was mandatory. A consultant obstetrician was also a fetal monitoring lead to improve doctors' competencies in their roles. Fetal monitoring continuous learning was shared through fetal monitoring case review meetings which all staff could attend.

Managers gave new staff a full induction tailored to their role before they started work and clinical educators supported the learning and development needs of staff.

The clinical educators supported the learning and development needs of staff. There was a team of 4 clinical educators that covered all 3 hospital sites. There was 1 band 7; 2 band 6 clinical educators and a support worker. They had developed mixed preceptorship and trainee midwives programme to support new staff. The trainee programme was a 3 year training programme created with the North West Local Maternity System (LMS) and covered all the topics required to meet the needs of trainee midwives. The preceptorship was for 12 months.

All trainee doctors had a clinical supervisor with allocated time to support their trainees and Royal College of Obstetrics and Gynaecology (RCOG) scheduled meetings to assess progression and wellbeing. All locum doctors within the department were allocated a clinical supervisor for the duration of their contract. All doctors were required to maintain RCOG e-portfolio which was actively reviewed as part of the Trust annual appraisal system.

Managers made sure staff attended team meetings or had access to full notes when they could not attend and had processes and procedures to manage medical and maternity staff in maintaining high professional standards.

Newly qualified midwives participated in a rotational placement within the services, in which they gained experience and had opportunity to develop skills between the different hospital and community locations.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

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

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

Maternity

Managers identified poor staff performance promptly and supported staff to improve.

Midwifery staff rotated between the delivery suite and the antenatal/postnatal ward to ensure they keep up their skills. Some community midwives also worked 1 or 2 shifts per week on the delivery suite or ward and had transferable competencies across community and inpatient services.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw a good example of planning well in advance for a woman who was likely to require mental health, local authority and safeguarding input when she gave birth and multidisciplinary meetings had been held to ensure all possible outcomes had been covered and also in the event that the birth was premature.

Staff referred women for mental health assessments when they showed signs of mental ill health, including depression.

The sites worked well together. If the middle grade doctor and consultant were in theatre at one site and they needed a third doctor they would call the consultant on-call.

Staff from gynaecology and the labour ward work closely together in relation to theatre occupancy with obstetric cases being given preference if it was likely that both theatres would need to be used simultaneously.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds twice a day, including weekends. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Bereavement support is offered 7 days a week. Patients have access to senior psychiatrist support.

Medical and anaesthetic cover was provided outside of normal working hours, with onsite emergency surgery services and caesarean section team available during working hours. At night an on-call team was available for emergency caesarean section.

Triage and assessment were now also available 24 hours a day, seven days a week co-located on the delivery unit.

Health promotion

Staff gave women practical support and advice to lead healthier lives.

An infant feeding specialist midwife attended the service one day a week to support new mothers.

The service had relevant information promoting healthy lifestyles and support on wards/units, including drugs, alcohol, and smoking cessation. Staff told us women were offered smoking cessation advice and devices at every opportunity throughout their pregnancy and following the birth.

Safe sleeping to prevent cot death was discussed by midwives at appropriate times during a woman's pregnancy journey.

We observed posters around the unit promoting support for women that had experienced traumatic births.

We observed leaflets around the unit which provided information on the effects of alcohol, drug use and smoking in pregnancy.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had processes, procedures and a dedicated perinatal mental health midwife and enhanced midwife team who supported more vulnerable women including those with mental health needs. They supported the clinical teams with advice and liaising with external agencies as required. There was a system in place for referrals to the enhanced midwives. This supported women, families, and clinical teams to put together personal care and birth plans. We saw evidence in safety huddles and handovers that staff were made aware of vulnerable women and their care requirements.

Staff completed risk assessments and made mental health referrals antenatally where women were either unwell or in need of additional mental health support. Staff said if there were immediate concerns identified the mental health team were contacted directly. Out of hours mental health services were accessible through the emergency department on site.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

We observed in records staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records. Women had mental health plans in place with psychiatry input which were available to staff involved in their care on the patient electronic record.

Staff understood Gillick Competence and Fraser Guidelines. Gillick competence is used to assess a child's capability to make and understand their decisions in a wider context. Fraser guidelines are applied specifically to advice and treatment that focuses on a young person's sexual health and contraception.

Since our inspection the trust have provided mandatory Mental Capacity Act and Deprivation of Liberty Safeguards training figures that show a 94.3% compliance rate for maternity staff at Royal Lancaster Infirmary.

Maternity

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good.

Compassionate Care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. We observed staff spoke to patients in a respectful and considerate way. Staff tried to take time to interact with women but were often too busy to provide the time that they would have liked.

Women said staff treated them well and with kindness. We spoke with five patients and their loved ones from the maternity ward and 4 out of 5 were complimentary about the staff, confirming that they had been kind and compassionate in their approach. All the women said they had recognised how busy staff were but were grateful for the care that they had received despite staff being under pressure.

Staff followed policy to keep women's care and treatment confidential.

Staff had a good knowledge of the women in the service. We observed staff identifying which midwives had contact with the patient in the past and tried to facilitate them completing their observations to achieve some continuity of care. Staff accommodated and responded to individual mental health or social needs appropriately and with a non-judgemental attitude.

Staff understood and respected the personal, social, and religious needs of women and how they may relate to care needs. We observed how staff had made appropriate referrals to the safeguarding team and staff were able to explain how they would support women with mental health issues including referrals to the mental health liaison service if required.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it.

The service had a bereavement midwife and offered a rainbow clinic service which was a specialist service for women and their families in a pregnancy following a stillbirth or neonatal death.

The early pregnancy assessment unit had a quiet room which allowed staff to break bad news to women and their families in a dignified and respectful way.

Maternity

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Women had the support of a dedicated bereavement team with two part-time Specialist Bereavement Midwives and a Lead Bereavement Consultant Obstetrician, working across bay.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff offered debriefing to women and families following difficult births through the 'listen with mother' initiative and could refer women directly for this support through the electronic patient record system.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. One patient told us that the delivery suite was "amazing" with them and their partner and explained the procedure in detail and in a way that they could understand.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. In addition to seeking feedback from women directly whilst on the unit, information was provided to women about listening groups so that feedback could be provided later. Women were also signposted to the patient advice and liaison service (PALS) when required.

Staff supported women to make advanced decisions about their care. Women were supported to make birthing plans and could look around the unit and discuss any fears they had about the birthing process.

Women's loved ones were able to stay overnight with them if they had been induced as well as the night following them giving birth. Loved ones were provided with a comfortable sofa bed.

Women gave positive feedback about the service. One patient told us that the maternity staff had supported her loved one to bond with their baby.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Women were offered choice of maternity care, depending on the level of risk. The service aimed to accommodate women's preferences in this. Community midwives provided antenatal care in local clinics as an alternative to hospital attendance.

They worked with the maternity voices partnership (MVP) and public health to align services to meet the needs of women in local communities. The MVP had reached out to young mothers in the community to obtain their views to inform and improve services.

Facilities and premises were mostly appropriate for the services being delivered. There were plans in place to reconfigure the department to locate the bereavement suite within the delivery suite but away from the delivery rooms so that it was closer to the operating theatres and to relocate the triage rooms.

The service had systems to help care for women in need of additional support or specialist intervention. The service had completed a successful bid for additional funding to extend the bereavement care service. An extra funded post will provide additional pastoral and emotional support to those families who require the services. It is the aim of the service to further increase bereavement cover across the trust to cover 7 days a week with a hybrid model of specialist midwives and bereavement support workers. Specialist Bereavement Midwives once trained will be leading on additional training for stillborn and neonatal death charity (SANDs).

The service collaborated with a wide range of charities who supported parents who had experienced infant bereavement or the removal of a child.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems or learning disabilities received the necessary care to meet all their needs. An enhanced support midwives team working across all three maternity trust sites (5 full time equivalents), supported families with additional needs. These included but were not limited to, domestic abuse, substance misuse, young parents, care leavers, learning difficulties and disabilities, refugees/asylum seekers, non-English speakers and homeless families. The allocated enhanced support midwives provided additional care over and above that provided by the named community midwife and wider multi-professional team.

New guidelines and pathways were in place for adult patients with learning difficulties, autism and complex needs. These were due to be ratified by the board by the end of April 2023. Staff said there was a good trust-based learning disability and autism lead who was accessible and hospital passports were tailored to the needs of people with a learning disability. Additional resources were available such as easy read documents supported with pictures and virtual tours of the unit. Extra time was arranged for a physical tour of the unit.

We observed the service had information leaflets available in languages spoken by the women and local community. Signposting information was evident for breastfeeding, bay wide maternity voices and how to access information the maternity app.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. The service used a language line interpretation service. Staff were able to access video or telephone interpretation 24 hours a day in hospital and the community.

Wards had access to a translator line (video language line) and the antenatal and postnatal ward had a specific room that patients could use if they needed a translator. The service used a website to provide information in different languages.

Some of the posters on the ward were in different languages including Polish.

Women with physical disabilities were invited on to the antenatal and perinatal ward prior to them being admitted to choose their room.

Women were given a choice of food and drink to meet their cultural and religious preferences and there was nutritional support from nutritional support workers. A diabetic menu was available for those who required additional choices.

Staff had access to communication aids to help women become partners in their care and treatment. There was a maternity application in place that assisted patients in checking appointments and provided links to other useful information.

The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role.

The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for health and social care staff. The trust had rolled out learning disability awareness training under the mandatory training core skills. All staff undertook Tier 1 training and clinical and front facing care, support and treatment providers also undertook Tier 2 training. Following our inspection, the trust reported that the compliance for staff in the women and children's care group at Royal Lancaster Infirmary was 96.7% for tier 1 and 100% for tier 2. Senior leaders told us that the training followed the principles of the Oliver McGowan training.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access services when needed and receive treatment within agreed timeframes and national targets. Waiting times were monitored in the day assessment unit and all appointments were booked. Women did not have to wait too long for their appointments.

Staff said they never had to cancel appointments which mostly ran on time. They reported always having medical cover. When women did not attend for their appointments, staff contacted women to rearrange their appointment and check everything was ok. If women failed to attend two appointments the community midwife followed up with a home visit and the consultant would be informed.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Women with complex needs were identified antenatally and had the support of the enhanced care team with multidisciplinary support including mental health where needed. Community midwives met regularly with health visitors to ensure women were best supported on discharge.

The service had a consultant fetal medicine lead based at the Royal Lancaster Hospital maternity service with a screening team across bay. Antenatal clinic managers were also supporting this role.

Managers and staff started planning each woman's discharge as early as possible.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs.

Maternity

Staff supported women and babies when they were referred or transferred between services.

Managers monitored transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. There was information displayed in patient areas on how to raise concerns.

Women were also asked to give personal feedback informally or through the maternity voices partnership that met regularly with the trust.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

The service had received low numbers of complaints. Data provided showed that, from 1 October 2022 to 31 December 2022, the service had received 5 complaints and from 1 January 2023 to 31 March 2023 it had received 2 complaints. The service was below their benchmark of receiving less than 1.33 complaints per month.

Of the 7 complaints received, 2 had been closed, 2 were not upheld and 3 were partially upheld.

Data showed that of the 2 complaints received from January to March 2023, 1 was partially upheld and the complaint was dealt with in 81 days and the other was closed within 6 days.

Managers shared feedback from complaints with staff and learning was used to improve the service. There was weekly oversight of complaints performance that was reported to the Executive Review Group. From 1 March 2023, the trust had introduced a new complaints procedure with a reportable process by which to monitor and audit the stages of the complaints to highlight themes or trends, recognise and why delays have occurred and providing data to drive improvement.

Information about complaints was also fed into the quarterly Women's Health Experience Report from the Director of Midwifery.

Is the service well-led?

Requires Improvement  

Our rating of well-led stayed the same. We rated it as requires improvement.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership in women and children's services (of which maternity was part) had strengthened since our last inspection with quadrumvirate leadership model in place, including a clinical director for obstetrics and gynaecology; a deputy director of nursing and midwifery; an associate director of operations and a clinical director for children and young people. The clinical director, deputy director of nursing and midwifery and the associate director of operations held joint roles across maternity and gynaecology.

They were supported by a head of midwifery, a senior consultant midwife, quality, safety and assurance lead and 5 deputy medical directors who had their own portfolios.

The maternity leadership team had strong connections with trust executive board members as they had been assigned a "buddy" who was on the board and had regular meetings with them. The clinical director advised that the Women and Children's Care Group was assigned to the trust chief executive and said that their meetings had helped to strengthen communications between the service and the board.

The trust had introduced leadership training for all consultants and the clinical director was keen to target leadership much earlier, from graduate level.

Leaders told us that regular walkarounds in the maternity departments took place by senior leaders. Staff told us that the head of midwifery and clinical director were visible and approachable. They also said they received great support from the consultant midwife. However, staff told us that they rarely saw the director of midwifery in the department.

Midwifery staff told us that the ward managers were supportive and encouraging.

Whilst we were encouraged by the strengthening of leadership at a local level, issues reported under other key questions reflected that senior leadership still needed to address some important areas, for example, use of audit outcomes to drive improvement at local level, adherence to systems and processes and completing the Ockenden recommendations.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, the vision and strategy had only just been approved and had not yet been rolled out to staff.

At our last inspection, the service did not have a clear vision and strategy in place.

The service had now developed a one year strategy. Reports to board said it was purposefully for 12 months so that it could be further updated once the maternity and neonatal 3-year delivery plan was launched. The strategy had just been approved and was waiting for distribution. Leaders told us that one of the reasons for completing a holding strategy was due to the complexity at the different maternity sites and to do it "well and properly" they decided not to rush it. Leaders wanted to do appropriate clinical modelling and service user engagement to ensure that the strategy was as robust as it could be. The strategy had not been rolled out at the time of our inspection and staff were not aware of the content.

Maternity

Leaders said they had engaged with national maternity voices, young mums', focus groups with families in areas of deprivation and staff engagement. They had also used information from complaints and listening sessions with mums when producing the strategy.

