

University Hospitals of Morecambe Bay NHS Foundation Trust

Furness General Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Accident and emergency

Good



Medical care

Requires improvement



Surgery

Good



Intensive/critical care

Requires improvement



Maternity and family planning

Requires improvement



Services for children & young people

Requires improvement



End of life care

Good



Outpatients

Requires improvement



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask about hospitals and what we found	4
What we found about each of the main services in the hospital	6
What people who use the hospital say	10
Areas for improvement	10
Good practice	11

Detailed findings from this inspection

Our inspection team	12
Background to Furness General Hospital	12
Why we carried out this inspection	12
How we carried out this inspection	12
Findings by main service	14

Summary of findings

Overall summary

We found that staff at the hospital were committed to providing safe and effective care for patients. There were good examples of compassionate and person centred care across all the core services.

The hospital was clean and patient waiting areas had been upgraded to make them more welcoming and comfortable.

Despite the trust positively recruiting 135 additional staff, we identified staffing difficulties in a number of services that were having an adverse impact on patient care.

We found that the nurse staffing levels in the Critical Care Unit /High Dependency Unit (CCU/HDU) were unacceptably low. We also found that medical cover was inappropriately organised. We raised this with the trust at the time of our inspection and requested written confirmation of the immediate actions the trust had taken to address this shortfall.

There were also concerns regarding the staffing levels and skill mix on the medical wards at this hospital.

Staffing levels in the accident and emergency department and paediatrics had been recently reviewed and business cases were in development to secure additional staffing for both departments as a result of identified shortfalls. The Paediatric staff business case was presented to the Executive Directors Group (EDG)

meeting on 28th January 2014. The business case required further work and when re-presented at EDG on 18th February 2014 it was approved. Recruitment subsequently commenced.

Specialist support services for people at the end of life were good and patients spoke highly of the care they were given by the palliative care and oncology teams; however the specialist service is only available during office hours.

Outpatient departments are still experiencing difficulties with obtaining patient records in time for clinic appointments and for scheduling appointments.

Staff are well-led at the frontline and have confidence in their managers to raise issues of concern, however, staff have less confidence in the Executive Team as management responses and improvement actions were seen as lacking vigour and pace.

The trust governance and management systems are inconsistently applied across services and the quality of performance management information requires improvement. We also found that performance information and learning from incidents was not effectively used to drive changes and improve practice.

There have been improvements in both the maternity and A&E services as a result of targeted and focused work by the trust, and patients are positive about their experiences of these services.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

A number of the services provided require improvements to consistently secure patient safety and protect them from risks. This is often due to nurse staffing shortfalls. There were particular concerns about staffing levels in the CCU/HDU and the medical wards at this hospital.

There were omissions in patient risk assessments and care planning documentation. Patient records were not always accurately maintained and consequently posed a potential risk to patients.

On the medical wards there were examples of pressure relieving equipment not being used effectively to support the prevention of patient harm.

There was a lack of clarity about incident reporting in some areas and learning is not systematically shared to prevent reoccurrence. The sharing and maintenance of 'harm free care' information such as 'safety crosses' (a system used by staff to record and monitor incidents of harm to patients) was not systematically embedded within the hospital.

Staff were trained to identify issues of adult abuse and neglect. Staff were able to describe abuse and how they would report and escalate their concerns.

The hospital was clean throughout and staff in the main followed good practice guidance in the prevention and control of infection.

Inadequate



Are services effective?

Care and treatment was delivered in accordance with national best practice guidelines and there was participation in national audits to monitor the quality of the services provided to patients. Where audits had identified service shortfalls action plans were developed to secure improvement and reported at board level.

We found examples where local audits had been carried out that had resulted in action plans that had secured on going improvement.

Multi-disciplinary teams worked collaboratively to secure effective treatment for patients in their care.

Staff had undertaken appropriate mandatory training.

Good



Are services caring?

We found good examples of compassionate and person centred care and many patients and relatives were complimentary about the care they received and the way staff communicated with them. Staff treated patients with dignity and respect. Staff also worked hard to promote patients privacy and confidentiality. Patients felt they were involved in their care and that they could make an informed decision about their care and treatment.

Good



Summary of findings

Staff were committed to providing a good quality service for patients and demonstrated a lot of goodwill and team work to maintain adequate staffing levels in the wards and departments.

Are services responsive to people's needs?

Patients' needs were met in a timely way. After targeted improvement work the hospital was meeting the national target for waiting times in A&E. Patient referral to treatment times were within acceptable limits. Similarly the number of cancelled operations and delayed discharges were within acceptable ranges for a hospital of this size. The hospital is still experiencing some difficulties in outpatients regarding the timely provision of patient records and the hospital had work underway to improve this element of the outpatient's service.

Requires improvement



Are services well-led?

We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. There were initiatives in place to engage staff in developing future plans for the hospital, however, staff felt that they were not always listened to and that trust's Executive Team needed to be more visible. In addition, a greater focus is needed at board level to resolve some longstanding quality and patient safety issues with particular reference to both medical and nurse staffing levels at this hospital.

Requires improvement



Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

We found that the A&E department was safe and staff were seen to be working quickly and efficiently particularly when the department was busy. The unit was well led at the front line and both matrons and the deputy chief nurse were seen to be working alongside staff during busy periods to increase capacity in order to treat patients in a timely way.

However, we found that the department did not have sufficient staff to release team members to attend training and staff were missing opportunities to develop and improve their practice as a result. Managers were aware of this and were in the process of developing a business case to seek the trust board's approval for the recruitment of additional staff as a matter of urgency.

There were also delays in patients being transferred to the wards due to the unavailability of beds; this was a particular issue in medicine.

Staff were not confident that the incidents they reported were being used to further improve the service. We also found that electronic monitoring systems were not being used consistently.

There were some delays in securing support for people who were mentally ill. There were also difficulties in accessing information about the department if English was not a patient's first language or if they had visual impairment.

Overall, people we spoke with were satisfied with the service and support they received. They had been fully informed at all stages of assessment and treatment whilst in the A&E department. They felt staff were caring and compassionate and worked hard to meet their needs.

Good



Medical care (including older people's care)

We found that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service.

The quality of nursing records required improvement as some patient records and risk assessments were incomplete and did not reflect the patients' needs and care management risks effectively. There were examples of pressure relieving equipment not being used effectively to support the prevention of patient harm.

Patients were looked after by caring and compassionate staff that worked hard to be responsive to their needs but were often hampered by staffing-related issues.

Requires improvement



Surgery

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. The majority of patients we

Good



Summary of findings

spoke with across the surgical services expressed satisfaction with the care received and felt that staff were knowledgeable and caring. Integrated care pathways were in use on the surgical wards and patients were making informed choices about the treatment they were receiving.

Surgical never events (events that should never happen) were appropriately investigated and learning was shared effectively across the service.

The surgical wards and theatres were clean and well maintained. Staff worked effectively as a team within the specialties and across the surgical services. There was sufficient capacity to ensure patients could be admitted promptly as the numbers of cancelled operations were in an acceptable range for a trust of this size.

Intensive/critical care

The care of patients on the Intensive Care Unit was of a good standard and patients were well cared for by a highly skilled team. Staff were appropriately trained to be able to respond effectively to changes in a patient's condition. Medical and nursing staff worked well together as a team, communication and information sharing was well managed. Patients and those close to them were positive about their care and treatment.

However, on the combined HDU and CCU, we found that nurse staffing levels were inadequate to provide safe and effective care for the number of patients being cared for and that medical cover required significant improvement. We raised our concerns with the executive team, who took immediate remedial action to secure the welfare and safety of patients receiving care and treatment on the unit.

There was no outreach service provided at this hospital.

Requires improvement



Maternity and family planning

All the women and relatives that we spoke with told us the quality of the care they received was of a good standard and that staff worked hard to ensure that their needs were met.

Maternity & gynaecological services are safe although some improvements were required. The service needs to continue to monitor the safety and quality of the provision at the hospital using a wider range of information relating to performance, incident reporting, workforce and lessons learned.

The high numbers of caesarean section births at the hospital should be reviewed.

The service needs to continue to address the cultural disparity between the hospital sites as there was little evidence of the hospital working closely with the service provided at Royal Lancaster Infirmary.

Requires improvement



Summary of findings

Services for children & young people

Paediatric services required improvements as the hospital was not flexible in responding to the changing dependency levels of children on the ward and the service was placed under pressure when the numbers of nursing staff fell below recommended ratios.

Facilities and equipment on the ward were well managed to ensure that they were always clean and properly maintained however action is needed to ensure that this is the case throughout children services.

Services were caring. Children and those close to them spoke highly of the care they received and were complimentary about the way staff looked after them.

The trust's ability to respond to people's needs required improvement. Information was not available for people whose first language was not English. There was no obvious consideration of cultural and religious needs with regards to food and nutrition.

The service was well led locally and we saw good examples of information sharing and active steps taken to improve services and respond to quality audits.

Requires improvement



End of life care

The trust has a dedicated palliative care team who provided good support to patients at the end of life. Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs and were actively developing their own systems and projects to help achieve this.

We found many examples of good compassionate care for patients and patients were very positive about the service from the specialist team.

The multi-disciplinary team worked well together to ensure that patients care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care

We found variation in the standard of records in relation to DNACPR documentation.

Good



Outpatients

The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a professional and caring staff team

Staff working in the department respected patient's privacy and treated patients with dignity and respect.

Requires improvement



Summary of findings

However, we found that waiting times for appointments were long in some departments and there will still difficulties in securing case notes and test results for patient's appointments.

Summary of findings

What people who use the hospital say

Friends and Family Test

The NHS Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be performing lower than the England average for the inpatient component of the test, while the A&E score is higher than the national rate. Overall the trust's score is higher than average, however response rates are low and this can adversely affect the results of the indicator.