Leaders recognised the need to develop a longer term vision and strategy for the service but had initially concentrated in strengthening governance and leadership in the service.

We reviewed the Maternity Strategy 2023 that was available in the trust board papers for approval. The strategy contained a vision that was: "To deliver high quality maternity care that is not only safe and effective providing the best possible outcomes, but that is responsive after listening to women's wishes, providing care that truly supports women's individual needs, ensuring informed choice and personalisation of care. Ensuring that women and their families are at the heart and centre of everything we do, providing excellent maternity experience at every contact."

The strategy had four strategic priorities, which were: Deliver outstanding care and experience; create the culture and conditions for our colleagues to be the very best they can be; make the best use of our physical and financial resources; and working in partnership.

For each priority, the strategy sets out how the trust planned to deliver this, how they will know what they are doing is working and how they will measure this.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had a freedom to speak up guardian and staff knew who this was and how to contact them. Staff confirmed they had attended training to support empowerment to speak out and challenge poor behaviours.

Staff told us that they had a good working relationship with doctors on the wards and felt respected and valued.

The service promoted equality and diversity and more than 95% of midwifery staff and 92% of doctors had undertaken training in equality and diversity.

Midwives and support workers told us that they enjoyed working at the trust and look forward to coming to work though shifts that were short staffed could impact on their job satisfaction.

Staff told us that there were no cultural issues on the maternity units.

Staff had been invited to attend "happy vibes" days to aid staff wellbeing.

Staff had access to mental health champions within the department.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Maternity

During our last inspection, leaders told us that they recognised the need to improve governance processes in maternity.

At this inspection we found that governance processes had been completely reviewed and all staff said that governance had very much improved. There was a new director of midwifery, and a new quality, safety and assurance midwife in place to strengthen governance oversight.

Leaders had produced a new accountability and assurance framework with specific maternity standards, so leaders were fully sighted on the issues in maternity and how to manage them. Information flowed from ward to board and was not just held at management level. All staff were given clear expectations for their work and roles by leaders.

Information relating to maternity services was discussed and communicated in a range of meetings such as monthly perinatal mortality review meetings; maternity policy and guidelines group; Women and children's risk register group; Labour Ward Forum; ATAIN group; MPLG Group; Maternity audit and effectiveness group and audit and perinatal mortality and morbidity meeting.

Information briefings from these meetings were fed into the Women's Health Quality Board and pertinent information was in turn fed into the Women and Children's Care Group Board which in turn fed into the trust governance framework of meetings up to board level.

The accountability and assurance framework had clear point of care to board governance structures within it with leadership accountabilities.

Owing to the requirement for the board to have direct oversight of maternity services, the Women's Health Quality Board reported to the overall Women and Children's Care Group Board (chaired by the Clinical Director(s), Associate Director of Operations or the Associate Director of Nursing and Midwifery) and to the Quality Assurance Committee to ensure executive oversight. The service had improved its position for compliance with the Maternity Incentive Scheme which rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is through an incentive element for contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 3 (results published February 2022), the trust was only meeting (3 out of ten) safety actions.

Board papers confirmed 7 out of 10 actions were submitted for compliance in year 4 and were complete. The Maternity Incentive Scheme (MIS) were asking all Trusts to review safety action 10 after they informed Trusts in March 2023, they could not validate this information. The trust had informed them that they were compliant with safety action 10 at the time but not in the year 4 reporting period.

The service was now using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard and had addressed the back log of investigations with all families contacted and a duty of candour carried out. They had taken action to improve transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme (ATAIN).

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Improvements had been made to local oversight and ownership of risk and staff said there had been much improvement. There was a cross site risk register overseen by the women and children's care group and a maternity site-specific risk register.

We observed a monthly women and children's care group risk management meeting. We saw that risks were managed well and there was good oversight. All risks on the care group risk register were discussed by a multidisciplinary team, risk scored appropriately with action plans to mitigate or reduce the risks in place and updated. Discussion took place on whether the action plans would be completed on time and next steps. Risk scores were agreed by the risk panel.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information systems were integrated and secure but staff told us that they were often slow with poor connection to the internet.

Staff could find the data that they needed. They were able to quickly find patient records and referral forms for patients on the secure patient records system.

Staff had access to performance data including specific dashboards for wards. Ward managers were able use the dashboards on the electronic system and used the data to monitor and improve performance.

The maternity dashboard had significantly improved with a dedicated digital maternity midwife with oversight. Staff reported it was much easier to obtain reports so they could compare their outcomes nationally. Leaders told us the maternity dashboard was an exemplary (textbook) model and was being reviewed by other trusts as the benchmark.

Staff in the governance team reported that improved systems made it easier to manage oversight of risks and policies.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had a strong relationship with the Maternity Voices Partnership (MVP). We interviewed the chair of the MVP who reported that they had regular meetings with senior leaders in maternity and felt listened to, valued and that commitments to improve experiences for women were genuine.

The chair told us that the consultant midwife had been a brilliant addition to the team and that they were keen for the MVP to be involved in collaborative projects with the trust. The trust were willing to make investments in suggestions made by the MVP and were very responsive if the MVP raised any concerns with them, such as arrangements during ambulance service strikes to reassure women.

Leaders told us that consultants, public health and GPs had been involved in devising the maternity vision and strategy at a strategy day.

Staff were invited to make suggestions for improvements to the department, for example, a midwife who was also a talented artist had suggested that delivery rooms could be brightened up with painted murals and had been allowed to paint designs in all of the rooms, that had received much praise.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We saw examples of continuous improvement and innovation in the service. One such example was the development of "HOPE" boxes. HOPE stood for "Hold on pain eases". The trust was a pilot site for the boxes that had been the idea of a lived experience group of women who had been separated from their babies temporarily or permanently by them being taken into care.

The trust had won an award for the development of the boxes. They had been rolled out from November 2022. There was 1 box for the mother and 1 for the baby. The boxes contained a poem that had been written by the lived experience group; a letter explaining what the box was for; a booklet to write memories in for the child to read later in life; an elephant toy to signify "never forget"; an inkless hand and footprint kit for the mother to make keepsake imprints; a "Guess how much I love you" book for the child which could be recorded in spoken word by the mother and a swapped item of clothing for the child and mother which was to signify "the power of smell".

The trust asked permission to contact parents 4 to 6 months after the child had been removed to gain an impact assessment on the boxes in a qualitative audit. This was ongoing.

The trust was planning to ask parents what they would like to see or require in the new bereavement suite that was being planned in order that parents got what was important to them.

The service had midwifery professional leads meetings, chaired by the director of midwives where staff speak about midwifery practice. The meetings were aimed at engaging staff so that they have a voice of their own and managers provided details of successes every 6 months via a PowerPoint slide deck.

The service had stage 1 baby friendly accreditation and the maternity dashboard had been identified as an exemplar for other trusts.

Medical care (including older people's care)

Good ↑↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory Training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

All staff were required to complete mandatory training but compliance rates for some courses were below the trust target of 95%. Following our inspection, the trust provided evidence that they had reduced their compliance target rate to 85% in May 2023 to align with other providers within their Integrated Care Board (ICB) and to ensure consistency across the Integrated Care System (ICS).

Data provided by the trust showed the following compliance rates, in April 2023, for nursing staff were:

- Advanced Life Support: 71%
- Basic Life Support: 90%
- Conflict resolution: 94.5%
- Equality, diversity and human rights 97%
- Fire safety: 96%
- Health, safety and welfare: 96%
- Infection prevention and control level 1: 99%
- Infection prevention and control level 2: 89%
- Information governance and data security: 95%
- Moving and handling: 96%
- Preventing Radicalisation: 72%
- Sepsis: 89%

Data provided by the trust showed the following compliance rates, in April 2023, for clinical support workers were:

- Basic Life Support: 93%
- Conflict resolution: 96%
- Equality, diversity and human rights 99%
- Fire safety: 95%

- Health, safety and welfare: 96%
- Infection prevention and control level 1: 99%
- Infection prevention and control level 2: 97%
- Information governance and data security: 98%
- Moving and handling: 97%
- Preventing Radicalisation: 90%
- Sepsis: 93%

Data provided by the trust showed the following compliance rates, in April 2023, for medical staff were:

- Adult Life support: 80%
- Basic Life Support: 75%
- Conflict resolution: 88%
- Equality, diversity and human rights: 87%
- Fire safety: 80%
- Health, safety and welfare: 88%
- Infection prevention and control level 1: 89%
- Infection prevention and control level 2: 64%
- Information governance and data security: 74%
- Moving and handling: 82%
- Preventing Radicalisation: 60%
- Sepsis: 75%

Staff told us they were able to access training through a training portal on the intranet which identified any new training for them to complete. Staff told us it was important to complete training and that they were sent reminders when training was due to be completed and were supported by managers to complete training. Training was a mixture of online learning, classroom based and delivered at ward level by practice-based educators.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. Staff completed training on learning disability and autism as part of their mandatory training core skills package. The service promoted autism awareness. Staff knew how to respond to patients with a learning disability or patients living with dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was also a key part of governance meetings; staff were reminded consistently to complete training by managers.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. The trust had set a target of 95% for staff attendance at safeguarding adults and children training. Following our inspection, the trust provided evidence that they had reduced their compliance target rate to 85% in May 2023.

Data provided by the trust showed the following compliance rates, in April 2023, for nursing staff were:

- Safeguarding children and adults level 1: 99%
- Safeguarding children and adults level 2: 92%
- Safeguarding children and adults level 3: 89%

Data provided by the trust showed the following compliance rates, in April 2023, for clinical support workers were:

- Safeguarding children and adults level 1: 99%
- Safeguarding children and adults level 2: 98%
- Safeguarding children and adults level 3: 94%

Data provided by the trust showed the following compliance rates, in April 2023, for medical staff were:

- Safeguarding children and adults level 1: 89%
- Safeguarding children and adults level 2: 80%
- Safeguarding children and adults level 3: 67%

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). We reviewed the documentation for four patients with protected characteristics and found them to be fully completed.

Staff could give examples of safeguarding concerns and knew how to make a safeguarding referral and who to inform if they had concerns. Each area had visual prompts for the process and the safeguarding adult and children's policies were available for reference on the trust intranet. We reviewed three safeguarding referrals on different wards and found them to be completed correctly.

Managers recruited staff safely within departments, this included an enhanced Disclosure and Barring Service certificate, history of employment and references, followed by a comprehensive local induction and training.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained.

All areas displayed cleaning schedules, cleaning records were up-to-date and showed all areas were cleaned regularly. Cleaning staff were trained how to clean to minimise the spread of infection. All staff took pride in the cleanliness of the ward areas.

Ward cleaning audits were up-to-date and showed all areas were cleaned regularly. Cleaning audits provided by the trust for the period April 2022 to March 2023 showed an average overall compliance rate of above the trust target of 95%. Care Group matron audits provided by the trust for the period September 2022 to March 2023 showed an average overall compliance rate above the Care Group target of 90%.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff wearing personal protective equipment within the hospital. There were enough masks, gloves, aprons, and antibacterial hand gel dispensers within clinical areas of the wards. Hand hygiene and PPE compliance audits for the Care Group for the period December 2022 to March 2023 showed an average overall compliance of 96%.

Notices at ward entrances reminded patients to wear a mask and to sanitize their hands before entering. We observed staff were bare below the elbow to prevent infections. Laminated signs identified patients who were in side rooms on several wards as being barrier nursed to prevent the spread of infection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green tags were attached to equipment with the date recorded of when it had been cleaned. We observed equipment being cleaned during inspection.

Between April 2022 and March 2023, the Care Group had 16 cases of clostridium difficile. Each case was investigated by the trust and a reduction strategy was in place.

The Care Group had 30 COVID outbreaks between October 2022 and March 2023. We saw that areas for learning had been identified and appropriate actions had been taken.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

At our last inspection in April 2021 we found there was no dedicated area on the stoke unit to treat acute stroke patients who have been thrombolised. At this inspection we found that thrombolised patients were now grouped together in a dedicated high dependency area of the unit.

At our last inspection we found patients were not always admitted directly to a stroke unit; which was not in line with guidelines and best practice. At this inspection we found the trust now ‘ring fenced’ stroke beds – ensuring they are only utilised for stroke patients.

We saw the patients were able to access the call bells in areas and staff were visible if support was required. Patients who needed enhanced observation were allocated beds in bays next to the nurse’s station. Staff assisted patients when they asked or called for help. For example, we saw a nurse and health care assistant walking with a patient to their rehabilitation session on the stroke unit.

The design of the environment followed national guidance. All areas met the standards set out in Health Building Note (HBN) 04 – In-patient care.

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance.

Each ward had fire extinguishers which had been serviced in the last 12 months. Fire exits were signposted clearly, and the wards had equipment to move patients in an emergency.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care. We observed patients undergoing rehabilitation on several wards and patients we spoke with said that the facilities were excellent and met their needs.

At our last inspection the service did not have enough suitable equipment to help staff to safely care for stroke patients. At this inspection we found that the unit had enough equipment to provide care for six acute stroke patients who need continuous monitoring for 72 hours after thrombolysis.

Waste was separated and stored securely before being disposed of safely. Sharps boxes were assembled, used and disposed of correctly.

The service ensured cleaning products were stored safely in line with Control of Substances Hazardous to Health (COSHH) Regulation 2002. The doors to the cleaning cupboards were locked so cleaning products could not be accessed by an unauthorised person.

Endoscopes were managed and maintained in accordance with health technical memorandum (HTM 01-06) Management and decontamination of flexible endoscopes.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service used the national early warning score (NEWS2) to monitor for deteriorating patients. There was also an electronic sepsis screening tool. There were triggers identified in the deteriorating patient policy so that staff were aware when they needed to refer for additional support.

There were pathways and processes for the assessment of people using services within the endoscopy and radiology units who were clinically unwell and required hospital admission.

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed these regularly, including after any incident. Of the 24 patient records we reviewed, all risk assessments were completed and had been reviewed in a timely manner in line with the trusts own policy. The electronic patient record included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff demonstrated that they had an awareness of any high risk patients and mitigations in place to manage the risk.

In addition, the trust used a Stroke Thrombolysis Observation Complication Chart and NIHSS to assess stroke patients. We reviewed 6 patient records who had been thrombolised in the month prior to our inspection and found that the relevant NIHSS Scores were found in all records.

The service had 24-hour access to mental health liaison and specialist mental health support and staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The trust had engaged with the local constabulary to develop a protocol and risk reduction tool to be used in the event of an adult with care and support needs going missing. It consists of a form that contained vital information about a person at risk that could be passed to the police at the point the person was reported missing.

Shift changes and handovers included all necessary key information to keep patients safe. Staff used a handover sheet to record key information when handing over care to other staff. All staff on duty attended a department safety huddle that was held at least twice daily.

We reviewed patient records and saw that endoscopy staff completed the World Health Organisation (WHO) surgical safety checklist.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and clinical support workers needed for each shift in accordance with national guidance. The trust used the Safer Staffing model to adjust the planned staffing numbers according to patients' needs.

The service target for fill rates was above 85%. Between October 2022 and March 2023, the average fill rate for day and night nurse shifts was 92%. Between October 2022 and March 2023, the average fill rate for day and night clinical support worker shifts was 93%.

At the time of our inspection, the service had 1.30 whole time equivalent (WTE) nursing vacancies. The service had recruited many international nursing staff during the last 12 months which had seen a significant reduction in vacancies.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. Staff were classed as supernumerary during their induction period. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

The service had low turnover and sickness rates compared to the sector average. In February 2023 the turnover rate for registered nursing staff was 4.39%. In February 2023 the absence rate for nursing staff was 3.97% which had reduced from 5.54% in September 2022.

Staffing issues were discussed monthly at Care Group Board meetings and actions were agreed to make any necessary changes. Staff told us that they were supported to learn and develop, and they had opportunities to progress within the organisation.

Medical care (including older people's care)

Medical staffing

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

The service had enough medical staff to keep patients safe. At the time of our inspection, the service had 23.57 whole time equivalent medical vacancies which equated to 16% of the medical workforce. The main area of medical staffing concerns fell within the gastroenterology specialism team. This was recorded as the top risk on the Care Group risk register and the trust were actively recruiting.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Staff told us the service always had a consultant on call during evenings and weekends. We were provided with data from the trust that showed additional consultant and doctor rota cover with mitigations when staffing did not meet optimal levels.

The service target for fill rates was above 85%. Between October 2022 and February 2023, the average fill rate for day and night shifts was 84.6%. The Medicine care group had a weekly review of medical staffing with an escalation route to the medicine triumvirate to ensure appropriate cover was in place. Specialties operated a 'Consultant of the Week' model to support continuity of care.

The service had low turnover and sickness rates for medical staff compared with the sector average. In February 2023 the turnover rate for medical staff was 7.40%. In February 2023 the absence rate for medical staff was 3.86%.

Managers could access locums when they needed additional medical staff. They made sure locums had a full induction to the service before they started work.

Staffing issues were discussed monthly at the Care Group Board meeting and actions were agreed to make any necessary changes.

Junior medical staff we spoke with said they had access to support and teaching and felt the hospitals academic and research links were an advantage to their ongoing development.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The electronic patient record contained relevant risk assessment bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed. The records reviewed were contemporaneous, legible and there was clear evidence of multidisciplinary team (MDT) working.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff including locum and bank staff told us that they could access all patient records easily. Electronic patient records were accessed through computers throughout the service. These computers were password protected. Staff ensured that computers were locked when they were not attended. Staff told us that they had enough computers to allow patient records to be completed contemporaneously.

Medical care (including older people's care)

We reviewed 24 patient records. All records reviewed had risk assessments, care plans, observations and NEWS2 scores recorded and had been reviewed in a timely manner.

Medicines

The service had systems and processes to prescribe and administer medicines safely. The trust was developing and investing in pharmacy workforce to support continued improvement in medicines optimisation.

Staff followed systems and processes to prescribe and administer medicines safely. The service had an electronic system for prescribing and administering medicines (ePMA) with access limited to staff who had completed system training. Nurses on the stroke ward checked a recognised reference source before crushing medicines to help ensure that it was done safely. However, medicines records were not always accurate because the ePMA records did not reflect that medicines were crushed or given in liquid form on first admission to the stroke ward. Paper records were used for variable rate infusions, we saw one example on the acute medical unit where the paper record had not been clearly completed and did not align with the prescription on the ePMA. This was addressed during our inspection.

Staff reviewed each patient's medicines regularly. Pharmacists used a clinical dashboard to prioritise patients for review, for example, patients with poor kidney function, or those prescribed antibiotics. However, on the stroke ward an alternative antiplatelet medicine had not been considered for one person who was unable to take the first line medicines. We raised this with the pharmacy team in order that this could be reviewed.

Since our previous inspection there was an increased focus on antimicrobial stewardship. The pharmacy antimicrobial stewardship team was completing increasing numbers of antimicrobial CDI (clostridium difficile infection) risk reviews and a baseline audit was underway to support appropriate antimicrobial prescribing.

Patients on the stroke unit were asked about smoking and prescribing was available to support smoking cessation. However, as also identified in a recent trust audit there were 'missed opportunities for interventions to help patients stop smoking when in hospital'. Following our inspection the trust provided evidence that they had employed a smoking cessation team whose roles commenced in April 2023.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The trust KPI for medicines reconciliation within 24hrs of admission at RLI was ~59% Q4 2022/23, which was an improvement from 36% in 2019/20). Wards made use of electronic messaging to contact pharmacy and there was nominated support for medicines reconciliation. Ongoing improvement work focussed on the timely supply of discharge medicines was in progress on one ward.

Staff learned from safety alerts and incidents to improve practice. The outcomes of pharmacy and medicine audits, incident sand policy updates were shared for learning at wards meetings.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

Between October 2022 and March 2023, the trust told us there were 747 incidents reported in the medical Care Group. The most common theme of incidents being reported was pressure ulcers and skin care. Each incident had action plans and lessons learned where appropriate. There were no never events on any of the medical wards in the 6 months prior to our inspection. We reviewed minutes from the Care Group's quality assurance committee and saw there was ongoing work streams to reduce pressure ulcers and falls.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy using an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Serious incidents were investigated jointly by a multidisciplinary team. Patients and their families were involved in investigations where appropriate. We reviewed 3 incident investigations. They were detailed, provided the root causes of the incident, actions were proposed with an action plan owner and review date to ensure continuity. Staff involved in reporting were given feedback at the conclusion of any investigation.

Managers shared learning with their staff about all relevant incidents that happened elsewhere in the hospital and trust. Staff told us that they felt informed about incidents that had happened on their ward and serious incidents elsewhere and that learning from incidents was shared well.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a clinical leads meeting and learning from incidents was fed back to staff in safety huddles and by email. We reviewed ward team meeting minutes and found that incidents and learning were discussed.

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, deliver and evaluate care and treatment. The document referenced the National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow.

Medical care (including older people's care)

Clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed generally well in national clinical audits.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. Handover information included details of psychological information where relevant. We observed an MDT meeting where these aspects were discussed if relevant.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were offered three meals a day. Staff supported patients to eat and drink if needed and provided fresh water.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service used the Malnutrition Universal Screening Tool (MUST).

Specialist support, from staff such as dietitians and speech and language therapists, was available for patients who needed it. Medical and nursing staff could make referrals for support from dietitians and Speech and Language Therapists for patients. Patients received individualised nutrition and hydration care plans. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed.

The service made adjustments for patients' religious, cultural and other needs. They had recently developed a dementia friendly food menu. As people with dementia can often find it difficult to eat a full meal, they have incorporated more finger-foods and snacks including picnic plates. It also included tips for families and carers on how to assist a person with dementia whilst they are eating.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice and patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately and pain scores were recorded in all patients notes we reviewed.

Staff used pictorial aids to assess the pain of patients who could not communicate verbally. Most patients said staff gave them pain relief when they needed it, and their pain was well managed.

Medical care (including older people's care)

The 2021 NHS Adult Inpatient Survey showed that responses for ‘do you think the hospital staff did everything they could to help control your pain’ the trust performed in line with the national average.

Pain specialists routinely reviewed patients during the week. They supported staff with complex pain management methods. Staff we spoke with were aware of the pain team and how to make referrals to them for individualised advice and said they would contact them for difficulties with pain management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas. The service participated in relevant national clinical audits.

The trust performed better than the national average for most key indicators in the national breast cancer in older patients audit 2022. The trust performed mostly in line with the national average for the national bowel cancer 2021 audit.

Since our last inspection the trust has shown continual improvement from E to C on their sentinel stroke national audit programme (SSNAP) scores and performed well when compared with other trusts both regionally and nationally in data validated in December 2022. Validated data provided in June 2023 showed a further improvement to a B.

Managers shared and made sure staff understood information from the audits. Staff we spoke with told us that they were informed of audit results via the ward newsletters and at handover and team meetings. We saw the minutes of the service meetings for January, February and March 2023 which showed that both national and local audits and quality improvement projects were presented and there was opportunity to escalate any issues.

The endoscopy service was accredited by Joint Advisory Group (JAG). JAG accreditation is a formal recognition that an endoscopy service has demonstrated it has the competence to deliver against the criteria set out in the JAG standards. The endoscopy service had been nominated for 2 awards in the 2023 Health Service Journal (HSJ) awards for their work on elective care recovery.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development, however not all nurse appraisals were completed in a timely manner.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Staff said the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff development and training was supported by clinical educators and practice development nurses.

Managers made sure most staff received specialist training for their role. Staff completed competencies for the specialist area they worked in. For example, staff working on the respiratory ward received training in non-invasive ventilation (NIV) and critical care level one training to manage level 2 (high dependency) patients, who were often managed on the respiratory ward.

Managers generally supported staff to develop through yearly, constructive appraisals of their work. The current medical appraisal rate supplied was 92.7% against a target of 90%. However, the nursing appraisal rates showed an average compliance across medical wards of 74.3% against a target of 90%. Following our inspection, the trust provided evidence that nurse appraisal rates had improved to 84.4% in July 2023. Junior medical staff had an allocated clinical supervisor.

Nursing staff attended daily safety huddles where all patients on that ward were discussed. There were handovers at shift changes, during which patients, operational matters and any incidents and complaints would be discussed.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective MDT meetings to discuss patients and improve their care. On the wards we visited there were daily MDT meetings which were attended by different members of the MDT which included doctors, physiotherapists, ward sister or manager and discharge planner. Items such as discharge dates, social backgrounds, occupational and physiotherapy, actions required, discharge paperwork, DNACPRs, investigation results, symptom management, medications and specialty reviews needed were discussed.

Staff we spoke with commented on the positive culture throughout the medical wards, they said they felt there was good team working across all clinical and non-clinical staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff could make referrals to other clinical specialties, including mental health, for advice and support. Physiotherapists, occupational therapists, dietitians and speech and language therapists, specialist nurses and social workers were involved in patient care as required.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff could make referrals to the psychiatric liaison service as required.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including on weekends. Patients were reviewed by specialist consultants depending on the care pathway. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

There was an on-call medical team available out of hours. The psychiatric liaison team was accessible for mental health support out of hours. Diagnostic tests required for urgent management decisions were available out of hours.

The service always had senior nurses on site and staff had access to an onsite operational commander and an on call tactical commander at weekends.

Medical care (including older people's care)

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. We saw posters and information leaflets in the service for patients and relatives to promote a healthy lifestyle.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The In-Patient Admission Bundle included sections which assessed aspects such as alcohol intake, smoking, eating well, physical activity and mental wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately. The service provided training in the Mental capacity Act, however, not all medical staff completed it.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were mostly completed correctly. Records of DNACPR decisions showed most were completed correctly.

Records showed managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff could access the trust safeguarding team for assistance and guidance with completion of DoLS applications.

Mental Capacity Act training was mandatory for nursing and medical staff. Compliance rates were 100% for both nursing staff and clinical support workers and 66% for medical staff. At the time of our inspection the trust had set a target of 95% for all staff in all mandatory training topics. Following our inspection, the trust provided evidence that they had reduced their compliance target rate to 85% in May 2023.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Medical care (including older people's care)

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Call bells were answered promptly by staff. Curtains were pulled around the bed areas to provide privacy when needed.

Patients said staff treated them well and with kindness. Patients we spoke with at the inspection told us that staff treated them with dignity and compassion. The 2021 NHS Adult Inpatient Survey showed that responses for 'did you feel you were treated with respect and dignity while you were in hospital' were in line with the national average.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients we spoke with at inspection told us that these various needs were met. We saw that handover sheets included information on these aspects.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with at inspection agreed that staff provided emotional support to them and their relatives when needed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients we spoke with at inspection told us that staff understood this.

The trust's palliative care team provided support to patients and their families who were in the final stages of their illnesses. The trust provided a bereavement service for families who had a relative die when in the hospital; this was in line with the trust's Care After Death policy. This service provided emotional and practical support for families who had been bereaved.

The hospital had a multi faith spiritual care service with 24hour access to a multi faith prayer room to support patients and their relatives.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand. Patients we spoke with at inspection reported that staff spoke to them in a way they could understand and would rephrase information differently or simplify it if required.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. All areas invited patients to provide feedback using the national Friends and Family Test (FFT). Data from the February 2023 Friends and Family Test showed that for those medical wards that had submitted enough responses they received an average 96% positive feedback.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients.

Medical care (including older people's care)

Is the service responsive?

Good ↑↑

Our rating of responsive improved. We rated it as good.

Service planning and delivery to meet the needs of the local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services to ensure they met the changing needs of the local population. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia specialist nurse and how to make a referral to their service.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation. There had been no reported mixed sex breaches in the past 6 months.

Managers monitored and took action to minimise missed appointments and managers ensured that patients who did not attend appointments were contacted.