Patient views during the inspection

There were very mixed reviews from patients about their experiences whilst patients were in the hospital.

Many patients cite very positive experiences of good and compassionate care from committed and professional staff. However, there were a number of patients we spoke with on the surgical and medical wards who informed us that although staff were very good and caring, they were very busy and that staff shortages meant staff could not spend time with them as they needed or would wish.

Listening event

We held a public listening event on 4 February 2014 and invited local residents to meet with the inspection team to share their experiences of services at the hospital.

Some participants told us of the difficulties that they or a relative had experienced at the trust. Some of these were still part of ongoing discussions or investigations by the trust. However, some people attended to tell us about the good care they had received, and that they were very happy with the care and treatment they had received at the hospital. All of the information shared with us was recorded and was used to inform the inspection.

Survey data

The Care Quality Commission undertook a survey of the people who had recently used the services of University Hospitals of Morecambe Bay NHS Foundation Trust.

The trust scored worse than other trusts for the A&E department, however for the specific questions the responses are still within the statistically acceptable range in comparison to others trusts.

Areas for improvement

Action the hospital MUST take to improve

- The hospital must ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided.
- The hospital must continue to actively recruit medical and specialist staff in areas where there are identified shortfalls.
- The hospital must improve the nurse record keeping on the medical wards.
- The hospital must improve its incident reporting. All staff must be aware of their responsibilities to report both incidents and implement remedial action and learning as a result.
- The hospital must ensure that appropriate action is taken in response to audits where poor practice is identified.

- The hospital must ensure that accurate and timely performance information is used to monitor and improve performance in all clinical areas.
- The hospital must ensure the timely availability of case notes and test results in outpatients department.

Action the hospital SHOULD take to improve

- The hospital should review the numbers of elective caesarean sections carried out in the maternity services.
- The hospital should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.
- The hospital should consider its investment into the diagnostic and imaging services to respond to increased demand.

Summary of findings

- The hospital should improve communication with staff on the wards.
- The hospital should review its facilities and equipment in A&E so that patients who are subject to delayed transfer do not receive sub-optimal care.
- The hospital should review the opportunities to engage its workforce in the 'better care together' initiative so staff are aware of the future of the services they work in.

Good practice

- A multi-disciplinary approach to care delivery is securing good outcomes for patients in a number of core services.
- Maternity and A&E services have improved as a result of targeted and focused work by the trust.
- There were some strong and positive role models particularly in surgery that were enabling and leading staff well.

Furness General Hospital

Detailed findings

Services we looked at:

Accident and emergency; Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; Services for Children & Young People; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

Chair: Jane Barrett, Consultant Oncologist.

Head of Hospital Inspections: Ann Ford, Head Of Hospital Inspection, Care Quality Commission (CQC).

The Inspection team had 30 members including medical and nursing specialists, Experts by Experience, lay representatives and eight CQC inspectors.

outpatients, diagnostics, therapies, and day case and inpatient surgery. Key departments and units include a 24-hour Emergency Department, Outpatients Department, a comprehensive range of elective and non-elective medical and surgical inpatient services, Oncology Unit, Breast Screening Unit, Coronary Care Unit, Endoscopy Unit, Day Case Unit, Intensive Care Unit (ICU), High Dependency Unit (HDU), Patient Progression Unit, Maternity Unit and Special Care Baby Unit. There is also a sub-regional service for upper gastro-intestinal surgery; diagnostic services, including Pathology, Radiology and Endoscopy; and allied health services

Background to Furness General Hospital

Furness General Hospital is operated by University Hospitals of Morecambe Bay NHS Foundation Trust, which provides a comprehensive range of acute and support hospital services for around 350,000 people across north Lancashire and south Cumbria.

The trust operates from three main hospital sites: Royal Lancaster Infirmary, Furness General Hospital in Barrow and Westmorland General Hospital in Kendal - serving a population spread across an area of over 1,000 square miles. It is also responsible for outpatient services at Ulverston Community Health Centre and Queen Victoria Hospital in Morecambe. Furness General Hospital provides emergency and planned care services, including

Why we carried out this inspection

University Hospitals of Morecambe Bay NHS Foundation Trust has been selected as one of the early trusts to be inspected under the CQC's revised inspection approach. The trust was selected for inspection as a trust where there were known risks to service delivery.

How we carried out this inspection

In planning for this inspection we carried out a detailed analysis of local and national data sources that was used to

Detailed findings

inform our approach and enquiries. The trust was given an opportunity to review the data and comment on its factual accuracy. Corrections were made to the data pack in light of the response.

We also sought and viewed information from national professional bodies (Such as the Royal Colleges and central NHS organisations). Also views from local stakeholders such commissioners of services and the local Healthwatch Team.

Our inspection model focuses on putting patients and those close to them at the heart of every inspection. It is of the utmost importance that the experiences of patients and families are included in our inspection of a hospital. To capture the views of patients and those close to them, we held a public listening event prior to the inspection on Tuesday 4 February. This was an opportunity for people to tell us about their individual experiences of the hospital and we used the information people shared with us to inform our inspection.

We also received information and supporting data from the trust and before and during the inspection.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is the service safe?
- Is the service effective?

- Is the service caring?
- Is the service responsive to people's needs?
- Is the service well-led?





The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients

As part of our inspection we spoke with patients in each of the service areas and actively sought their views and the views of those close to them so we could develop a rich understanding of the services provided at the hospital. We held a number of well attended staff focus groups as well as interviews with the Senior Management Team and Board Directors. We looked closely at staffing levels and spent time examining notes and medical records. We also checked departmental records for cleaning and maintenance checks.

We also returned to the hospital unannounced on Sunday 16 February and visited the medical wards and the Critical Care Unit.

Accident and emergency

Safe	Requires improvement 
Effective	Not sufficient evidence to rate
Caring	Good 
Responsive	Good 
Well-led	Good 

Information about the service

The University Hospitals of Morecambe Bay NHS Foundation Trust has A&E departments on two of its three sites. They are located at Furness General (FGH) and the Royal Lancaster infirmary (RLI). The A&E departments are open 24 hours a day, seven days a week and serve a population of approximately 350,000. In 2013 the department saw 33,090 patients.

The department had been recently upgraded and was clearly divided into different areas for major, minor and resuscitation casualties. This meant that patients were treated in an area best suited to their needs and helped reduce waiting times. Reception staff receive new patients and begin the patient's pathway.

Summary of findings

We found that the A&E department was safe and staff were seen to be working quickly and efficiently particularly when the department was busy. The unit was well led at the front line and both matrons and the deputy chief nurse were seen to be working alongside staff during busy periods to increase capacity in order to treat patients in a timely way.

However, we found that the department did not have sufficient staff to release team members to attend training and staff were missing opportunities to develop and improve their practice as a result. Managers were aware of this and were in the process of developing a business case to seek the trust board's approval for the recruitment of additional staff as a matter of urgency.

There were also delays in patients being transferred to the wards due to the unavailability of beds; this was a particular issue in medicine.

Staff were not confident that the incidents that they reported were being used to further improve the service. We also found that electronic monitoring systems were not being used correctly.

There were some delays in securing support for people who were mentally ill. There were also difficulties in accessing information about the department if English was not a patient's first language or if they had visual impairment.

Overall, people we spoke with were satisfied with the service and support they received. They had been fully

Accident and emergency

informed at all stages of assessment and treatment whilst in the A&E department. They felt staff were caring and compassionate and worked hard to meet their needs.

Are accident and emergency services safe?

Requires improvement 

Cleanliness and hygiene

The department was clean, well-maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as hand washing facilities and alcohol hand gel available throughout the ward area, staff following hand hygiene and 'bare below the elbow' guidance and staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care. In addition there were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps.

Medicines including controlled drugs were safely and securely stored and equipment was clean, well maintained and ready for use.

Staffing

At the time of our inspection the department was adequately staffed to meet patient's needs, however when we spoke with staff they told us that they often struggled to take up training opportunities as if they did this would leave the department short staffed. Senior nursing staff had recently measured staffing levels against the needs of the department and had found that there was not sufficient staff on duty at all times. Managers had put forward a business case to the trust board with a view to increasing staffing within the emergency department to address the shortfalls and allow staff to pursue their professional development. The Paediatric staff business case was presented to the Executive Directors Group (EDG) meeting on 28th January 2014. The business case required further work and when re-presented at EDG on 18th February 2014 it was approved. Recruitment subsequently commenced.

The department also provides emergency care for children and young people however the department is not able to provide paediatric nurse cover 24 hours seven days a week.



Accident and emergency

Staff handovers were clear and accurate and staff reported feeling well informed about the condition of their patients. Staff communicated well and worked together as a team.

Mandatory training and safeguarding

The trust gave us information that indicated that over 95% of staff had completed safeguarding of vulnerable adults and children training and that there were policies and procedures in place that supported their training.

Systems, processes and practices

There were systems for reporting clinical incidents and untoward incidents. Staff were aware of the process and could describe the type of incidents that required reporting, however they were not always given feedback or were informed of actions taken as a result despite there being an automatic feedback system available. This had damaged confidence in the system and staff felt that incident reporting was merely a process and not something that consistently led to learning and improvement.

The Hospital was equipped to receive and send casualties via helicopter, and the Trust has a Helicopter Landing and Departing Safety Procedure that demonstrated how to safely disembark or transfer a patient from a helicopter.

Monitoring safety and responding to risk

Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, falls and infection control risks.

Staff recorded these risks and provided care to prevent patient developing such complications.

There was an electronic system for monitoring patient's progress through the department that included how long patients had been waiting as well appropriate equipment to monitor patient's heart rate, oxygen levels and blood pressure. This equipment was fitted with alarms that would alert medical and nursing staff if a patient's condition deteriorated.

Since 2009 the College of Emergency Medicine (CEM) has encouraged trusts to contribute to 16 national audits to benchmark the performance of their department. Furness General provided us with their results from four of these audits.

The trust needs to improve its processes around treating patients with severe sepsis. In the CEM audit only 34% of patients received fluid in the first two hours compared with the target set by the CEM of 90%. In addition only 40% of patients received antibiotics within two hours compared with the CEM target of 90%.

Anticipation and planning

While we were in the department demand increased and the department became very busy. At one point seven ambulances were either in A&E or on their way. To accommodate this influx of patients the staff utilised part of the neighbouring outpatients area to see minor casualties. The triage nurse was still able to see patients within 15 minutes and prioritise their needs effectively. Staff remained calm and professional throughout the busy period and continued to communicate effectively with both their colleagues and patients.

A written escalation process was in place that outlined procedures for dealing with increasing levels of pressure within the department. This process was used when waiting times and service demand increased.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Evidence-based guidance

Care and treatment was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Clinical Excellence (NICE) and nationally recognised assessment tools.

We observed good practice in the assessment and treatment of chest pain, stroke and tachycardia. Patients were seen and treated effectively by appropriate staff and received diagnostic tests promptly. National guidelines for care and treatment of these conditions were implemented and followed.

Accident and emergency

Benchmarking performance

Patients who had a fractured hip received pain relief quickly as the trust performed within the upper quartile for this quality indicator. They were also in the upper quartile for the percentage of patients undergoing an X-ray within 60mins. However, no patients audited had their pain score recorded, which is a clear area for improvement for the department.

Staff, equipment and facilities

We were made aware that there had been circumstances when, due to adverse weather conditions or road blockages, patients could not be transferred to another hospital. Although there were no formal incidents recorded, Staff told us that on these occasions some people had not received optimal care due to lack of particular specialist supplies and equipment.

Multidisciplinary working and support

We spoke with staff within the A&E department who told us that when they required specialist opinions from doctors or nurses from other departments they rang or bleeped them and asked them to come to attend. Response times were variable, however, we saw a nurse who specialised in stroke care promptly attend the department several times during our inspection.

Are accident and emergency services caring?

Good 

We noted that the department achieved good outcomes on their friends and family recommendation scores and that the amount of people completing this survey had increased.

Compassion, dignity and empathy

We spoke with patients and their relatives throughout the day of our inspection. We also case tracked patients who had been admitted to the hospital following their assessment in A&E and spoke with them about their care. We observed that people were safe and comfortable and were being treated with compassion, dignity and empathy one person told us, "They are absolutely first class."

Involvement in care and decision making

We asked people if they felt that they were involved in their care and treatment they told us that they did. One person said, "They explained everything to me, I was able to ask questions." Another added, "They spoke with me and told me what they were going to do."

Trust and communication

We spoke with people who were using and had used the service. They told us that they felt well informed and believed that staff were doing a "lovely" job. One person said, "I got in right away, everything was done in minutes." Another told us, "They explained my diagnosis to me." Staff were clear and open with patients about proposed care and treatment explaining what was happening in a language that patients could understand. Where appropriate, staff sought appropriate consent from patients, taking care to ensure the patient and those close to them understood what they were consenting to.

Emotional support

Communication with patients was warm and professional. Patients felt well supported and informed. Staff were committed to giving patients a positive experience even when they were pressured by increasing service demand.

Additional support was also available from the hospital chaplaincy. The bereavement office also provided advice guidance and support for people who were bereaved.

Are accident and emergency services responsive to people's needs? (for example, to feedback?)

Good 

Access to services

The majority of patients (over 95%) were seen, treated and either admitted or discharged within the four hour national target. Everyone was triaged within 15 minutes of their arrival. This meant that patient needs were identified quickly and they were seen in the areas best suited to their individual needs.

Accident and emergency

There were clear policies and procedures to ensure that people were seen in a timely manner. However, on the day of our inspection there were six patients who were waiting for beds on the wards.

We were told that beds had been allocated for these patients but five of the six beds were still occupied. This meant that patients had to wait in the department while patients were discharged or transferred to other areas. The delays in patient transfers meant that patients were not always cared for in an appropriate care setting and placed additional pressures on the department when it was busy.

The trust worked closely with the North West Ambulance Service (NWS) to ensure that patients were transferred to an appropriate hospital, as some emergencies were better dealt with by a major trauma centre such as Preston.

Vulnerable patients and capacity

Patients with mental health needs were risk assessed at triage to ascertain the level of risk the patient may present to themselves using a recognised suicide risk assessment tool. There was a specially adapted cubicle which had had all unnecessary equipment removed to prevent people harming themselves or others. Staff explained that if someone required extra support due to their vulnerability a member of staff would be allocated to sit with them until specialist support was available.

There was no mental health liaison staff as this service was provided by the local crisis team who were employed by a different trust. Staff were able to give examples of how patients had had to wait for over 4 hours to receive support from the crisis team. This meant that people with mental health difficulties were subject to delays in their care and treatment. The delays also required staff who were already pressured to provide care for patients without appropriate specialist support.

The trust is aware of the difficulties in securing timely mental health support and has recorded this issue on its risk register, it is working with the CCG and the trust providing the support to formalise a Service Level Agreement (SLA) with a view to improving response times for mentally ill patients who present at A&E. The SLA has yet to be finalised and implemented.

When patients lacked the capacity to make their own decisions, staff sought professional support so that

decisions were made in the best interests of the patient. People who suffered from dementia were managed sensitively and were given extra support and close monitoring to maintain their safety.

Reception staff explained that they were able to access interpreters if required and that they would personally assist anyone with hearing or sight impairment. We spoke to a senior member of staff who had already identified some of these issues and had begun to address them.

Leaving hospital

Discharge plans were robust and had been agreed with the patient and their carers. Information was shared with GP's in a timely way. There were some delays with people having to wait for medication to take home with them. Senior staff pointed out that there were occasional difficulties in securing appropriate adult social care packages to enable people to leave hospital safely. However the hospital continues to work closely with the local authority to ensure that these delays are minimised and patients benefit from timely well planned discharge arrangements.

Learning from experiences, concerns and complaints

We found that complaints leaflets were readily available for the public. Vending machines and new furniture had recently been installed in the waiting area as the result of comments made by patients and those close to them.

Are accident and emergency services well-led?

Good 

Vision, strategy and risks

When we spoke with senior managers about the A&E department they were aware of the issues within the department such as staffing levels, mental health support and the ability to deal with the occasional incidences of ambulances being unable to transport patient to Preston or Lancaster. Local strategies were being put in place to address these issues. However, the trust had been aware of the problems for some time and little progress had been made in addressing them with the exception of medical staffing levels that had improved.

Accident and emergency

Governance arrangements

The A&E department is part of the Acute and Emergency Medicine Division. The Division is headed by a clinical Director, supported by a Divisional General Manager and an Assistant Chief Nurse. They in turn are supported by Matrons and Clinical Service Managers. Each Clinical Specialty has a Consultant with dedicated management time to act as Clinical Lead. Each Division also draws on dedicated support from Finance, Human Resources and Governance.

Risks are escalated and recorded on the risk register, the two key risks relating to A&E were the recruitment of medical staff and mental health support to patients attending A&E. Actions are assigned and owned by a senior manager and progress is regularly reported to the board.

Leadership and culture

Staff were well led at department level by managers who were professional and competent. Despite the department being very busy during the afternoon of our visit, staff were working efficiently and were being supported by their managers who were working alongside them. We saw that all staff including receptionists and a deputy chief nurse worked together to provide an efficient and timely service. We saw that managers at matron level were visible and when we talked to them they were aware of the operational challenges within the department. However when we spoke to junior staff about leadership at trust level they were unaware of the trust's strategic plans for future service delivery and some of them were unsure about who the members of the board were.

Some staff told us that there was a culture of openness and friendliness whereas others talked about a punitive atmosphere especially around incident reporting.






Patient experiences and staff involvement and engagement

The trust gathered information about patients experiences through the friends and family survey and its complaint system. When we spoke with staff they were unable give any examples regarding what improvements were made in response to patient's views and experiences, other than changes to the waiting area. However recent improvements had been made about the way this information was gathered and senior staff hoped that this would lead to further suggestions and responses about how the service could improve.

Learning, improvement, innovation and sustainability

Staff who worked in the department had very little time to engage in activities where they could continuously learn and improve the service provided. Doctors had access to training sessions twice per week that provided opportunities to review incidents and discuss new ways of working. However we were told by some staff that they never received feedback about incidents or lessons learned. Some of the senior staff who had responsibility for the department were new in post and had quickly identified areas where things needed to change in order to create an environment that supported improvement and service sustainability. A clear example was the staffing review, managers felt if the staffing establishment was increased then staff could be released to attend training sessions and be more involved in making positive improvements to the service.

Medical care (including older people's care)

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

Information about the service

The acute medical services at Furness General Hospital are provided on wards 6, 7, 9 and the medical assessment unit (MAU). They offer care and treatment to patients who have general and specialist medical problems, that include respiratory illnesses, strokes, cardiac problems, and care of the frail elderly. We visited all these wards during our inspection. Ward 9 also cares for oncology patients this specialist area has been reported on in the end of life section of this report.

We talked with 20 patients, relatives, or carers, and 22 members of staff as well as doctors, consultants, senior managers and support staff. We observed care and treatment and looked at patient care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We held focus groups with consultants; junior doctors, qualified nurses and student nurses, and we reviewed performance information about the trust.

Summary of findings

We found that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service.

The quality of nursing records required improvement as some patient records and risk assessments were incomplete and did not reflect the patients' needs and care management risks effectively. There were examples of pressure relieving equipment not being used effectively to support the prevention of patient harm.