The service had systems to help care for patients in need of additional support or specialist intervention. There was access to dietitians, speech and language therapists (SALT), physiotherapists, and other clinical specialties for opinions. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations. The premises were mostly airy and welcoming.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The psychiatric liaison service was available 24 hours a day and 7 days a week.

Staff and leaders worked to relieve system pressures and improve patient experience by delivering same day care and treatment when appropriate to prevent unnecessary admissions.

The Care Group had developed a multi-disciplinary Frailty Intervention Team whose key role was to assess older frail patients for admission avoidance to the Emergency Department in addition to assessing suitability for home management via a virtual frailty ward. We saw evidence that most days between 6-8 admissions were avoided, and patients were supported to stay at home.

Meeting people's individual needs.

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical care (including older people's care)

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The Psychiatric Liaison Service provided 24-hour advice on mental health conditions. The Psychiatric Liaison Service would support staff and patients with an acute presentation or changes in condition relating to dementia.

The trust safeguarding team were able to support staff with urgent issues or provide advice. There was a learning disabilities team available during normal working hours.

Wards were designed to meet the needs of patients living with dementia. The hospital used recognised guidance to ensure the hospital environment and wards were dementia friendly.

We saw that patients with dementia or cognitive impairment had a butterfly displayed over their bed to indicate they had needs associated with dementia or cognitive impairment. Staff we spoke with were aware of how to access specialist mental health or learning disabilities advice and support.

Patients who had a learning disability, dementia or other cognitive impairment were identified at ward handovers and safety huddles.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and ‘Forget-me-not’, patient passports. There were activities coordinators who completed 'all about me', or 'this is me' documentation for patients with a cognitive impairment, dementia or learning disability. The trust had recently recruited an Admiral Nurse to provide a service to all staff, patients, and visitors for dementia care from Monday to Friday.

The Care Group was also taking part in the John’s campaign which allows for extended visiting rights for family carers of patients with dementia.

Staff were aware of ways to meet the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to support patients to be able to communicate effectively with staff.

The Care Group was involved in the launch of the trust’s new end of life strategy launch in December 2022 where they have embraced the signs, words, actions and needs (SWAN) model of care for the dying patient. The SWAN model is used to support and guide the care of patients and their loved ones during end of life care, and afterwards.

Managers made sure staff, patients, relatives and carers whose first language was not English could access interpretation services when needed. There was a telephone-based interpretation service which allowed immediate access to an interpreter 24 hours a day. Face-to-face interpreters required booking in advance. British Sign Language support could be arranged through the Patient Advice and Liaison Service (PALS). Low vision support services were available, which included printing documents in larger font sizes.

Staff had access to hearing loops to communicate with patients and their carers or family. Patient information was available in alternative languages.

We saw examples of innovative practice being used to support patient’s individual needs.

Medical care (including older people's care)

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and generally received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure they started discharge planning as early as possible. The trust had a dedicated bed management team to manage and maintain patient flow.

There was a complex discharge team who were responsible for ensuring patient discharges for patients with more complex needs. They worked across 7 days and facilitated discharges for patients nearing the end of life or going to a care home.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The service moved patients only when there was a clear medical reason or in their best interest.

Managers monitored patient transfers and followed national standards. Site meetings were held 4 times a day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Staff supported patients when they were referred or transferred between services. Staff supported patients with additional needs to be discharged to hospices, care homes or patients' own homes.

In January 2023, 71% of patients on the waiting list were treated within 18 weeks. This placed them in the top 25% of trusts when compared with other trusts nationally.

In March 2023 there were no patients waiting over 78 weeks for treatment.

The trust was on par with or better than other providers and the national average for cancer waiting times. The 14 day cancer referral rate was 85%, above the national average of 72%. The rates for 31 and 62 days were 89% and 69%, slightly below and above the national averages of 94% and 61% respectively.

In November 2022 the trust had 6% of patients waiting more than 6 weeks for a diagnostic test and 0.6% of patients waiting more than 13 weeks which was in the top 25% of trusts when compared with other trusts nationally.

On 28 March 2023, the overall occupancy of the trust was 86% which was better than the regional average.

The Care Group had developed and expanded upon the Priority Assessment and Discharge Unit (PADU) since it opened in February 2021. The PADU is a clinical assessment and treatment area that actively pulls patients from the emergency department and medical wards that are fit for discharge but may require further monitoring, non-urgent clinical tests or awaiting discharge medicines from pharmacy. The PADU was a seven-day service that averaged 800 discharges per month ensuring access and flow within the hospital has improved with over 300 discharges coming in directly from the emergency department alone.

Medical care (including older people's care)

At the time of our inspection, the trust did not have any medical outliers (medical patients placed on a non-medical ward). The trust outlying patient policy included escalation procedures. The policy included a clear criteria that staff were required to consider before a patient was deemed suitable to outlie in another inpatient area.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas. Details about how to raise a concern or make a complaint were displayed on the trust website and displayed in ward areas. The service displayed quality boards in the ward areas. Staff updated these boards monthly and recorded the number of complaints received for each area for patients and visitors to see.

Between October 2022 and March 2023, the medical Care Group received 35 formal complaints raised through the patient advice and liaison service (PALS).

We asked for but did not receive data from the trust regarding timeliness of complaint responses. At the time of our inspection the Care Group only recorded final response times. For the period October 2022 to March 2023 the average complaint response time was 80 days. Following our inspection, the trust told us they had updated their complaints policy and implemented a reportable process by which to monitor and audit all stages of new complaints. The top category for complaints was “inadequate care and treatment”.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with during the inspection were able to explain how they would approach patients and relatives who wished to make a complaint. Managers investigated complaints and identified themes. The ward and unit managers were responsible for investigating complaints in their areas. Managers shared feedback from complaints with staff and learning was used to improve the service.

Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Complaints were reviewed at Care Group governance meetings.

Patients received feedback from managers after the investigation into their complaint.

We reviewed 3 complaint responses and saw that they were comprehensive, and concerns raised by complainants were addressed. The trust had acted when learning was identified from complaints and learning was shared with the relevant teams and across the wider trust.

Is the service well-led?

Good ↑↑

Our rating of well-led improved. We rated it as good.

Medical care (including older people's care)

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders of the medical Care Group worked in a multi professional Care Group Triumvirate which included an Associate Director of Operations, a Clinical Director, and an Associate Director of Nursing.

Medical wards had a ward manager who were supported by a speciality triumvirate consisting of a Matron (quality and safety), a service manager (operational) and a clinical lead (medical). The ward managers we spoke with on the wards we visited were visible and engaging and had good knowledge of operational matters and the patients on their wards. Matrons met with ward leaders on a one-to-one basis and discussed issues such as workforce and current trends and themes around risk and issues.

As part of the inspection, we interviewed ward managers and matrons, head of nursing and clinical leads and general managers. All were engaging and demonstrated good understanding and knowledge of clinical and operational matters.

Staff we spoke with found leaders approachable and accessible. Leaders proactively sought to make themselves visible and accessible to both staff and patients. Ward manager details were displayed on wards to enable easy contact by patients and relatives, and some ward managers said they would approach new patients to introduce themselves and explain their role.

We observed good leadership skills in all ward areas. Leaders were seen giving clear directions and support to junior colleagues. The Care Group had recently hosted a ward managers study day with the focus being on providing support.

Staff were encouraged and supported to develop their skills and take on more senior roles. The trust had development programmes for staff aspiring to be leaders.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff at all levels could describe a vision and strategy for their individual wards. The trust wide vision was displayed in all ward areas. Care Group leaders said Care Group strategies were developed based on the needs of the local population and were aligned to the trust vision and strategy.

The trust listed 4 strategic priorities within their Patient First 5-year strategy due to run until 2027;

- Develop outstanding care and experience.
- Create the culture and conditions for our colleagues to be the very best they can.
- Make the best use of our physical and financial resources.
- Working in partnership.

Medical care (including older people's care)

The trust's 4 strategic priorities were embedded within the Care Group's Medicine plan on a page strategy document for 2023/24.

The trust vision “Creating a great place to be cared for and a great place to work” was included in trust documents and in records of leadership and governance meetings.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during the inspection were positive about the culture, saying that it was friendly, with lots of support, and that people all helped each other. They felt the service was open and honest. Clinical leads said they all supported each other, even when not on call, and that there was good will amongst the consultant body.

Staff felt valued and supported by their immediate managers. At a ward and unit level, staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients. Staff spoke positively about wellbeing resources provided by the trust.

The 2022 NHS Staff survey showed that for items such as ‘colleagues are understanding and kind to one another’ and are ‘polite and treat each other with respect’ the Care Group performed well when compared to the rest of the trust. On the questions of ‘I enjoy working with the colleagues in my team’, and ‘feel valued by my team’ the Care Group performed well when compared to the rest of the trust.

The workforce across the medical services was multicultural. Staff felt their identity and culture was respected.

The trust had developed several staff networks.

- Black and Minority Ethnic (BAME)
- Disability
- Lesbian, Gay, Bisexual, Transgender (LBGT)
- Armed Force

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders we spoke with had confidence that the systems for incident and safety matters were robust. We saw that incidents, complaints and audit results were discussed at clinical service governance meetings and mortality reviews, with some actions identified for improvements.

There were governance structures within the trust with good representation from all disciplines. Care Group governance group meetings fed into the quality or governance meetings which reported to the executive management committee and to the committees of the board.

Medical care (including older people's care)

There was a clear governance structure within the Care Group. They held their own clinical governance meetings. We reviewed clinical governance meeting minutes and we saw that matters including incidents, audits, complaints, compliments, patient experience, risks, risk register and risk management and action logs were discussed at these meetings.

A programme of audits measured the performance of the service, including staff adherence to trust policies and guidance.

The trust board received routine reports on waiting time performance and national audit programmes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service maintained a risk register which gave details of risks, the control measures in place, ownership, review date and risk rating level for the different clinical service lines. Ownership of risks and their control measures was allocated to specific individuals, and there was an area on the register where they could provide date and time-stamped risk reviews to monitor progress. Risks could be escalated by Clinical Service Lines to the Executive Board, which could provide Executive support and oversight of risks as deemed necessary.

Risks were recorded at ward, Care Group, and trust level, in accordance with the governance framework. Leaders told us that high scoring risks from the Care Group risk register were escalated and considered at a more senior level and for the most significant risks at board level.

Records of governance meetings showed that risks were considered at most meetings. Risk registers set out who was responsible for the risk and the dates the risk had been reviewed which included actions taken to reduce or mitigate the risk.

The clinical and non-clinical leaders we spoke with as part of the inspection demonstrated a good awareness and understanding of the risks existing in their areas and for the service as a whole.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust collected, analysed, managed, and used information to support its activities, using secure electronic systems with security safeguards. The trust's website provided annual quality performance reports and board reports which included data about performance. This gave patients and members of the public a range of information about the safety and governance of the hospital. Senior leaders had confidence that data was accurate and reliable.

Information governance and data security training was part of the mandatory training programme, compliance had been met by nursing staff and clinical support workers, however medical staff fell below the required compliance target of 95% with just 74% of staff completing the training. There was an action plan in place to improve mandatory training compliance in general.

Wards had computer terminals to allow staff to access patient results and trust guidelines and policies through the trust intranet. Staff had individual logins and passwords to access this information.

The trust had 4 information governance incidents in the last 6 months. The severity of 3 of these incidents did not meet the criteria to be reported to the Information Commissioner's Office (ICO), 1 was still under investigation. The trust had taken appropriate action to investigate the closed incidents and mitigate any ongoing risk.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward leaders and staff explained that they would introduce themselves to new patients and relatives on the ward, so they knew who to come to if there were any problems. Details of ward leaders were displayed in the main areas of wards to inform patients and their relatives of who to contact with any queries or concerns. When patients were ready to be discharged staff collected feedback from them.

Staff we spoke with told us they felt involved and engaged and listened to by leaders and felt they could approach them with suggestions for improvements or concerns. The trust participated in the 2022 NHS staff survey to gain staff views on multiple aspects of their work. We saw that for the parameter 'Able to make suggestions to improve the work of my team/dept' some of the medical wards performed well when compared with the comparator organisation results overall. Similarly, the parameter 'Able to make improvements happen in my area of work' the results from clinical staff on medical wards performed well when compared with the comparator organisation results overall.

Information about incidents, complaints, compliments, and operational aspects was shared with staff at daily ward handover meetings and via ward newsletters. There were also 'safety huddles' where staff reviewed all patients on the ward and were able to raise any problems.

We reviewed minutes of the quarterly patient experience group where a 'Patient Story' and local Health Watch reports were standing agenda items.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

A sundown lamp was being trialled on the Acute Medical Unit for patients with dementia. The light from a sun lamp is believed to have a positive impact on serotonin and melatonin. These chemicals are believed to help control the sleep and wake cycle. Serotonin also helps reduce anxiety and improve mood.

All wards and departments were being supported to identify areas for improvement and use quality improvement methodology to bring about the changes. A monthly 'Learning to Improve' bulletin was issued trust wide.

Furness General Hospital

Dalton Lane
Barrow In Furness
LA14 4LF
Tel: 01539716689
www.uhmb.nhs.uk

Description of this hospital

Furness General Hospital (FGH) is one of three hospital sites of University Hospitals of Morecambe Bay Foundation Trust's and is one of the two main hospital sites. It serves the population of Furness and the surrounding areas in South Cumbria with consultant led maternity services.

At Furness General Hospital the maternity department consisted of one ward of 14 en-suite rooms where obstetricians and midwives provided antenatal, intrapartum, and postnatal care. Two maternity theatres adjoined this area and a specialist bereavement suite, a separate antenatal clinic and day assessment area. There was also a triage area on the birthing ward with trained rotational midwives providing cover.

Around 2,800 babies are delivered within Morecambe Bay Maternity services per year.

We carried out this unannounced comprehensive maternity inspection because at our last inspection we rated the service overall as inadequate. The trust was receiving mandated support as it was placed in SOF4 by NHSE. It was also in receipt of mandated maternity support.

Details of our last inspection on 20 April 2021 and the actions taken were published on 20 August 2021 and can be accessed on our website.