Patients were looked after by caring and compassionate staff that worked hard to be responsive to patient's needs but were often hampered by staffing related issues.

Medical care (including older people's care)

Are medical care services safe?

Inadequate 

Cleanliness and hygiene

Clinical areas were clean and well maintained. Floor areas were in good condition, and cleaning staff followed a cleaning schedule. We saw cleaning schedules had been completed as we visited the wards and departments.

There were adequate hand washing facilities available on each ward, the liquid soap and hand towel dispensers we checked were adequately stocked. Staff adhered to safe practice guidelines in relation to hand hygiene and the control and prevention of infection.

There was an ample supply of personal protective clothing such as gloves and aprons available. We saw staff following infection control procedures and wearing personal protective clothing appropriately. We saw that patients who presented a risk to others were 'barrier nursed' (nursed in isolation) appropriately. Staff told us infection control and prevention was always discussed at handover meetings.

There was a very visible advertising campaign running all over the hospital to alert patients, staff and visitors about the need for ensuring hand hygiene when in the hospital. This had been implemented as part of forward planning around winter pressures to reduce the effect of the Norovirus on patients in the hospital during the winter months as last year (2013) the trust had to close beds at FGH to try to contain the spread of this virulent infection.

Staffing

Senior staff told us that the wards were staffed on the basis of one nurse to eight patients. However, from the staffing rosters and discussions with patients and staff demonstrated it was evident that the usual ratio was one nurse to 12 patients. Staff told us they were working long hours and were doing extra shifts during their annual leave and days off to cover the wards. One nurse told us "yes it was nice to get paid the overtime, but I do the extra shifts really to support my colleagues as I don't want to let them down".

Speaking with two of the ward sisters they told us they had to provide personal care themselves despite the fact that they were supernumerary to ensure patients' needs were

met in a timely way. Both sisters told us this had an adverse effect upon them being able to carry out their managerial duties and limited their opportunities to develop the team. Staff told us training opportunities were available but they were often too busy to attend. Two members of staff told us they did whatever training they could in their own time as it was almost impossible to get time off the ward to complete anything otherwise.

The medical matron told us there had been a recent staffing review. Using an acuity tool (a tool used to grade each patient by their care needs to assist in calculating staffing needs) we were told proposals had been submitted to the trust board to increase staffing on the medical wards. We were told that to cover for shortfalls due to staff sickness and until additional nurses had been recruited shortages were made up using bank staff and their own staff doing additional hours. We saw that some wards asked for the same member of bank staff to ensure continuity of care to patients.

Staff told us that they were not expected to undertake any tasks that they did not feel competent to do and they confirmed that they had completed an annual appraisal that included looking at their own personal development.

Incident reporting and risk assessment

We talked to staff about the system in place for reporting and learning from incidents. All the staff we spoke with were able to discuss the process for recording incidents and the ward sisters were able to discuss the risks on the risk register that were pertinent to medicine. However staff acknowledged that being able to complete incident forms at the time an incident occurred and record incidents on the risk register was not always possible due to time pressures. Staff told us they did not always have the time to meet with each other to discuss the feedback and learning from incidents as there were not always enough staff on the wards to find time on a regular basis for team meetings.

We spoke with medical staff at focus group sessions about the incident reporting system and they were able to tell us about the process for alerting the trust to incidents. They did however feel that they did not always have the time to complete the incident forms and would often have to ask the ward sister to do this for them. They told us about their educational meetings where any learning points were discussed that had arisen from clinical incidents.

Medical care (including older people's care)

We looked at one particular incident where a patient had wrongly been prescribed antibiotics. The trust had identified this issue, investigated it and recorded this as a clinical incident, the medication had been withdrawn and staff had discussed the incident with the patient concerned. This was a positive example of the trust being open and transparent about incidents.

Patients' medical needs were assessed on admission and medical care was planned to meet those needs, however, Individual risk assessments did not consistently identify the risks to each person nor fully explain the guidance for staff to minimise the risk to each person.

We case tracked several patients records and looked at their risk assessments that included falls, nutritional requirements, the use of bed rails, skin integrity, moving and handling. As part of this process where a patient was identified as vulnerable (at risk of falls due to a history of falls or dementia) then the patient assessment stated that a further assessment should be undertaken. However, whilst individual patients were identified as 'vulnerable' we saw a number of records that did not contain any further reviews of the risk assessments. When asked, staff were unable to provide us with these. We found that risk assessments were not completed even when falls were highlighted on the trust's acute medicines risk register that was last updated in December 2013. This showed that effective systems were not in place to provide appropriate care to patients at risk of falling.

We looked in more detail at nine sets of patient records that included patients on the medical wards and medical outliers on the surgical and gynaecology wards. We found that a number of the risk assessments were incomplete or where risks had been identified they had not been reviewed on a regular basis.

We saw that one patient had had a total of nine falls during six weeks in hospital. After any fall the trust has in place a procedure whereby a 'post fall found on floor checklist' had to be completed. This enabled staff to evaluate the actions that needed to be put in place to prevent a repeat fall. This checklist was only completed for four of the nine falls for this patient. We were told by the ward sister that a decision had been made to have a staff presence in the bay in order to reduce the risk of this person falling again, although there was no evidence of how they had arrived at this decision in the notes or on the risk assessment. We saw that the patient was nursed on a low profile bed (nearer to

the floor) and 1:1 ratio of nursing was in place. However the nurse was not directly with the patient but positioned at the opposite end of the six bedded bay. The patient was known to roll out of bed so the nurse due to her position may not have been able to get to the patient in enough time to prevent another fall.

Another patient had a risk assessment completed in relation to having bed rails on the bed. The patient had requested that bed rails were not put on to the left side of the bed so they could access their locker. This request was upheld and subsequently the patient fell out of bed. There was no evidence in the records that the risk to the patient had been discussed with them if the bed rail was left off that side.

We also looked at pressure sore risk assessments in the nine sets of records. In the Department of Health Safety Thermometer information, The trust scored higher than the national average for the proportion of patients suffering new pressure ulcers at grade 3 for 11 out of 12 months from November 2012 to November 2013. We saw that all patients had Waterlow scores (pressure risk score) completed on admission. At least three of the patients' records we looked at had high scores where a pressure relieving mattress was recommended to be used as part of the actions to alleviate pressure and reduce the risk of getting a pressure sore. We saw that no pressure relieving mattresses were in place. Nurses told us they could access pressure relieving equipment from a central storage cupboard. They also told us that they did not always have time to go and get the equipment from the cupboard where pressure relieving mattresses were kept and when you did go you would get one "if you were lucky". This meant that staff were not using appropriate equipment to minimise the risks to patients and that necessary equipment was not always readily available.

On the wards, staff used a system called 'intentional rounding's' where they carried out regular checks to ensure patients were safe and receiving the right care and support. However we identified from patient records and by talking with patients that there was inconsistent recording and monitoring of fluids and foods for patients. This showed the 'intentional rounding' system was not always effective in monitoring at risk patients.

When we carried out our unannounced visit there was a high number of medical outliers (patients who have medical problems that are cared for in another speciality).

Medical care (including older people's care)

Staff on the wards with medical outliers were doing their best to care for them. However, we found staff had not always received the relevant information in the form of a suitable handover when the patients had been transferred from other wards. Handover records were sometimes noted on pieces of paper and some key information for example Mrs A refusing crucial medication. Mrs B had developed small blisters (the start of pressure sores) on her heels. This meant that critical information was not effectively shared at the point of handover and the receiving ward did not have all the relevant information for patients to receive good care. We saw a risk to a patient when we looked at their records and identified them as being allergic to latex gloves. When we asked the nurse caring for that patient they had not been made aware of this allergy at handover.

The trust had its own early warning trigger system Physiological Observation Track and Trigger System (Potts) in place. Staff were able to tell us about its use and the systems of audit in place to identify improvements and problems. All the charts we looked at were completed and staff told us they were confident in its use. However this tool is specific to this trust and has been in use for some years. We were able to see where that the trust had formally reviewed the effectiveness and use of this tool against other research based response tools used nationally.

Mandatory training and safeguarding.

Staff we spoke with could tell us what abuse was and they were able to discuss the process for reporting concerns. Safeguarding vulnerable adults training was mandatory for all staff and staff we spoke with confirmed they had completed this through E learning. There was evidence of safeguarding concerns being escalated appropriately.

Environment and equipment

Medical and emergency equipment and devices were well maintained and ready for use when required.

Nursing staff told us there was enough equipment available and that the majority of equipment was standardised across the hospital. This meant that staff would know how to use equipment that transferred with a patient from another ward or department. Staff and training records confirmed that they were trained on any new pieces of equipment that were in use.

Medicines

Appropriate arrangements were in place for recording medicines. Medicines were stored securely and patients had their treatment and medicines clearly explained to them. Medicines were seen to be safely administered. A patient told us they had been supported to ensure they were using their inhalers in the right way and the nurse had explained about how each inhaler worked. Administration records were completed immediately after each person had taken or been given their medicines.

Learning and improvement

Nursing staff and medical staff told us about a never event (a never event is classified as such because the incident is so serious that it should never happen). Although this was considered a surgical event it was also relevant to medical wards and staff in all areas were made aware of the actions taken as a result of this event. Staff were able to discuss the learning from this incident. This incident had been correctly reported and escalated as a never event to the National Reporting Learning System (NRLS). Staff told us they had received training to use the new equipment brought in to use as a result of the incident.

We found that staff had received specific training in dementia care. On one ward we observed a staff member who had been assigned to supporting patients with dementia care needs or those who were at risk of falls. Dementia link nurses were available to provide guidance and support to staff and patients on the ward. A scheme was in place, the Butterfly Scheme that supported appropriate care for people with dementia whilst they are in hospital. We were told that this scheme was in place on the medical wards although we could not see any physical evidence of this such as patient and carer guides.