Our rating of this location improved. We rated it as requires improvement because:

- The service had enough staff to care for women and keep them safe. Most staff had training in key skills and understood how to protect women from abuse. Staff managed safety well. Staff assessed risks to women, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Key services were available seven days a week.
- Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.

Our findings

- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders had improved information systems and supported staff to develop their skills. Staff were focused on the needs of women receiving care and were clear about their roles and accountabilities. The service was improving engagement with women and the community to plan and manage services. All staff were committed to improving it.
- Leaders had identified and acted on cultural issues where not all staff felt respected or valued.
- The service used systems and processes to administer and document medicines safely.

However:

- Women receiving maternity care, who were assessed as at risk of sepsis, did not always follow the required care and treatment pathway in line with national guidance and antimicrobial medicines were not always prescribed appropriately.
- The was no documented prioritisation of women requiring an induction of labour and there were delays in accessing fetal anomaly referrals. Staff did not always follow best practice guidance when monitoring the fetal heart rate and followed out of date emergency protocols.
- Medical staff mandatory training including safeguarding compliance had not improved since our last inspection and staff did not know or understood the service's vision and values, or how to apply them in their work.
- The service did not always control environmental infection risk well or remove equipment when out of service. There was not always enough blood pressure monitoring equipment.

Maternity

Requires Improvement ↑

Is the service safe?

Requires Improvement →←

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.

Staff said they received and were up to date with mandatory training. Midwifery staff were compliant with their mandatory training but compliance for medical staff had not significantly improved from our last two inspections.

All targets were set at 90%. GAP/Grow set by the perinatal institute was 75%. The trust provided data as of December 2022 for core competency framework multidisciplinary training (MDT) compliance and service core skills, which showed training compliance for midwives (MW) was meeting the required standards. However, medical staff (Drs), with the exception of New Born Life Support (Face to face), were failing to meet the minimum required standards for training for, Saving babies lives 56%, Emergency Skills and Drills (Face to Face) Drs 88%, Basic Life Support (Face to face) 58%, Safeguarding level 3 children 54%, GAP GROW Theory for Drs 70%, Personalised care 73%, Infection prevention and control 77%, Baby Abduction 45.5%.

Both medical staff and midwives had not met the trust training target of 90% for Fetal Surveillance Monitoring in labour from data provided to the end of March 2023, Drs 70% and Midwives 76%.

K2, which was a bundle training package for fetal monitoring, was mandatory with a theory and competency assessment required. Fetal monitoring (Cardiotocography, CTG) was also included in practical obstetric multi-professional training (PROMPT) with three training sessions. Training compliance was monitored by the fetal monitoring midwife lead and an escalation process was in place for staff who did not complete training when required. However, K2 was being removed as mandatory training and replaced with a fetal surveillance day to improve compliance to complete the training in a timelier manner.

All CTG's followed a nationally recognised criterion. Fresh Eyes duration audits had been completed indicating a compliance rate of 95%.

There was evidence that staff were emailed when they were not compliant with mandatory training. Four days protected time was allocated for staff to complete their mandatory training and support offered where this could not be met. Sickness and long-term absence were an impacting factor on training figures.

It was identified in the board report for February 2023 that there was an issue with the monitoring and reporting of role specific training and being able to report and quality assure training across multi professionals. Actions were implemented to ensure that all the education team could provide accurate training statistics across the professional groups, and not just the education lead to provide more accurate training compliance data.

Maternity

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, medical staff did not always complete it.

Nursing and midwifery staff said they received training specific for their role on how to recognise and report abuse and could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Information provided by the trust regrading compliance with mandatory safeguarding training was 96% for midwives.

We were told medical staff were now receiving training specific for their role on how to recognise and report abuse.

The service had a specialist multiskilled enhanced maternity team consisting of two midwives, a maternity support worker with enhanced skills, and a community midwife manager who provided safeguarding support to staff. They were the initial point of contact for vulnerable women and had their own maternity caseloads to ensure women and families identified appropriate care to provide and implement a personalised birth plan.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman's mental health). The enhanced care midwives completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide.

Systems were in place to identify vulnerable women and families on the electronic record system to ensure staff could provide appropriate care. The service worked well with other agencies to protect women and families.

Staff followed safe procedures for children visiting the ward. An access swipe card system had recently been installed to maintain security throughout the building. Staff had to be approved before a swipe card was issued through internal processes. The swipe card speeded up access to areas which was an improvement on the previous keypad coded system. Staff offered challenge to persons trying to enter without permission or following someone who had (Tail gating).

The service had a baby abduction policy. Information post inspection showed abduction drills had taken place in September 2022 and May2023.

Midwives were compliant with baby abduction training, but medical staff were not.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff mostly used equipment and control measures to protect women, themselves, and others from infection. However, they did not always keep equipment and the premises visibly clean.

he service had processes in place to audit cleaning and infection prevention and control measures. Audits carried out by the South Lakes Birthing Centre cleaning team were above 98% compliant between January and March 2023. Staff cleaned equipment after patient contact, and we observed 'I am clean stickers' on equipment. The birthing pools were cleaned daily and domestic staff had a weekly deep clean on their checklist. We saw housekeepers on the birthing unit carrying out cleaning tasks.

Information boards on the birthing unit and data provided showed 100% compliance for hand hygiene and constantly over 98% for environmental cleanliness from January to March 2023. Discharge rooms were not used until a terminal clean had taken place and signed to say it was cleaned.

Clinical areas were mostly visibly clean and had suitable furnishings. However, we noted computers on wheels in antenatal clinic were visibly dusty and some toilets were only cleaned once a day in the morning according to a completed schedule. Hand hygiene gel did not always have expiry dates on the bottle and some handwritten dates added were out of date.

On the birthing unit we noted a shower head had limescale which posed an infection risk in a birthing room.

When reviewing the theatres undertaking maternity procedures, we escalated some infection and prevention control (IPC) concerns to the theatre managers and director of midwifery who said the theatres IPC were managed by the surgical team and not the maternity team. We asked that these concerns be escalated and addressed without delay. The director of midwifery confirmed she would discuss the concerns with the surgical leads. Following our inspection, the trust confirmed all IPC concerns had been addressed and actions taken.

A new Infection Prevention dashboard was under construction in the trust that would hold and collate the data for all Infection Prevention mandated data, such as, E. Coli blood stream infections, Clostridium Difficile (C. Diff) blood stream infections, MRSA, and MSSA blood stream infections plus COVID, Flu and RSV for under 16-year-olds. No data was provided when requested for infection rates such as C. Diff, MRSA, and E. Coli, however, a narrative response was provided after the inspection that confirmed there were no cases of E. Coli, MRSA or C. Diff at South Lakes Birth Centre in the last 12 months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, they did not always remove equipment when it was out of service.

Women said they were given call bells and staff responded quickly when called. Due to the nature of the birthing rooms this was not observed. No call bells were heard on inspection.

Equipment maintenance and servicing was carried out by an ISO 9001:2015 accredited service based on each hospital site. It provided a full range of services linked to the management of medical devices. We observed compliance with equipment maintenance, servicing and portable electrical equipment testing which was supported by data provided.

The service had suitable facilities to meet the needs of women's families.

Staff carried out daily safety checks of specialist equipment, such as adult resuscitation and baby resuscitates, which we observed, and data confirmed had a high compliance rate of 98.9%. These were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag.

However, one resuscitation trolly in antenatal clinic had a last recorded check on 8 August 2022 when the check book was full. A new check book had been ordered 8 December 2022 but had not been replaced. We escalated this immediately and was told the equipment was out of use. We asked that the equipment be removed, or clear signage displayed informing staff it was not in use.

Maternity

The service mostly had enough suitable equipment to help them to safely care for women and babies. However, staff told us there were not enough blood pressure checking equipment (two). If one of the machines required repair this left one machine available for 14 birthing rooms if in use.

The service had recently installed contactless key cards to facilitate easier door access and quicker transfer response times from one area to another which was an improvement on the keypad doors previously.

The day assessment unit had been moved and was now situated in the antenatal clinic making it more directly accessible which was an improvement since our last inspection.

The high dependency and intensive care unit were located an approximate 5-minute walk away from the birthing unit. Planned caesarean sections were scheduled twice a week in the maternity theatres with one theatre kept available for unplanned emergencies.

The design of the environment did not always follow national guidance as the high dependency and intensive care unit, were not accessible to the birthing unit in an emergency except through another ward. This has previously been reported on as a concern by CQC.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

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

Staff completed risk assessments for each woman on admission and arrival, and reviewed this regularly, including after any incident. A review of 10 patients records confirmed staff completed risk assessments to identify women at risk of deterioration and escalated them appropriately.

Staff used maternity obstetric early warning score (MOEWS) charts to quickly alert them to a deteriorating patient. Audits provided showed a 100% compliance for MOEWS for all 13 standards including women requiring review had a clear management plan documented.

Staff knew about and dealt with specific risk issues such as venous thrombosis and sepsis. We saw evidence of risk assessments being completed and recorded in patient records. Staff told us they complete VTE risk assessments at every opportunity, on admission to the hospital and post birth.

However, the trust had identified venous thromboembolism (VTE) assessments were not always being completed at appropriate times throughout pregnancy and following birth which placed women at risk of not having appropriate thromboprophylaxis which could lead to a pulmonary embolism. The trust had issued a briefing to staff in February 2023 and maternity was monitoring this weekly via the maternity dashboard to ensure compliance. Focus for the month in safety huddles was VTE assessment and recording.

A comprehensive policy and protocol for sepsis had been implemented in 2022 and staff had specific training. Sepsis management was included in skills & drills training. The service had a target of 100% for compliance to the policy. However, data provided for April 2023 showed staff at the South Lake Birth Centre (SLBC) did not always adhere to the policy and audits showed they were not achieving the 100% in most of the 15 benchmark standards.

This had been identified from audit reviews as an across Bay issue and an action plan implemented to improve recording of sepsis management and adherence to national guidelines. Where better reporting could be addressed mandatory fields have been added to e-records. Sepsis was discussed at unit and ward meetings to raise awareness of poor compliance and recording. Other actions included, all women commenced on the sepsis care bundle to be discussed with a consultant obstetrician regardless of time of day and updating antibiotic choice in guidelines with microbiology. The full action plan was due for review May 2023 and added to the risk register. The service had reported one sepsis incident 12 months ago before the new policy was implemented.

We attended routine staff safety huddles on the unit and found representations from all departments. In addition, there were also daily across Bay safety huddles for managers to raise concerns and discuss the staffing status. We also observed shift changes and handovers which included all necessary key information to keep women and babies safe.

When reviewing records, it was noted a women booked for an induction of labour (IOL) due to reduced fetal movements and additional risk factors, was told not to attend due to a lack of capacity on the unit. The woman was given advice for reduced fetal movements, but it was not clear how she had been prioritised for delayed treatment.

Leaders said women scheduled for IOL were reviewed at daily triage and discussed at handovers and safety huddles. Medical staff made the decision who had priority. Delayed induction of labour was on the risk register. Leaders said they were developing a standardised pathway to ensure women were receiving timely care.

However, there was no documented process or prioritisation of order for women needing induction of labour. Individual risk assessments were recorded in the records of women waiting for induction, but staff could not articulate which induction was a priority.

There was evidence that delayed induction of labour had been reported up to the Women's Health Quality Board Meeting and themes were identified with challenge offered to ensure women are getting face to face reviews by consultants and middle grade doctors.

A rise in the delayed induction of labour numbers was said to be due to the capturing of the information more clearly and these being reported. The trust had recently been flagged as an outlier for induction of labour for reduced fetal movements. A thematic review was completed, and the service said they were assured good clinical practice was taking place across the Bay.

Midwives were not currently trained in high dependency practice, but consideration had been given to this; however, there were concerns about maintaining competencies for this specialism. Women requiring intensive or high dependency care were transferred to the trust's intensive care unit (ICU) after consultation with the unit; this was a consultant to consultant and multidisciplinary decision. We were told specialist staff from the high dependency unit (HDU) could also come to the birthing room to care for women where possible reducing the separation of mother and baby. However, the transfer of patients from the birthing unit who required intensive or high dependency care still had to pass through another ward. This has been on the Woman and Childrens Service risk register since February 2020. From 1 April 2022 to 31 March 2023 there had been one transfer from the birthing unit to ICU.

The service had a range of comprehensive escalation and transfer polices and protocols in place to care for women who may deteriorate and require escalation and enhanced care. Escalation to another site was normally said to be identified and acted on antenatal to mitigate risks where possible. Women with cardiac conditions were booked at a specialist hospital in the region, but women may present at the unit and require stabilisation prior to transfer.

Maternity

We reviewed several complex management plans of higher risk women and found this had improved since our last inspection. We pathway tracked some women on the birthing unit and found clearly documented and appropriate care had been provided following the designated pathway. Where a more complex patient was receiving care the MDT team, consultant and anaesthetist were situationally aware. Telephone advice was sought appropriately from specialists outside the trust and all explanations to women were recorded in the notes.

All women were seen on the day of admission by a consultant and again within 14 hours due to the presence of consultants on the unit and twice daily ward rounds.

Planned caesarean section birth lists were scheduled twice a week in the maternity theatres with two women booked on each list. This could be extended to three if required. We were told caesarean section lists were never cancelled. A request has been made for an additional scrub team member out of hours to support with unplanned caesarean sections. Trust wide data indicated the caesarean section rate was comparable to national benchmarking.

The service had adopted an evidence based standardised triage tool to assess women presenting themselves with unexpected pregnancy related problems or concerns. The day case assessment unit and triage had recently been remodelled and moved locations. Triage and assessment now took place in a dedicated room on the birthing unit. Once triaged using the set criteria women were allocated a colour code, so hospital staff could identify and prioritise high risk women. This was 24-hour service 7 days a week. Only appropriately trained midwives were rostered to carry the triage phone and assess women when presenting. The service provided data demonstrating they were achieving assessment within the 15-minute standard. Additional senior midwives were being trained in the use of standardised triage tool to cover this service. The day assessment unit was now situated within outpatients and was following outpatient policy and procedures. All women attending the day assessment unit were booked in advance and only during clinic hours. This ensured medical cover was available should a review or escalation be required. Women requiring out of hours support women could contact the triage and assessment phone line or in person and would be triaged and assessed accordingly.