Anticipation and planning

The trust had a plan to deal with emergency pressures during the winter months and plans had been put in place to improve discharge arrangements. However the trust were unable to recruit sufficient staff to support and care for patients in identified escalation areas and this had an impact upon the number of medical outliers (patients who are receiving care on a ward that is not within the appropriate speciality). Staff reported that there have always been medical outliers and the numbers of these vary on a week by week basis.

Medical care (including older people's care)

Are medical care services effective? (for example, treatment is effective)

Requires improvement 

Using evidence-based guidance

Care and treatment was delivered in accordance with best practice guidelines and the trust participated in all but two of the clinical audits for which it was eligible.

The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards highlighted that the service needed to make improvements to the care and treatment of patients who had suffered a stroke. There are two parts to the audit – Organisational and Clinical. The hospital is in the bottom quartile nationally in the organisational part and scored 'E' in the overall clinical part. This is the lowest grade awarded.

Furness General Hospital was found to be performing worse than expected for two of the Myocardial Ischaemia National Audit Project indicators; The proportion of eligible patients with a discharge diagnosis of nSTEMI (non-ST segment elevation myocardial infarction) who were seen by a cardiologist or member of their team and the proportion of eligible patients with a discharge diagnosis of nSTEMI who were referred for or had angiography. The hospital does not provide immediate percutaneous coronary intervention (PCI) as this is carried out in the Cardiology Centre in Westmorland General hospital.

Local clinical audit

We reviewed the trust's Clinical Audit Forward plan for 2013/14 as well as its Annual Report for 2012/13. This informed us that the trust had undertaken 104 local clinical audits between 2012/13, 29 of which were by the medical directorate. There were 42 planned for the year 2013/14 which will be reported on in May. According to the forward plan, Doctors from FY2 to Consultant were involved in the audit process and these were reported locally at the Quarterly Divisional Governance meetings as well as to the trust board annually.

Multidisciplinary working and support

We saw an example of effective and collaborative multidisciplinary working on the stroke ward. For example, as well as allied health professionals a representative from the Stroke Association attended the multidisciplinary team meetings (MDT).

Are medical care services caring?

Good 

Compassion, dignity and empathy

Patients, carers and visitors we spoke with told us the staff were caring and compassionate. One patient told us, "The staff are brilliant here. They get a chair to support me when I need it. They respond quite quickly here, I believe they are skilled at what they do. They are kept busy on the ward but I receive medication as I need". Another patient told us, "It's a good hospital. The staff are good although they change their minds at times about my discharge arrangements but they communicate well" and "I had to use the buzzer in the night, the staff came and I didn't have to wait too long. I'm very happy with the care and the food".

Patients were given the opportunity to provide feedback through the 'Friends and Family Test' and 'I want good care' feedback boxes which encouraged patients to write about the care they received. Comments included: "Everybody seems to care if you try to be a good patient"; "Everything was first rate" "Attentive nurses" and "Everyone was very caring".

Results from the 'Friends and Family Test' 2013 from ward seven were overall positive. Results showed out of the twenty two people who responded, 12 people said they would be extremely likely to recommend the ward, eight were likely to and only one person said unlikely.

Staff spoke to patients in a kind and respectful manner. On one ward, we saw relatives seeking information from medical staff. We were told by these relatives they were given detailed answers to the questions they asked.

Involvement in care and decision making

Patients told us they felt involved in their treatment choices and decision making and that staff explained treatment in terms of benefits and risks in a language that patients understood.

Medical care (including older people's care)

Trust and communication

Patients and relatives told us they had positive experiences. However two patients told us they could not sleep in a bay with other patients as they were noisy and disruptive in the night. We saw that one patient was so distressed that they were asking to be discharged home from the hospital before their treatment was completed. This situation requires active management so that all patients have their needs met and are able to sleep in hospital.

We had a mixed response from patients at the listening event we held in Barrow who felt that the trust had not always responded to their concerns in a timely and open way.

Emotional support

We saw on the wards staff communicated well with each other and with patients, relatives and carers. We saw good interaction with a family and staff on a ward following a recent bereavement. Ward staff told us that the bereavement service was very responsive and if chaplains were needed the telephone switchboard was able to contact chaplains who would always attend as quickly as possible.

Are medical care services responsive to people's needs?
(for example, to feedback?)

Requires improvement 

Meeting people's needs

Ward environments were appropriate for the delivery of patients care and treatment. All wards had single-sex accommodation, either in bays or side rooms so that staff could maintain patient's dignity. Screens were used to ensure that patient's privacy was maintained during care delivery. Staff were conscientious when delivering sensitive information so that private conversations could not be over heard.

Vulnerable patients and capacity

A risk assessment completed for a patient with dementia and challenging behaviour, following a series of falls suggested putting the patient in a chair with a tray table in order to prevent further falls. There was a comment made on the risk assessment 'may be seen as restraint. However

designed to maintain posture for safe positional eating and drinking'. This could be seen as a deprivation of a person's liberties. There was no information in the records that showed whether anyone had considered a best interest meeting to discuss the care of this patient.

Staff told us and we could see in medical records that there were problems accessing mental health support for patients from the Cumbria Partnership Trust. As a result, it sometimes meant that discharge plans were delayed and therefore effective management of beds was not always possible.

Access to services

When we carried out our unannounced inspection of the hospital it was extremely busy and we were told the more stable medical patients had been moved to other areas to make room on the acute medical wards for patients who were less well. The gynaecology ward (ward one) had eight medical patients and one surgical patient. A six bed contingency bay had been opened on one of the surgical wards to accommodate medical outliers. The bed manager told us that at the Friday bed meeting there had been forward planning for the weekend where the decision was made to staff additional beds. This had been authorised by the Medical Director. In total at the time of our visit there were 24 outliers. The bed manager confirmed that Royal Lancaster Infirmary (RLI) had similar problems and therefore it was not possible to divert emergencies to the RLI. Additional staff had been called in to help and the previous day's bed manager was working on the contingency bay that was admitting medical outliers within the surgical unit.

On all the wards that had been identified as taking medical outliers each patient had been seen over the weekend on each day by a medical registrar or staff grade doctor without the outlying ward having to ring the doctor to visit. Medical records confirmed this. This was not always the case on the medical wards themselves where staff and records confirmed that patients were not routinely seen each day at the weekend unless they 'were poorly'.

We were told that the gynaecology ward was used on a regular basis at weekends to accommodate medical outliers. The women and children's division had highlighted in their top three risks the use of the service for medical outliers for three months from October to December in 2013. These were the risks identified by the division to the trust:

Medical care (including older people's care)

1. The opening of beds for outliers to increase the capacity for other divisions during times of increased activity across the trust.
2. A failure to match resources to actual demand.
3. May result in poor patient outcomes and increased financial burden on the women's and children's division.

The action identified by the division to alleviate the risk was as follows: "Although there is a clinical strategy for the long term utilisation of the gynaecology ward which is currently under review the trust was saying that the staffing establishment should meet the requirements for a contemporary gynaecology service whilst safely supporting the care of medical outliers". It was not possible however to see how the trust had mitigated any of the risk identified around the medical outliers at our February visit some five months after the risk was identified.

Leaving hospital

The Hospital has a discharge planning team in place that tried to enable early and effective discharge from hospital to the community. The trust had been working with the Clinical Commissioning Groups and the Local Authority to streamline discharge planning processes with a view to better informed winter planning. An electronic discharge system was in use across the hospital, this was an electronic referral system that helped staff to refer patients to social services and to start the discharge planning process as quickly as possible. There were also daily board rounds which included physiotherapists, doctors and a nurse to help improve and streamline discharge planning. The trust had recently put a senior nurse on the board round to help monitor discharge planning and report any pertinent issues.

During our case tracking of records we were not able to always see clear documented discharge plans in place. For each patient an estimated length of stay is made on admission. In one set of records it stated estimated length of stay 48 – 72 hours. The patient was still in hospital eight days later but their estimated length of stay had not been reviewed. As the records had not been reviewed it would be difficult for the trust to be able to forward plan effectively for either the patient or for new admissions. Another patient who was deemed fit for discharge could not be discharged because a place in a nursing home was not available. This meant that the use of an acute medical bed was being occupied by someone who did not require it.

This is not necessarily the fault of the trust but it does not help them secure effective capacity planning when beds are taken up with patients who no longer require acute care.

Learning from experiences, concerns and complaints

We spoke to staff about the management of complaints as we were told the trust had been working to improve the way it handled them. Ward sisters told us they now managed a lot of complaints directly and were encouraged to talk to patients and try to resolve a complaint straight away at a local level.

Patients at our listening events told us they had been unhappy with the speed of response and adequacy of the trust's response to their complaints. The trust had systematically reviewed the management of complaints in the last six months so that it could be more responsive and effective. It was not possible yet to evaluate the effectiveness of the new processes in place specifically for medicine.

There was information available on how to make a complaint or how to make a comment on the ward. There were Patients Advice and Liaison Service (PALS) leaflets available where patients could get advice if they had a concern or worry about the service they had received. Written information was not available in other languages but staff were able to access a translation service if they needed to.

Are medical care services well-led?

Requires improvement 

Vision, strategy and risks

Staff we spoke with were uncertain about the direction of travel for the trust and concerned about the future of Furness General Hospital. Staff had little understanding of the 'Better Care Together' strategy and could not comment on development plans for the medical directorate.

Governance arrangements

We saw records of monthly ward level governance meetings. The minutes of meetings showed infection control, audits, comments and complaints, handovers, lessons learnt from incidents and records all of which were standing agenda items.

Medical care (including older people's care)

Audits were in place and included infection control and case files. Action plans were developed from issues raised. We saw evidence of learning from incidents and incident reporting taking place. For example, two new staff we spoke with told us they had an induction to the ward and staff on duty had a handover about the patients on arrival. Staff on the medical wards knew patients' needs well. Staff confirmed they valued the opportunity to learn and develop following incidents. However as incident reporting is inconsistent, the hospital cannot be assured that incident management is effectively recorded and managed. The hospital cannot be assured that its management information is accurate or robust.

Leadership and culture

We were told by staff that clinical leader's days were held every six to eight weeks. These meetings helped to foster a trust wide culture and sense of identity as well as to impart information to be cascaded to ward and departmental staff.

There was good local leadership with staff feeling supported at the front line by their immediate line managers. However, staff we spoke with had mixed reactions as to whether executive directors and the trust






board were visible at the front line. Some staff were able to state they had met members of the executive team and others stated they had not. Staff also felt that senior managers did not respond to staff concerns in a timely or active way.

Learning, improvement, innovation and sustainability

Despite a winter bed plan being in place that had used learning from previous years the trust was still experiencing considerable problems with patient capacity. It was evident that the hospital had not been able to use its escalation plans effectively as the trust had been unable to recruit sufficient members of staff to support 'escalation beds'. This had resulted in high numbers of medical outliers and additional staffing pressures at the frontline.

Medical staff talked to us about new pieces of equipment and specialist nurse practitioner posts that they would like to see the trust invest in as they felt that these would ultimately improve the patient experience, and after an initial investment reduce the cost of treatment. However they told us that they felt the trust was reluctant to invest in innovation at FGH.

Surgery

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

Information about the service

We visited a range of surgical wards and operating theatres in the hospital and spoke with Doctors nurses in the Day Surgery unit, theatres and wards 2, 4 and 5

We observed care and treatment and looked at patient records. We also spoke with a range of staff at different grades including support staff, nurses, doctors, consultants and the senior management team.

Summary of findings

There were effective systems and processes in the surgical ward and theatres to provide safe care and treatment for patients. The majority of patients we spoke with across the surgical services expressed satisfaction with the care received and felt that staff were knowledgeable and caring. Integrated care pathways were in use on the surgical wards and patients were making informed choices about the treatment they were receiving.

Surgical never events (events that should never happen) were appropriately investigated and learning was shared effectively across the service.

The surgical wards and theatres were clean and well maintained. Staff worked effectively as a team within the specialties and across the surgical services. There was sufficient capacity to ensure patients could be admitted promptly as the numbers of cancelled operations were in an acceptable range for a trust of this size.

Surgery

Are surgery services safe?

Good 

Cleanliness and hygiene

The wards and theatres were clean, well-organised and well maintained.

There was an ample supply of hand washing facilities and alcohol gels to support good hand hygiene. Staff observed 'bare below the elbow guidance', personal protective equipment (PPE) such as gloves and aprons were provided and used appropriately.

Hand sanitizers were available on entry to wards, in corridors, bays and side rooms. We found these were filled and paper hand towels dispensers were well stocked.

Hygiene audits completed in theatres showed 100% compliance for the previous month.

Staffing

There were adequate numbers of staff to meet the needs of patients. On the wards visited staffing levels were maintained at a ratio of one nurse per eight patients; however the senior staff were also included in those numbers, and so often were unable to maintain a supervisory role. We saw from duty rotas there were consistent numbers of staff and an appropriate skill mix of qualified and support staff.

In theatres, there was long term sickness rate of 8%. (higher than the national average) Staff covered extra duties on the bank and agency staff were also used when required. We were told vacancy reviews had been completed and recruitment was on going for two band five nurses; A trust wide skills analysis had been submitted to senior managers, the outcome was not known at the time of our inspection. Some concern was expressed in relation to recruiting future staff into theatres and maintaining appropriate staffing establishments.

We were told that on Ward 2 that staff had difficulty getting a medical response out of hours when requesting doctors to review patients. Staff verified this was the case during most nights and at weekends. This included when a patient's condition was deteriorating. This level of response is of concern as a patients care and safety may well be compromised by the lack of timely medical intervention.

We asked about the senior medical cover on wards and found that there were adequate arrangements for on-call attendance by Consultant Surgeons

Environment and equipment

Equipment check lists on the wards were completed. Resuscitation trollies were checked daily and defibrillator discharge checks completed. Staff could be confident that emergency equipment was well maintained and well serviced. In theatres we found that equipment and surgical instrumentation was safely managed.

Incident reporting and learning

We found improved incident reporting across surgical services. Managers reported that nursing and support staff had increased confidence in reporting incidents more effectively. Managers within the surgical unit had committed to improving education and support for staff in incident reporting.

Staff on wards, day surgery and theatres were able to articulate the incident reporting system and staff verified the types of incidents they had reported. Some staff felt that feedback was lacking if an incident was not classified as serious. We spoke with senior managers who explained all serious incidents were taken to a rapid review panel for investigation and root cause analysis as soon as possible. It was acknowledged that feedback to staff had not been effective in the past It was envisaged that the reporting system "Safeguard" now had an improved feedback facility to address this issue.

Surgical safety checklist

In theatres and day surgery records confirmed that the five Steps for Surgical Safety were followed, which meant that staff were carrying out recognised safety checks for each patient. We spoke with staff who were able to explain the procedures undertaken, to ensure time was taken to complete the required checks to ensure a safer patient experience through theatres.

Mandatory training and safeguarding

Staff were appropriately trained to care for and meet the individual needs of patients. There was a practice educator in post, who provided a high level of support to staff who worked in the surgical wards and theatre department. Training records confirmed that attendance at mandatory training had increased, with the trust's Training Management System (TMS) fully utilised, to enable focused training to be targeted for individual staff.

Surgery

We saw qualified and support staff had undergone vulnerable adults safeguarding training. Staff were able to explain the process they would follow if safeguarding concerns were raised.

Risk Assessment

In patient care records, we saw staff had documented risk assessments to identify potential problems such as venous thromboembolism (VTE), falls and pressure ulcers. Care was planned and delivered to reduce these risks, for example wards were clear of clutter to prevent falls, staff aided people to mobilise safely and we saw patients wearing anti embolus stockings as identified in their assessments, before and after surgery.

Systems, processes and practices

A patient observation chart was developed in the trust to combine physiological observation charting with the calculation and recording of an early warning score (EWS). The Physiological Observation Track and Trigger System (POTTS) charts had recently been reviewed and there had been an increased frequency and accuracy of EWS recording. Audits had been undertaken which demonstrated identification of patients at risk of deterioration had improved.

On the surgical wards intentional rounding checks had been undertaken. These were regular monitoring of the environmental or personal risks that could cause harm. This included beds working at a low level to prevent falls, appropriate access to call bells, availability of drinks and pressure relieving aids.

Wards had quality boards that displayed key performance and quality indicators, which included falls and pressure ulcers. On all but one ward these were up to date. Safety crosses were completed which displayed current incidents. These were visual displays of the numbers of incidents that had happened on the ward on a daily basis, such as falls or pressure ulcers.

We found one productive ward board on the same ward was out of date and no safety crosses completed for three days.

Learning and improvement

We saw evidence of learning from never events in theatres. Procedures had been reviewed and more detailed check lists and recording systems introduced to reduce risks to patients. Audits had been planned to be undertaken to

ensure compliance. Learning also been shared across to staff in theatres located in the Royal Lancaster infirmary. Both nursing and support staff were able to explain to us what action and learning had resulted from these events.

Anticipation and planning

Pre-operative assessments for patient's planned surgical procedures were undertaken in an appropriate time frame. This meant improved pre-operative planning which was decreasing the cancellation of procedures on the day of surgery, due to medical issues. Patient's long term medical conditions were being managed more effectively in preparation for surgical interventions.

There was a dedicated emergency theatre allocated for emergency procedures. This meant that surgery was not delayed due to emergencies being added to routine operating sessions. Staff were routinely allocated to work in this theatre to avoid any delays.

Are surgery services effective? (for example, treatment is effective)

Good 

Using evidence-based guidance

The service was using national and best practice guidelines to care for and treat patients. The trust participated in all but two of the 38 audits it was eligible to take part including the fractured neck of femur audit and national bowel cancer audit.

There were no risks or recommendations identified in relation to the fractured neck of femur audit, The number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database was also statistically acceptable and the orthopaedic wards had recently implemented the enhance recovery programme.

The trust was found to be performing worse than expected for two of the five National Bowel Cancer Audit indicators. The first of these was regarding the number of patients seen by a specialist nurse. In relation to patients seeing a specialist nurse the trust scored significantly worse than the national rate of 82%. In addition the level of data

Surgery

completeness was only 1% for the 87 cases having major surgery. The national level is 71%. This lack of data means that the service may not be able to assess its effectiveness in this area.

Information on patient-reported outcome measures (PROMs) was gathered from patients who had had groin hernia surgery, vascular vein surgery, or a hip or knee replacement. No risks were identified in relation to outcomes for these groups.

In addition, the surgical services are performing within expectations for the number of emergency readmissions for both emergency and elective surgery and there are no outstanding mortality indicators for this hospital.

We found comprehensive use of integrated care pathways. Care pathways were used to ensure patients receive care for a particular condition or procedure as agreed by the clinical team.

Multidisciplinary working and support

Staff within wards and theatres indicated that there was effective multidisciplinary working between medical, nursing and allied health professionals. This included physiotherapists, dieticians and occupational therapists.

Are surgery services caring?

Good 

Compassion, dignity and empathy

Patients expressed a high level of satisfaction with the care they had received on the surgical wards.

One patient said “I have no problem at all, they always close the curtains and treat me with respect”. Another said “I watch what goes on, the staff here are very good, they make sure things are done in a dignified way and they maintain your privacy”.