This was an improvement from what we found on our last inspection.

Birthing pool evacuation training was in place.

Maternity staffing

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

The service had enough nursing and midwifery staff to keep women and babies safe. The service target for fill rates was above 85%. A summary of actual versus planned midwifery staffing for a six-month period showed an improving staffing ratio between January and March 2023 when the service maintained above a 90% fill rate.

The service was working with Birthrate+ to develop a specific model of care delivery for determining safe staffing for labour, delivery, recovery and postnatal (LDRP) and trialling different tools.

The acuity tool used by the trust to determine staffing requirements showed safe staffing levels, including 1 to 1 woman to midwife ratio in labour. Daily staffing was being maintained daily using the maternity escalation policy and

implementation of the Operational Pressures Escalation Levels Maternity Framework (OPELMF). Since implementation of the new maternity escalation policy there has been a marked reduction in the number of internal deflections required. Experienced bank and agency staff make up short falls in staffing. Most agency staff have worked for the trust for 10 years and understood the service.

With the birth rate+ acuity tool managers accurately calculated and reviewed the number and grade of midwives and midwife support workers needed for each shift in accordance with national guidance and the number of midwives and midwife support workers mostly matched the planned numbers.

The service had low vacancy rates against the staff establishment; actual and vacancies as of 01 March 2023 had a variance of 2.72WTE against a budgeted 60.1. Midwifery staffing was 39.07WTE in post against 47.28 budgeted. A midwife appointment had been made and they were due to start in the service.

Within the time period March 2022 to February 2023, the service had a low midwifery turnover rate; 3.67 WTE midwives left the services and 1.6 WTE (2) community midwives, mostly due to retirement.

For midwifery staff there was an upward trend in sickness from June 2022 to December 2022; from 4.5% June 2022 to 8.5% December 2022.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels using locum and substantive staff.

The service mostly had enough medical staff and actions in place to manage vacancy shortfalls. The trust had recruited eight consultants to the South Lakeland Birthing Centre from September 2022. There were two consultant vacancies at the time of inspection, one of which had been recruited to and was joining the service in September 2023. The other post had been readvertised in April 2023 with interviews scheduled for July 2023. Consultant vacancies were covered by locums or staff covering additional sessions.

The trust had planned for an over establishment of consultants (8). Information provided in the March 2023 'Safe Today' papers indicated there were 7 consultants in post out of an establishment of 6.35 (minimum required) and 7 middle grade doctors out of an establishment of 4 (minimum required).

Consultants provided 24-hour consultant on-site cover Monday to Friday, with ongoing provision from middle grade doctors. The service had a consultant on call during evenings, and weekends with a requirement for consultants to be able to attend within 30 minutes on the unit if required. At weekends middle grade doctors were resident to cover, with consultants off-site for support if needed. Consultant obstetricians led twice daily ward rounds in the birth centre.

There was a shortfall in middle and intermediate junior grade doctor posts with less than optimum deanery trainee posts due to rota changes.

There was an upward trend in sickness rates from September 2022 to December 2022. Some data points were missing from June 2022 to October 2022. From 1.5% in May 2022 to 5.5% Dec 2022.

There is no current national requirement for consultants to be resident overnight on maternity units. However due to the remote location of the service this was a new model put in place since our last inspection.

Medical staff described that although women were booked under named consultants, all clinicians would be aware of individual women's care needs during admission to the birth centre and care would be managed continuously at the time. Due to the number of deliveries in the unit there was no separate antenatal or postnatal ward – all inpatients were cared for in individual ensuite rooms which had beds for antenatal and postnatal care and were swapped with beds for delivery.

Managers made sure locums had a full induction to the service before they started work.

Records

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

We reviewed 10 patient records including paper and electronic and found them to be comprehensive and all staff could access them easily. Staff could access diagnostic results in a timely manner. We saw record audits from the service identifying areas that required some improvement to reach the 100% benchmark with actions to address these.

With the new electronic recording system when women transferred to a new team, there were no delays in staff accessing their records. We were told by staff that CTG could not be recorded on the electronic recording system following transfer from the birth room to theatre, so there was a short gap in the CTG recording due to connectivity issues. However, the trust informed us post inspection that this was not an ongoing issue and that an audit was completed for assurance, which demonstrated 100% compliance. This risk on the Care Group risk register had been closed prior to the inspection.

Records were stored securely, and staff had individual log ins for electronic records. We did not observe any computers left unattended and logged in.

Medicines

The service used systems and processes to administer, record and store medicines safely. However, they did not always safely prescribe some medicines.

Staff stored and managed all medicines and prescribing documents in line with the trust's policy. However, we found some records showing controlled drugs, medicines that require additional security and records, had been given but were not always completed. The ward manager was working with the pharmacy team and other departments to address this issue. The pharmacy team completed audits of the controlled drugs with data showing the wards were 78% compliant in the January to March 2023 audits, the trust had confirmed all actions had been completed.

Pharmacy staff supported ward staff with the supply of medicines. We found medicines were stored safely and securely. There was a process in place to monitor the temperature of medicines storage including medicines that need to be stored in a refrigerator. There was a process in place to ensure medicines were not used passed their expiry date. Emergency medicines were available with systems to ensure they were checked daily and were within the expiry date.

Audits were completed to demonstrate the safe and secure storage of medicines. Overall, the audits' found medicines were managed safely and securely, however an audit had highlighted an issue with the appropriate security measures applied to the storage of flammable liquids and medical gases. We found this to be an issue for community midwives, however it was rectified on the day. Information provided by the trust confirmed all actions from audits in 2022 had been completed.

Staff completed medicines management training. The training records showed more than 85% of midwives at the birthing centre had completed their training and 96% of community-based midwives were compliant with their training.

We found the community midwives had a process in place for management of medicines when attending home births. At the time of the inspection the community midwives did not have access to pain relief for women who were planning a home birth. The service had recently stopped providing the pain relief gas, Entonox, due to concerns around over exposure to midwives. However, the service had not removed the Entonox cylinders from the department and were storing Oxygen cylinders in transportation bags marked for Entonox. There was a risk community midwives could mistake the Entonox for Oxygen and put people at unnecessary risk of harm due to delays in Oxygen treatment in a medical emergency. Once highlighted to the Trust, they took swift and appropriate action to rectify the concern.

Medicines prescribed for discharge were obtained from the hospital site prior to going home. There was a system in place if women left without their medicines.

The pharmacy team had supported the service with the development and implementation of guidelines to support midwives with administration of certain medicines, (midwives' exemptions) without the need to wait for a doctor to prescribe the medicine, allowing for the swift treatment of a number of conditions. There was a patient group directive in place to allow midwives to issue medicine to women who were at risk of pre-eclampsia, a condition that affects some pregnant women. We found guidelines were in place to support staff with the swift identification and treatment of sepsis, this included the most appropriate antibiotics to give depending on the source of infection. However, an audit competed by the trust for treatment of sepsis January to April 2023 showed not all staff were following the guidance. Areas for improvement identified in the audit included adherence to the guidelines for choice of antibiotic prescribed, poor documentation in patient notes and not all women having the correct blood samples taken. The trust had already worked to address some of the actions with suitable timelines in place for the remaining actions to be completed.

The pharmacy team did not routinely support the maternity department with the reconciliation of medicines; however, they were available to support on request. There was a process in place for the ward staff to complete a medicines reconciliation when women were admitted to the birthing centre.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had clear reporting responsibilities and reporting mechanisms in place. Managers investigated incidents and used a multidisciplinary approach for 72-hour reviews. The governance lead had daily updates regarding incidents and 72-hour reviews and incidents upgraded to a Root Cause and Analysis (RCA) where they meet the criteria for further investigation. Additional RCA mandatory training has been introduced for staff including doctors. Additional support was offered where staff needed help with incident reporting or completing RCAs. Immediate learning and change from serious incident reviews was shared with all staff through weekly emails, bulletins, forums, and briefs. In addition, electronic notice boards could be accessed through QR codes to allow staff to receive timely who don't access emails frequently.

There was evidence that changes had been made because of feedback. An example was given of how two guidelines were streamlined to guidance and to changed immediately following a serious incident review.

Maternity

We observed and staff reported daily incident reviews took place across sites via teams with ward managers. The maternity open incidents for South Lakes Birth Centre (SLBC) were reducing monthly from 70 in August 2022 to 18 in April 2023. Overdue incidents in August 2022 were 37 and no open incidents for April 2023.

All incidents were reviewed and allocated out in the Care Group's daily incident triage meeting which had multidisciplinary attendance to ensure incidents were managed appropriately and within appropriate time frames.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust/provider policy. They reported serious incidents clearly and in line with trust policy.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Woman and their families received a verbal and written duty of candour and improvements were said to have been made with involving families in incidents investigations. Families were invited into the service for a verbal discussion and a duty of candour carried out whilst on the ward.

Managers shared learning from incidents. Staff confirmed they received feedback by email when they reported incidents. Learning was shared through 3-minute briefings, safety huddles, handovers and bulletins. Managers also debriefed and supported staff after any serious incident.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. Managers mostly checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance.

We reviewed a wide range of policies and found they were comprehensive and up to date.

New policies and procedures had been introduced following our last inspection providing guidance for maternal conditions that should prompt consideration for escalation and transfer. The service had a protocol to transfer babies from the bereavement suite after they had died.

There was a system in place specifically for a 'fresh eyes' approach to CTG interpretation. CTGs were recorded on the e-records and both staff members recorded their assessments with the opportunity to record comments on the CTG. Fresh Eyes duration audits had been completed indicating a compliance rate of 95%. All CTG's followed a nationally recognised criterion and there was standardised guidance to document CTG observations in line with best practice.

However, guidance for CTG's for reduced fetal movements in the perinatal period was not always followed. We noted a senior clinician had instructed auscultation of the fetal heart rather than CTG as per national guidelines.

Emergency protocols for staff to follow in clinical areas were not always updated following policy review. For example, the postpartum haemorrhage proforma was due for review and updating on the 1 March 2020 and had not been replaced since our last inspection and conditions imposed. We highlighted this whilst on inspection to a senior member of staff and was told the process was the same. A shoulder dystocia protocol was due for review 1 March 2023, a month out of date, and a theatre cleaning policy book was out of date. We requested action was taken to remove the out-of-date protocols and be replaced.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff were observed referring to the psychological and emotional needs of women, their relatives and carers.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff fully and accurately completed women's fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition.

Woman and families confirmed satisfaction with the food and drink they had received during their stay.

Specialist support, from staff such as dietitians, was available for women who needed it. Midwives assessed and made onward referrals where women required dietary advice for conditions such as diabetes, or a high body mass index. Breastfeeding advice and support was available for women and further development of roles for breastfeeding champions were being identified in the service to promote this.

The Trust has been awarded stage 1 baby friendly accreditation. There was a range of support and advice on the maternity app and website. This was an improvement from our last inspection.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain, however, pain relief was not always given in a timely way.

At the time of inspection community midwives did not have access to pain relief from Entonox for women who were planning a home birth. The service had recently stopped providing the pain relief gas, due to concerns around over exposure to midwives. Women were informed about this prior to choosing to birth at home. Several maternity services have had to withdraw analgesia gas as an analgesic option due to excess occupational exposure to gases. This was an ongoing Health and Safety Executive investigation nationally.

An audit shared by the service showed 100% of women requiring an epidural were provided with one within 30 minutes of being requested.

Maternity

The trust had sent a survey to all women who had given birth in the previous 6 months. The survey results showed 15% of women stated they felt they did not get pain relief in a timely manner. Most women said they received pain relief soon after requesting it except for one occasion when a woman had had to wait 2 hours for pain relief at night. The trust was working to improve this.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements however, it was not yet clear how improved actions were achieving improved outcomes for women.

The service participated in relevant national clinical audits such as MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). The purpose of the report and audits is to provide information for trusts and health boards in comparator groups for perinatal mortality rates by gestational age; the effect of ethnicity and deprivation on perinatal mortality; the effect of twin pregnancy on perinatal mortality; causes of death; and the timeliness of notification of perinatal deaths. We asked the service to provide any reports or action plans against MBRRACE outcomes. The information supplied was specific to across Bay maternity service action plans to reflect shortcomings identified in the MBRACE audit and related directly to the standards. However, it did not reference any local learning or action plans.

The trust benchmark against the MBRRACE report October 2022, showed an average of perinatal deaths of 4.85% per 1,000 total births). Comparator trusts and health boards were sitting at around 5% when adjusted for other contributing risk factors. Information in trust surveillance reports said, 'since maternity services had reverted to pre-pandemic pathways of care the live data monitoring tool showed a decrease in perinatal mortality rate to 3.7 per 1000 births, which was within 5% of the group average at UHMBT'. From January 2022 to 31 March 2023 of eleven incidents that related to deaths, five were eligible for notification to MBRRACE and all have been notified within seven working days. The service was not an outlier nationally.

All perinatal deaths were reviewed using the perinatal mortality review tool (PMRT) to identify themes and trends. There was an increase nationally in perinatal mortality during the pandemic said to be due to women contracting covid and reduced access to services.

Trends and themes were monitored at PMRT and there was an action plan to address any areas for improvement. We saw evidence the trust had oversight and action plans to address and monitor progress against the national maternity and perinatal audit 2018-2019. The service was working hard to address previous PMRT backlogs and had completed all 26 historical reports. Much thought had been given to the sensitivity around this approach due to the time lapse using the support of the bereavement midwife who had continued contact with families. Updates were included in the women's health quality board. This was an improvement from our last inspection.