One patient asked to speak with us to make sure we knew the level of support they felt they had received. We were told: “Staff have encouraged me all the way, they have given me my confidence back, they have been fantastic, they gave me all the support when I needed it”

We observed staff interacting appropriately with patients. Conversations were undertaken in a caring and sensitive way. Patients were treated with dignity and respect. On the

day surgery unit we noted curtains were drawn around a patient’s bed and staff speaking at a discreet level when explaining discharge arrangements and checking dressings.

Involvement in care and decision making

Patients on the wards told us they felt they had been involved in their care planning.

Patients said “I see the doctor most days; he explains everything and always asks if I understand and want to discuss any other options”.

Records demonstrated staff had explained procedures to patients. Patients told us: “Staff always explain what they are doing and why”.

We noted that consent forms for surgery were fully completed. When consent had been obtained in the out-patients department during consultations, this had been confirmed again on the day of surgery. Risks and benefits of the procedure had been discussed with patients and had been appropriately recorded in their notes.

When we spoke with patients in recovery they said they were aware of the procedure they were having before surgery and that both doctors and nurses had ensured their understanding.

Trust and communication

Overall we found positive patient experiences on wards and in theatres. We spoke with patients following day surgery and we were told; “Everything has been explained really well” and “The staff have explained everything at every stage, I have been well looked after”.

Relatives on the ward during the visit told us they felt the ward staff had kept them informed of their relative’s condition and that they felt assured and had confidence in the staff.

Patients said they were being informed throughout their stay about what was happening and about discharge arrangements.

Emotional support

We found a high awareness of the support required when caring for patients who were living with dementia. Wards had nominated dementia champions. Each ward had a “butterfly board”, which outlined for staff the basic dementia interaction skills. Staff reported they were able to

Surgery

support patients with dementia in a more appropriate way. We found training for staff was well supported, with some staff undertaking a facilitators course externally, to enable them to train and support staff more effectively.

Patients on day surgery said staff were caring and able to put people at ease very quickly. We were told “staff go the extra mile” on the trauma and orthopaedic wards.

Patients expressed a high level of satisfaction and support on the Arthroplasty unit. One patient said “Staff patience on this unit is inexhaustible. They always have time to explain things, give reassurance and they never show any tension at all”. Another said “It’s just the right level of assistance and encouragement; staff are wonderful”.

Are surgery services responsive to people’s needs?
(for example, to feedback?)

Good 

Meeting people’s needs

The surgical service at Furness General Hospital was performing within expectations in relation to the number of cancelled operations. The service was also performing within expectations in relation to the time patients received diagnostic tests and the time they waited to have their operations. This indicated that the surgical service at this hospital was responding to people’s needs in a timely way.

Within theatres there had been progress with “cross trust working” with the theatres at RLI. A productive theatre project was in place that monitored theatre utilisation and efficiency, aiming to reduce cancelled operations due to lack of theatre availability.

Vulnerable patients and capacity

Staff understood their responsibilities accessing services for patients who lack mental capacity. Where patients lacked capacity to make decisions staff sought appropriate support so that a decision about care and treatment could be made in the best interests of the patient.

We observed clinical support staff who had a passion about caring for people with dementia. There was clear evidence of actions taken in the clinical area to enhance patient experience, including the thoughtful improvements to one ward that incorporated dementia-friendly colour

schemes. This enabled patients suffering from dementia to recognise different areas within the ward environment. On wards where some patients were frail and elderly, we saw staff cared for them in an area designated for high levels of observation. This meant that falls in particular could be avoided.

We were made aware of plans for a reminiscence room on one ward for the use by patients living with dementia. Support staff told us they felt this would enhance their care by having an area to sit and talk with these patients in a less clinical environment.

Staff raised some concerns about the use of security staff used to observe patients with dementia, particularly at night. This issue had been raised with the trust previously. We were informed this was only when patients had become physically challenging and it was assessed as appropriate. Security staff had no clinical or personal intervention with the patients. Staff confirmed some security staff spent time reading to the patents and this had had a very positive and calming effect on the patient’s behaviour.

Access to services

Systems had been put into place for the management of medical outliers. These are patients cared for on a ward, which is not the intended ward for admission. One bay on the surgical ward was used flexibility. Medical patients were admitted and cared for by appropriately skilled staff from the weekend to each Wednesday. From Wednesday the beds were then used for patients requiring surgery. This meant increased availability of beds on other wards for more poorly patients or emergency admissions.

A specialist arthroplasty unit for elective orthopaedic surgery had been developed. The unit had 10 beds and carried out predominately hip and knee replacements. It provided an environment which enhanced the recovery of patients through a rigorous clinical care pathway. These beds were never used for any other outlier or specialty and to date there had been no readmissions of patients following surgery. They had a single point of access team and worked closely with other health and social services to support the patient’s admission and discharge. These included mental health workers and social workers.

Leaving hospital

Patients we spoke with told us they were happy with arrangements made for their discharge.

Surgery

On the Day Surgery unit we spoke with three patients who were waiting to be discharged home. Each confirmed they had been given medicines to take home and appointments to return to out-patient clinics. Contact numbers for the unit had been given for use in any emergency or if the patients had any concerns or queries. We were told by staff that patients were contacted the following day after discharge to check on the patient, answer any queries and also to obtain any feedback on their experience.

Staff told us that due to the difficulties in obtaining patient records, letters to patients GPs were sometimes delayed. We were told by staff that letters to GP's had been delayed due to the delay in obtaining patient medical records to set up the electronic system prior to surgery. Senior staff explained this had now been addressed by improving the availability of medical records and the additional capacity provided by ward clerks working out of hours to target the sending of discharge summaries in a timely way.

Learning from experiences, concerns and complaints

We found there was an effective system in place to manage complaints. Ward managers and matrons were proactively meeting patients and families when issues were raised to try to resolve these complaints as soon as possible at a local level.

We saw information on how to make comments or complaints on wards and the day surgery unit for patients. The "We're Happy to Help" leaflet for the Patients Advice and Liaison Service (PALS) was easily accessible. Written information was not in other languages but staff said they would access 'Language Line' a translation service if required.

Are surgery services well-led?

Good 

Vision, strategy and risks

Staff we spoke with seemed unclear in relation to the trust's vision and values. There was limited understanding of the trust's Better Care Together Strategy and staff were unclear as to what this meant for them or the hospital. However, improving patient experience and high standards of care was cited as a priority by most staff working within the surgical division.

Governance arrangements

Monthly governance meetings were held within the surgical division. A surgery and critical care risk register had been compiled to identify areas of risk within the wards and departments. Each risk area had a nominated lead and regular updates on actions taken were recorded.

However there was lack of accuracy in the management and performance information provided by the electronic system. One ward manager expressed some concern about the reliability and accuracy of the reports produced. Another said although data was collected in relation to incidents, falls and pressure ulcers, there was some concern that action plans were not always fully implemented and evaluated. Consequently staff are unable to measure performance effectively and target remedial action where it is necessary.

Leadership and culture

We were told clinical leaders days were held approximately every six weeks. This was to promote leadership strategies and to ensure continuous learning and improvement for the service.

Staff we spoke with generally felt they were adequately supported by their line managers. The acting matron for surgery was particularly cited as an excellent role model, who provided leadership and support. We were told she was "highly visible" on wards and departments and visited frequently to deal with issues and often worked with staff on the wards during busy periods.

We were told the new executive lead nurse had also visited the ward and theatre areas. A ward manager's away day had been held where staff had the opportunity to raise issues and discuss their own ideas on how services could be improved.

Ward staff felt the "no blame" culture had been reinforced within the service and when asked said they would report incidents as soon as they could.

We were given an example of how a staff member had been effectively supported when they had raised concerns about the practice of another staff member.

Patient experiences and staff involvement and engagement

Information from the General Medical Council (GMC) National Training Scheme Survey 2013 for doctors

Surgery

indicated the trust was performing better than expected in the trauma and orthopaedic speciality. This included a high level of satisfaction in the induction, workload and access to educational resources and regional education.






Early indications from the latest staff survey in 2013 show some positive improvements. These include more effective communication between senior managers and staff, improved training and recommending the standard of care delivered at the hospital to family and friends.

Learning, improvement, innovation and sustainability

Staff reported they felt they had better ward based support to ensure training was undertaken in a timely manner however concerns were raised about the sustainability of the hospital having only one doctor on call at night for the whole hospital.

Theatres had an effective ordering system for a wide range of surgical items. Items were electronically matched against each procedure per theatre and patient. This had seen increased cost improvements and reduced wastage.

Intensive/critical care

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

Information about the service

The Intensive Care Unit was a six bedded purpose built unit that provided care for seriously ill patients requiring constant close monitoring and highly specialist support.

There was also an 8 bedded combined Coronary Care Unit (CCU) and High Dependency Unit (HDU). The HDU/CCU cared for patients who were both medical and surgical patients and patients who required coronary (heart disease) care.

Summary of findings

The care of patients on the Intensive Care Unit was of a good standard and patients were well cared for by a highly skilled team. Staff were appropriately trained to be able to respond effectively to changes in a patient's condition. Medical and nursing staff worked well together as a team, communication and information sharing was well managed. Patients and those close to them were positive about their care and treatment.

However on the combined HDU and CCU, we found that nurse staffing levels were inadequate to provide safe and effective care for the number of patients being cared for and that medical cover required significant improvement. We raised our concerns with the Executive Team who took immediate remedial action to secure the welfare and safety of patients receiving care and treatment on the unit.

There was no outreach service provided at this hospital.

Intensive/critical care

Are intensive/critical services safe?

Inadequate 

Cleanliness and Hygiene

Intensive care was provided in a unit that was clean, well equipped and well organised. There were an appropriate numbers of hand wash basins and hand gels. Staff followed the hygiene standards and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, whilst delivering care.