The Maternity Incentive Scheme rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is through an incentive element to trust contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 3 (results published February 2022), the trust had not met seven (out of ten) safety actions. However more recent governance reports provided by the trust indicated this had improved to 7 out of 10. Senior leaders also confirmed this.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There were engagement meetings and follow-up of audit outliers.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. We saw evidence in meetings that these were discussed and reported to the women health quality board and learning taken forward into actions. For example, partogram (graphical record of key data during labour) and growth charts are now included in the bereavement notes and audits of assurance to be undertaken.

However, some outcomes for women were not always positive for example, the percentage of 3rd and 4th degree tears were higher than expected at 4.5% for the period August 2021 to July 2022 compared with the national average of 3%. The service had oversight of this and had implemented an OASI training bundle which was being monitored and reported on. (OASI is an obstetric anal sphincter injury which can occur during vaginal birth, sometimes referred to as severe perineal tearing.) Data reviewed on the maternity dashboard for February 2023 showed this figure was decreasing and the service was no longer an outlier.

The service had policies and procedures for Major Obstetric Haemorrhage (MOH) including Antepartum and Postpartum Haemorrhage.

An audit was undertaken by the service of 18 electronic patient records of women experiencing a postpartum haemorrhage (PPH) of more than 1500ml between January and February 2023 to understand any repeat themes in management of PPH's across the Bay. There were 7 at the South Lakes Birth Centre of the 18 records reviewed. Actions had been taken to improve outcomes such as, skills and drills training for PPH with doctors and theatre teams. Blood loss was now recorded on theatre white boards, so all staff had oversight of blood loss volumes. Theatre staff could also instigate the major obstetric haemorrhage emergency procedure and request blood from blood banks. A 'whole team' responsibility approach has been implemented.

All reported PPH over 1500 millilitres had to undergo a 72hour review and be classified as moderate harm or above. The governance lead had oversight of all major obstetric haemorrhages and communicated with the ward manager to review investigations progress. The service relied on a multi-disciplinary team review off risk factors for women at increased risk of a PPH and a plan put in place to mitigate risks. New PPH risk assessments were being implemented that trigger specific pathways and protocols depending on blood loss to improve outcomes for women experiencing a PPH.

Staff said incident and governance reporting and feedback to staff had improved.

Managers said they could now monitor performance and benchmark against other services for PPH through the improved maternity dashboard. The maternity dashboard for February 2023 showed an increasing trend of PPH across the trust over the last six months, which was in the upper 25% when compared to other trusts but not an outlier.

Information obtained from data analysts noted from 1 April 2022 to 31 March 2023 one postpartum haemorrhage, and one massive obstetric haemorrhage at SLBC had required admission to ICU.

Managers shared and made sure staff understood information from the audits and implemented actions to improve outcomes for women and babies.

Competent staff

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

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

Maternity

As indicated in the training figures earlier in the report staff were not always compliant with competencies such as for saving babies lives and fetal surveillance in labour. However, the service had recently introduced a fetal monitoring training day as they had identified the training was not always completed as it was spread over several days. Fetal monitoring continuous learning was shared through fetal monitoring case review meetings which all staff could attend.

A fetal monitoring lead midwife had been appointed to work 15 hours per week to ensure midwives had access to training and competencies which was mandatory. A consultant obstetrician was also a fetal monitoring lead to improve doctors' competencies in their roles. They had allocated PA time in the job plan.

A learning alert is now circulated to advise antenatal CTGs for fresh eyes once it exceeds one hour. This was implemented by the governance lead following learning from an incident.

Managers gave new staff a full induction tailored to their role before they started work and clinical educators supported the learning and development needs of staff. Staff we spoke to confirmed this took place.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most staff at the SLBC had received an appraisal (86%) and obstetricians (92%). Staff told us they had the opportunity to have appraisals.

All trainee doctors had a clinical supervisor with allocated time to support their trainees and Royal College of Obstetrics and Gynaecology (RCOG) scheduled meetings to assess progression and wellbeing. All locum doctors within the department were allocated a clinical supervisor for the duration of their contract. All doctors were required to maintain RCOG e-portfolio which was actively reviewed as part of the Trust annual appraisal system.

Managers made sure staff attended team meetings or had access to full notes when they could not attend and had processes and procedures to manage medical and maternity staff in maintaining high professional standards.

Newly qualified midwives participated in a rotational placement within the services, in which they gained experience and had opportunity to develop skills between the different hospital and community locations.

Staff said they could discuss training needs with their line manager and were supported to develop their skills and knowledge. There was an allocated training fund for staff to access for additional training courses. Midwife support workers had opportunities to gain additional competencies which benefitted the service such as, taking bloods, infant feeding and bereavement support.

Staff undertaking the midwifery conversion course confirmed they had opportunities to learn and gain competencies. Four nurses had started the midwifery conversion course and three apprentice maternity support workers had also been recruited this year.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Clinical multidisciplinary team handovers were an improvement from our last inspection.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed multidisciplinary team (MDT) handovers with outgoing and incoming staff. Attendees included a midwife shift

coordinator, obstetric team including a consultant, anaesthetist and two operating department practitioners. Staff introduced themselves by name and all were invited to contribute. All women, antenatal, intrapartum, and postnatal were discussed. The meeting was recorded electronically using the white board available and followed 'Situation, Background, Assessment, Recommendation' (SBAR) tool.

However, it was observed on one consultant ward round there was no presence from the maternity team. In addition, in the MDT handover, midwifery staff attended but made no contribution in the meeting. We were aware that unit was experiencing an acuity of patients and was on divert.

Staff worked across health care disciplines and with other agencies when required to care for women and referred women for mental health assessments when they showed signs of mental ill health including depression.

Seven-day services

Key services were available seven days a week to support timely care.

We found there had been some improvement since our last inspection.

Leaders said consultants led daily ward rounds twice a day, including weekends depending on their care pathway. Consultants were available and on call 24 hours a day's seven days a week with rostered overnight presence on the unit with a second consultant on call within a 30-minute journey time if needed. Consultants rostered for second on call who could not travel within 30 minutes were required to stay overnight at the hospital.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Medical and anaesthetic cover was provided outside of normal working hours, with onsite emergency surgery services and caesarean section team available during working hours. At nights an on-call team was available for emergency caesarean section.

Triage and assessment were now also available 24 hours a day, seven days a week co-located on the birthing unit as previously stated earlier in our report.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in public and clinical areas. There was also information easily accessible on the maternity app.

Staff assessed each woman's health when booked and provided support for any individual needs to live a healthier lifestyle. Data showed that the service was an outlier for women still smoking at birth but there was evidence in records that women were supported to stop smoking and carbon monoxide was monitored as a part of this. Staff said women were offered smoking cessation advice and devices at every opportunity throughout their pregnancy and following the birth. This was now only an 'opt out service'. Midwives discussed vitamin D and folic acid antenatally to promote a 'healthy start'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Maternity

The service had processes, procedures and a dedicated perinatal mental health midwife and enhanced midwife team who supported more vulnerable women including those with mental health needs. They supported the clinical teams with advice and liaising with external agencies as required. This supported women, families, and clinical teams to put together personal care and birth plans. We saw evidence in safety huddles and handovers that staff were made aware of vulnerable women and their care requirements.

Staff completed risk assessments and made mental health referrals antenatally where women were either unwell or in need of additional mental health support. Staff said if there were immediate concerns identified the mental health were contacted directly. Out of hours mental health services were accessible through the emergency department on site.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

We observed in records staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records. Women had mental health plans in place with psychiatry input which were available to staff involved in their care on the patient electronic record.

Staff understood Gillick Competence and Fraser Guidelines. Gillick competence is used to assess a child's capability to make and understand their decisions in a wider context. Fraser guidelines are applied specifically to advice and treatment that focuses on a young person's sexual health and contraception.

Since our inspection the trust have provided mandatory Mental Capacity Act and Deprivation of Liberty Safeguards training figures that show a 91.9% compliance rate for maternity staff at the South Lakeland Birthing Centre.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Women told us ‘They could not fault the care, advice and support they had received.’

Women said staff treated them well and with kindness. Other comments were that women and their partners were treated with ‘dignity’, and they felt ‘respected’.

Staff followed policy to keep women’s care and treatment confidential.

Maternity

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Women and their partners told us the “mental health staff were amazing. They did not always see the same person, but they were always responsive” when they needed them.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. The service had a midwife trained to support women who may be very nervous or anxious. This was said to be having good results for women receiving this support.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Women said staff signposted them to support and information on the maternity app which they found helpful.

Women had the support of a dedicated bereavement team with two part-time Specialist Bereavement Midwives and a Lead Bereavement Consultant Obstetrician, working across Bay. The Specialist Bereavement Midwife at South Lakes Birth Centre had recently retired, but a new staff member was due to start imminently. Cover was being provided from the Royal Lancaster service in the interim.

Staff offered debriefing to women and families following difficult births through the ‘listen with mother’ initiative and could refer women directly for this support through the electronic patient record system.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. Partners said they were allowed to stay and be involved in the birth were possible and had 24/7 access to the birthing unit.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. In addition to seeking feedback from women directly whilst on the unit, information was provided to women about listening groups so that feedback could be provided later. Women were also signposted to the patient advice and liaison service (PALS) when required.

The friends and family test (FFT) scores March 2023 had a low response rate for the service which had been identified and several actions taken to improve it, such as introducing QR codes in clinical areas which linked to the FFT surveys. Links in the maternity app were also sent to women following contact with the service.

Maternity

Available data showed an overall satisfaction score of over 96%. There were two negative responses compared to 27 positive comments. One of which was regarding a mixed-up appointment time, but comments were that staff tried hard to rectify this and were kind.

Women gave positive feedback about the service. Women told us they were “really happy with their care.”

Staff supported women to make advanced decisions about their care though informed choice. Women and their partners said they could look around the birthing centre to allay any fears they may have and were supported to make birth plans.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Women were offered choice of maternity care, depending on the level of risk. The service aimed to accommodate women’s preferences in this. Community midwives provided antenatal care in local clinics as an alternative to hospital attendance.

They also worked with the maternity voices partnership (MVP) and public health to align services to meet the needs of women in local communities. The MVP had gone out to young mothers in the community to obtain their views to inform and improve services.

Facilities and premises were mostly appropriate for the services being delivered. The South Lakes Birth Centre had been purpose built, opening in February 2018. The centre provided a ground floor ante natal unit, with the birth centre on the first floor above. This had 14 individual rooms, providing facilities for labour, delivery, recovery and postnatal care. Each room had provision for women’s partners to stay overnight to provide support. A suite was available to provide bereavement support for women who needed this, including en-suite kitchen and sitting room facilities. This was situated in a quieter part of the unit, having its own entrance and corridor, allowing some privacy.

The service had systems to help care for women in need of additional support or specialist intervention. The service had completed a successful bid for additional funding to extend the bereavement care service. An extra funded post will provide additional pastoral and emotional support to those families who require the services. It is the aim of the service to further increase bereavement cover across the trust to cover 7 days a week with a hybrid model of specialist midwives and bereavement support workers. Specialist Bereavement Midwives once trained will be leading on additional training for Stillborn and neonatal death charity (SANDs).

The service collaborated with a wide range of charities who supported parents who had experienced loss.

Maternity

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems or learning disabilities received the necessary care to meet all their needs. An enhanced support midwives team working across all three maternity trust sites (5 full time equivalents), supported families with additional needs. These included but were not limited to, domestic abuse, substance misuse, young parents, care leavers, learning difficulties and disabilities, refugees/asylum seekers, non-English speakers and homeless families. The allocated enhanced support midwives provided additional care over and above that provided by the named community midwife and wider multi-professional team.

New guidelines and pathways were in place for adult patients with learning difficulties, autism and complex needs. These were due to be ratified by the board by the end of April 2023. Staff said there was good trust-based learning disability and autism lead who was accessible and hospital passports were tailored to the needs of people with a learning disability. Additional resources were available such as easy read documents supported with pictures and virtual tours of the unit. Extra time was arranged for a physical tour of the unit.

We observed the service had information leaflets available in languages spoken by the women and local community. Signposting information was evident for breastfeeding, bay-wide maternity voices and how to access information the maternity app.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. The service used a language line interpretation service. Staff were able to access video or telephone interpretation 24 hours a day in hospital and the community.

Women were given a choice of food and drink to meet their cultural and religious preferences and there was nutritional support from nutritional support workers. A diabetic menu was available for those who required additional choices.

Staff had access to communication aids to help women become partners in their care and treatment. Patients said the maternity app was really user friendly to use and helpful. They said it was good for checking appointments which were available to view with helpful inks to information in different formats. Women also received appointments by post.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access services when needed and receive treatment within agreed time frames and national targets. Midwives assessed and treated using a recognised prioritisation system for triage and were meeting time frames within a target of 15 minutes. Waiting times were monitored in the day assessment unit and all appointments were booked. Women did not have to wait too long for their appointments.

Staff said they never had to cancel appointments which mostly ran on time. They reported always having medical cover. When women did not attend for their appointments, staff contacted women to rearrange their appointment and check everything was ok. If women failed to attend two appointments the community midwife followed up with a home visit and the consultant would be informed.

Maternity

Data provided between January and March 2023 showed a large percentage (91.2% average) of women were seen within 15 minutes of their antenatal clinic appointment. With the next wait time being in the 15-29 minute category demonstrating a minimal waiting time for appointments.

Between January and March 2023 data for 20 women, who were identified by a midwife as needing a scan, showed 85% percent of women were scanned within the trust's 72 working hour benchmark. The remaining 15% were scanned within 96 hours(4days). The issue of scan capacity was on the risk register and reviewed at the Women and Childrens Care Group risk register meeting. The service was exploring additional clinic rooms availability and had utilised the day assessment unit to carry out scans where possible.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Women with complex needs were identified antenatally and had the support of the enhanced care team with multidisciplinary support including mental health where needed. Community midwives met regularly with health visitors to ensure women were best supported on discharge.

The service was achieving 98% for women receiving a 20-week screening scan for fetal anomaly. This was between the acceptable level: greater than or equal to 95.0% and the achievable level: greater than or equal to 99.0%. However, the service was aware they were not meeting fetal anomaly referrals to specialist units due to the lack of available appointments with partnered trusts as units across the region were struggling with capacity. This was on the risk register and action was being taken to establish more service level agreements with other trusts to improve referral rates. The service had a consultant fetal medicine lead based at the Royal Lancaster Hospital maternity service with a screening team across the Bay. Antenatal clinic managers were also supporting this role.

Woman could be transferred internally to the trust's neonatal unit across bay. If neonatal cots were not available for babies over 28 weeks when requested, they went through the cot bureau procedure consultant to consultant.

Staff supported women and babies when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. Data provided showed there was a consistently low number of complaints about the service with a reducing rate from October 2021. The service was below their benchmark of 1.33 complaints per month with 1 complaint per month within the same time frame.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. They worked with the maternity voice partnership to ensure women had the opportunity to give their feedback in a range of ways. We saw evidence that these were reported and reviewed through the Women's Health Quality Board. There were action plans in place and oversight when trackers were becoming overdue.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Maternity

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the right skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, they were not always visible and approachable in the service for patients and staff.

There had been a significant improvement in leadership since our last inspection with several new appointments. Leaders understood and managed the priorities and issues the service faced. They worked together to ensure leadership did not fall onto individuals. There was a quadrumvirate (four leaders) approach to issues that arose including a Director for Obstetrics and Gynaecology, a Deputy Director of Nursing and Midwifery, an Associate Director of Operations, and a Clinical Director for Childrens and Young People'.

There was evidence of clear reporting and oversight at board level. Staff also said they had noticed an improvement in leadership and governance.

Leadership schemes had been implemented to support leaders in their roles and was due to take place over the next 18 months. The trust had brought in leadership training for all consultants, and it was recommended they attend.

The Clinical director said he has much more interaction with senior executives on the board and a monthly meeting with the Chief Executive due to the "buddy system" in place.

Leaders said they did 'walkarounds' often. The director of midwifery said they had done a weekly 'walkaround' to speak to staff. However, some staff said they felt disconnected from higher level management with community staff being particularly affected as they were not always aware when meetings were taking place.

Almost all staff said senior leaders were not visible at South Lakelands Birthing Centre, (SLBC) except for the head of midwifery. Staff expressed that they would like to see more of the senior leadership team at SLBC.

Vision and Strategy

The service had a short term vision and strategy for what it wanted to achieve, developed with some relevant stakeholders and staff.

At our last inspection the service did not have a clear vision for what it wanted to achieve nor a strategy to turn it into action.

At this inspection, the trust did not have a completed vision and strategy, however, leaders said they had a strategy development plan in place which included looking at a wide range of population needs and reviewing what provision was already in place.

Maternity

A trust strategy day had been held with consultants and public health. General practitioners had also been invited to attend. Leaders said a large focus of development for the maternity strategy had been on understanding the needs of the local population. They were working with public health to support this and had engaged with some community groups such as young parents, travellers and the maternity voices partnership. Maternity and neonatal champions were developing and supporting the focus on health inequalities.

The service had developed an initial one year holding strategy to comply with our previous requirements. Reports to board said it was purposefully for 12 months so that it could be further updated once new guidance was released later this year. The holding strategy had just been approved and was waiting for distribution. We were also told one of the reasons for completing a holding strategy was due to the complexity at the different maternity sites and to do it "well and properly" they decided not to rush it. Leaders wanted to do appropriate clinical modelling and service user engagement to ensure that the strategy was as robust as it could be. Leaders said they had engaged with national maternity voices, young mums', focus groups with families in areas of deprivation and staff engagement. They had also used information from complaints and listen ins with mums when producing the holding strategy and vision.

They said they recognised the need to develop a longer-term vision and strategy for the service, but they were focused on ensuring governance and leadership was in place and improvement work underway before developing this fully.

Staff we spoke to could not describe and/or were not aware of the one year holding vision and strategy.

The one-year strategy was some improvement from our last inspection.

Culture

Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, not all staff always felt respected and valued.

Some black and minority ethnic staff (BAME) reported feeling excluded by their colleagues in listening events held by the trust.

A significant amount of work was being undertaken by the trust to tackle racism and this concern had been added to the risk register in November 2022. This was being monitored monthly at the risk meeting.

A comprehensive action plan was in place and on target to meet the action plan deadlines. A range of stakeholder engagement meetings had been held and training implemented. A 'Restorative Practice' pilot programme commenced in the trust in May 2022 to support the development of a restorative practice approach within UHMB. Funding had also been secured for additional cultural training for staff but had not yet been implemented. A BAME network was now in place. An inclusion café was in the early stages of discussions and development. Alongside these activities, the trust ran an Anti-Racist Nursing Leadership Programme which continues to be attended by Head of Midwifery and Matron for the South Lakes Birth Centre.

Training figures for equality and diversity for midwives was 100% and 64% for medical staff. The trust target was 90%.

On our last inspection some medical staff said there could sometimes be a resistance to change amongst colleagues, with the perception that any issues raised were not always progressed or responded to consistently. The clinical director was committed to improving the culture among medical staff and for trainees. Trainees had a supervisor who worked closely with the university so issues could also be identified and addressed through external streams of communication.

There was evidence processes were in place to address and improve positive behaviour in work and senior leaders said poor behaviour was dealt with appropriately and swifty.

Most staff we spoke to were positive about the working culture at the service and whilst acknowledging it was sometimes difficult to maintain morale said they felt supported and were happy working at the service. Some black and minority ethnic (BAME) staff said they had noticed some improvements in the culture. However, leaders stated initial measures had not had the impact they wanted. Therefore, in January 2023 an external chartered occupational psychologist was engaged to deliver an evidence-based culture diagnostic questionnaire, psychometric assessments, individual and group discussions, a leadership clinic and observations in the work environment to deliver a more targeted approach.

Staff confirmed they had attended training to support empowerment to speak out and challenge poor behaviours. There was a band 7 coordinator freedom to speak up guardian (FTSUG) across bay.

Staff reported they had access to mental health champions. There are also plans in place to introduce diversity champions.

We found the culture had begun to improve since our last inspection. Most staff, including community midwives described a culture of supporting each other despite some staffing challenges. Support workers expressed they "felt equally valued" when they gave their opinions or concerns. They were positive about the use of band 4 staff to support with clerical duties to free up clinical time.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection improvement work on governance processes was ongoing and not completed. Some staff said they were not given clear expectations for their work and roles by leaders. The maternity dashboard was not location specific so staff could not map performance to identify areas for learning in their areas or locations.

On this inspection we noticed improvements in governance processes throughout the service and with partner organisations. Managers carried out a range of local audits with improved mechanisms and systems for reporting these audits to senior managers and leaders. There were systems in place to share learning with staff about the performance of the service. For example, an audit for antimicrobial treatment of sepsis showed areas for improvement. The trust had already worked to address some of the actions with appropriate timelines to complete the remaining actions.

The maternity dashboard had improved so staff could now map performance to identify topics for learning in their areas or locations set against national benchmarks.

Leaders had produced a new accountability and assurance framework with specific maternity standards, so leaders were fully sighted on the issues in maternity and how to manage them. Information flowed from ward to board and was not just held at management level. All staff were given clear expectations for their work and roles by leaders.

The service had improved its position for compliance with the Maternity Incentive Scheme which rewards trusts meeting the ten safety actions designed to support the delivery of best practice in maternity and neonatal services. This is

through an incentive element for contributions to the CNST (Clinical Negligence Scheme for Trusts). In year 3 (results published February 2022), the trust was only meeting 3 out of ten safety actions. However, leaders said they were now on track to meet 7 out of 10 safety actions for year 4. Board papers confirmed 7 out of 10 actions had already been submitted for compliance.

The service was now using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard and had addressed the back log of investigations with all families contacted and a duty of candour carried out. They had taken action to improve transitional care services to support the Avoiding Term Admissions into Neonatal units Programme (ATAIN).

Leaders had oversight of this and were confident they would achieve all 10 standards. The outstanding actions cited were maternity workforce staffing and available transitional care for one of the other maternity sites not SLBC.

However, from information provided, medical staff at SLBC were not achieving 90% or above with all five elements of the Saving Babies' Lives care bundle Version 2. Due to the overall compliance rates across the trust some training figures were achieving the required compliance rates of 90% or above for CNST. Saving Babies Lives training figures were manually calculated due to the nature of the contents being spread across numerous training days. Staffing shortages and strikes were said to have impacted on training attendance with staff being pulled from training to work clinically.

We were told on site that training completion rates for level three safeguarding adults and children for medical staff had improved to 100% but had slipped to 89%. Managers said they had oversight of these figures and were working hard to maintain compliance. However, data provided by the trust showed no improvement since our last inspection with a compliance rate of 45% for level 3 safeguarding training.

The Deputy Associate Director of Operations and Performance in woman and children services (WAC) had worked with the education team to allocate Obstetricians training in advance on the rota. Training compliance was monitored at the Women's Health Quality Board, WAC Care group Board and included the Perinatal Quality Surveillance model.

As previously said, a review of the fetal monitoring training had been undertaken with actions to improve compliance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Improvements had been noted in the investigation and oversight of incidents with an improved investigation process and sharing learning from incidents and complaints. From August 2022 there had been much improvement in Maternity StEIS cases escalated within the required 72-hour time frame. (StEIS is a term used by the National Patient Safety Agency (NPSA) in its national framework for serious incidents).

The Maternity services held weekly multidisciplinary meetings to ensure actions from 72-hour reviews and investigations were completed. There was mentorship in place with a tool kit for self-assessment which staff and mentors then tailored a plan to address any learning needs.

Root cause analysis (RCA) actions were reviewed at the weekly WAC action plan meeting. Evidence was submitted for quality assurance checks and approved by the senior team for agreement the action has been addressed to ensure evidence was submitted to close RCA actions.

Improvements had been made to local oversight and ownership of risk and staff said there had been much improvement. There was a cross bay risk register overseen for by the WAC care group and a maternity site-specific risk register for the SLBC. The trust's maternity meetings were held monthly by the head of midwifery, director of midwifery, ward managers, and the governance team. All high-risk scores were reviewed, and action plans updated on the intranet recording system and tracker. Managers and staff could identify the top three risks facing the service. The top risks cited were staffing and improvement sustainability with staffing and culture the top risks for the SLBC service.

The trust had identified it was at moderate risk of not meeting the 10 Ockenden recommendations. The Trust was awaiting a workforce review, completion of the guideline of women who chose to birth outside guidance and audit of shared decision making.

As identified on our last inspections, concerns were raised about access to the acute intensive care unit, (ICU). New escalation and transfer policies were now in place to transfer women out of the unit should it be required. Were told there had been no issues with escalation and transfer from maternity services to ICU services.

Leaders said escalation processes had improved and they worked closely with local maternity network services (LMNS). Due to increased pressure in the system with tertiary services they had developed a maternal medicine standard operating procedure so if a primary provider was not available, they now had links with other units outside the LMNS. They said they had also improved links between emergency departments and NWAS.

The trust said the facilities for a service of this size followed national guidance and women requiring a higher level of care would be transferred to intensive care.

Due to the geography of the service, there was an adverse weather policy. The service also offered major incident awareness training.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information management was a significant improvement since our last inspection.

New reporting systems were said by staff and leaders to be making it easier to have oversight of risk and issues and were supporting improved governance and awareness so that actions could be taken. For example, a recent audit of 40 maternity electronic records showed the use of the new Maternity electronic reporting system (EPR) system was effective at ensuring high standards of documentations. It also showed how built in proforma prompts and auto population of risks etc served as an excellent aide memoir when conducting care. Actions had been identified to address partial compliance for some options to ensure live correct capturing of data and to improve care where it could be better.

The maternity dashboard had also significantly improved with a dedicated digital maternity midwife. Staff reported it was much easier to obtain reports so they could compare their outcomes nationally. Leaders said the maternity dashboard was an exemplary (textbook) model and was being reviewed by other trusts as the benchmark.

Information was consistently submitted to external organisations.

Maternity

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In comparison to other trusts, University Hospitals of Morecombe Bay NHS Foundation Trust (UHMBT) scored about the same for 45 questions in the 2022 CQC Maternity Experience Survey, 'better than expected' for two questions, 'somewhat better than expected' for three questions, and 'worse than expected' for one question. Women were eligible for the survey if they had a live birth under the care of a participating trust in February (and in some cases, January) 2022 and were aged 16 years or over at the time of giving birth. UHMBT ranked 3rd in the North West and 15th nationally overall. The service reported these findings to the board and had plans to consider and implement an action plan with the maternity voices partnership (MVP) chair and service users where improvements could be made.

The NHS staff survey for 2022 for the women and children's service at Furnace General hospital was comparative for all nine questions in the survey, including "we are compassionate and inclusive." 'Staff engagement', 'morale', 'we are safe' and 'we are recognised and rewarded' all compared to the national benchmarks.

The service engaged with the local MVP and meetings were well attended by UHMBT representatives. Work had been undertaken to gather the experiences of young parents. Themes for improvements have been extracted and noted by the head of midwifery.

We saw and leaders said there was improvements to a service wide approach between maternity services. Leaders said they had to address cultural issues between the two sites.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders said innovation was a latter part of the improvement process as the focus had been staffing the Care Group safely. There was however some innovation work completed such as quality improvement midwives being involved in projects including "saving babies lives" and a maternity support worker winning a leading apprenticeship award.

The service had midwifery professional leads meetings, chaired by the director of midwives where staff speak about midwifery practice. The last one was well attended by 45 staff. The meetings were aimed at engaging staff so that they have a voice of their own and managers provided details of successes every 6 months via a PowerPoint slide deck.

Action plans received from the trust showed the service was on track to complete all actions against the Commission's must's and should's from our last inspection.

The maternity service was collaborating with the local Public Health Consultant to build a clearer picture of unmet needs and health inequalities across Morecambe Bay to understand better inequalities and service need.

The service had been awarded stage 1 baby friendly accreditation.

As previously reported the maternity dashboard had been identified as an exemplar for other trusts.