Steps were taken to ensure patients were appropriately protected from cross infection risks and staff could nurse people whose condition meant they were susceptible to infection in a safe environment.

The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This demonstrated that the number of unit acquired infections such as methicillin resistant staphylococcus aureus (MRSA) and clostridium difficile were within expected for a unit of this size.

The HDU/CCU was also clean, well equipped and well organised although less spacious and very compact.

Staff followed good practice in relation to hygiene standards and in the control and prevention of infection. There were ample supplies of hand washing facilities and alcohol gels.

Patients care was managed to reduce cross infection risks and promote safe care.

Staffing

In the ICU there were adequate numbers of skilled nursing and medical staff to provide safe care to critically ill patients. Staff ratios were always at least one nurse to each patient and staff were appropriately trained and skilled to be responsive to any changes in the patient's condition. Medical and nursing staff worked well together to provide a high standard of care and treatment for patients.

There were daily consultant led ward rounds and multi-disciplinary working was well established. There was 24 hour medical cover with a registrar on call for additional support.

However in the HDU/CCU the nurse staffing were inadequate to meet the needs of patients.

When we visited the unit there were only three registered nurses on duty, supported by one clinical support worker. The unit was caring for eight critically ill / highly dependent patients.

Senior managers informed us that the staffing ratio was one nurse to every two patients, for both days and nights. In reality on the day of the visit however, the numbers allocated were three qualified staff to eight patients and two qualified staff to eight patients during the night. The staffing levels did not support safe and effective care and were below the national guidance levels for patients requiring this level of support and monitoring. Staff told us staffing levels had been a concern for some time and that these concerns had been reported to senior managers. This meant that the trust was aware of the staffing concerns within the HDU/CCU and yet no action had been taken nor was the issue recorded on the trust's risk register.

During our inspection of this unit we saw one patient's condition deteriorate rapidly; all the staff responded quickly and attended to this patient immediately. However, as a result of the low staff numbers this left other patients whose conditions were also serious without support.

When we spoke with the critical care matron and the assistant chief nurse we were informed a number of consultants were involved in the care of patients. There was no named consultant for the unit. We were told there was time wasted in calling medical staff to the unit in an emergency, as they could be anywhere within the hospital. There was also inconsistency in the numbers of staff required to care for patients.

Our concerns about staffing levels and medical cover were raised with the trust's Executive Team who took immediate remedial action. The trust closed two beds on the HDU/CCU, which meant nurses were able to provide care on a one nurse to two patient ratio over the 24 hour period. The trust arranged appropriate medical cover and a named consultant who would supervise the treatment of patients.

We undertook an unannounced visit nine days following actions taken to address concerns we raised about staffing levels in HDU/CCU. We found that nurse staffing levels were now appropriate to the needs of patients and there was

Intensive/critical care

additional support staff provided. However, staff informed us the additional support staff tended to be taken from the unit to help out on the ward areas, particularly during night duty.

Medicines

Medicines, including controlled drugs, were securely stored on both units. Staff also carried out daily checks on controlled drugs and medication stocks.

Equipment

On both units equipment was clean and fit for purpose. Resuscitation equipment was readily available and we found equipment was checked on a daily basis. Cardiac arrest emergency drugs were ready for use and within expiry dates.

Incident reporting

Staff on the ICU had a good understanding of incident reporting and were confident in raising issues of concern and there was evidence of shared learning to prevent incidents reoccurring.

However, there had been no clinical incidents reported since October 2013 by the HDU/CCU Team. As the dependency and risk factors associated with patients cared for on the unit was very high, the lack of incident reporting may indicate that there was no systematic approach to the management of risks within the unit. The absence of reporting any incidents requires further investigation so the trust can assure itself that the management of risks on this unit are adequately documented and mitigated.

Outreach team

Staff in ICU explained there was no formal outreach system within the hospital. Outreach is when specialist staff from ICU respond to requests to review any patients being cared for on other wards when their condition was deteriorating.

Systems, processes and practices

On the ICU there were detailed care bundles in place. These are specific best practice guidance for care of the critically ill patient to improve care by having standardised methods of care whilst in intensive care settings. On the units these included central catheter care, which provides fluid administration and ventilator care, which is a machine which mechanically breathes for the patient.

We found risk assessments for patients in ICU reflected their individual needs and promoted safe and effective care.

Mandatory training

Records demonstrated that the majority of staff on both units had completed mandatory training.

Anticipation and planning

In the HDU/CCU we found there were no formal admission or discharge protocols in place. This meant that nursing and medical staff were not working to an agreed, shared and understood criteria. Patients potentially could be transferred between the wards and the HDU/CCU inappropriately. It also meant that patients may have been placed at risk and their care compromised as a result of this practice. We raised this issue with the trust who took action to address this shortfall. The trust provided us with a copy of the admission and discharge criteria following the inspection.

Are intensive/critical services effective? (for example, treatment is effective)

Good

Using evidence-based guidance

The care bundles in use in the ICU and HDU/CCU ensured patients were receiving care and treatment that reflected current, evidence based practice that promoted patient safety and good quality care.

Performance, monitoring and improvement of outcomes

The Intensive Care National Audit and Research Centre data demonstrated that mortality outcomes for the unit were in line with national and comparable equivalent units.

Multidisciplinary working and support

The ITU nursing staff told us they felt well supported by medical staff and were able to contribute effectively to improving care by implementing nurse led protocols.

The teams worked well with other health professionals; there was also good support from allied health

Intensive/critical care

professionals such as physiotherapists. The critical care service benefitted from good pharmacy support and required medicines and fluids were provided quickly and effectively.

Are intensive/critical services caring?

Good 

Compassion, dignity and empathy

On both units care was given in a caring and compassionate way. A relative of a patient who had been in intensive care for a long period told us, “Nothing is too much trouble for the staff.” Another relative told us, “The staff are very professional and hardworking and they genuinely care about the patients.”

Staff on the unit worked hard to ensure that patient’s dignity and privacy were maintained. Staff also gave good support to people close to patients taking time to explain care and treatment and keeping them informed about the patient’s condition.

Nursing staff on the HDU/CCU used a system called “intentional rounding” whereby they carried out regular checks to ensure patients were safe and their care needs were being met. We saw these records were appropriately completed. This ensured that the team responded to changes in a patient’s condition in a timely way.

A patient on the HDU/CCU said: “I have been in here for two weeks and I have no complaints at all. The staff are very caring and when they are able they sit and talk”. We were told: “There are some males in the unit but this hasn’t been a problem at all, staff always make sure the curtains are pulled around and they treat me with respect”. This practice helped to ensure patients privacy and dignity was maintained and supported. Despite staff being very busy they treated patients in a caring and compassionate way. Time was taken to allay patient’s fears and anxieties. Explanations were given regarding care and treatment in a way that patients and those close to them could understand.

Patients looked comfortable and cared for. Call bells were close to patients and they were able to easily summon assistance when required.

Involvement in care and decision making

A patient told us in that they felt involved as far as possible in their care. Another patient said: “Everything about my treatment has been explained, they have made sure I understand the options and have made sure I consent to everything”.

Those close to patients felt that they too had been consulted and kept informed about the patient’s condition and progress, they were positive about their involvement in care decisions.

Trust and communication

Staff communicated with patient’s in an open and honest way. Staff encouraged patients to ask questions and staff were clear and helpful in their responses. It was evident that patients and their relatives had trust and confidence in the support and care that was being provided by the critical care teams.

Emotional support

Patients and relatives told us they felt they had been very well supported during and after a serious illness. They felt staff responded to their needs well and offered emotional support to them at all times.

Are intensive/critical services responsive to people’s needs? (for example, to feedback?)

Requires improvement 

Access to services

We found that there were times when patients were not always cared for in an appropriate setting. Patients were sometimes moved due to a lack of capacity within the HDU/CCU. As patients’ needs changed, staff worked within available resources to ensure appropriate arrangements were implemented for transferring patients when they required high dependency care. This was also a concern when patients were “stepped down” as no longer requiring this level of care as the absence of clearly understood admission and discharge criteria on the HDU/CCU meant that there was a risk of patients being moved in and out of the unit inappropriately.

We followed through recent patient discharges from the HDU/CCU to the medical wards. When we arrived on the

Intensive/critical care

wards we found they were extremely busy. We were informed by staff that due to bed pressures patients who were very poorly had been transferred from HDU/CCU Staff reported this was extremely stressful for relatives and staff.

In addition, due to lack of capacity elsewhere in the hospital there were occasions when patients who no longer required the ITU were not able to be discharged to the wards. The ICNARC data confirms that delayed discharges for more than four hours were an issue at this hospital.

Vulnerable patients and capacity

When patients lacked the capacity to make their own decisions, staff sought appropriate professional support so that decisions about care and treatment were made in the best interests of the patient.

Are intensive/critical services well-led?

Requires improvement 

Vision, strategy and risks

The trust had not yet produced a clinical strategy, nor did we see any evidence that the trust had articulated its vision and values within critical care services. This meant it was difficult for staff to be fully engaged in the development of services over the medium to long term.

Governance arrangements

There was a governance system in place that allowed risks to be escalated. However, this system was not working effectively in the CCU/HDU as the staffing issues identified were not included on the trust's risk register and no action had been taken to mitigate the risks associated with low staffing levels until the matter was raised by our inspection team. This meant staff were often working outside of best practice guidelines in relation to staffing levels for patients who were critically ill.






Leadership and culture

There was good leadership locally and frontline staff had confidence in their line managers. The nursing and medical teams worked well together and there was a sense of pride in their work.

The ICU had good local leadership and effective clinical support. There was evidence of learning from incidents that was supported by processes to record and cascade the learning within the unit.

Staff were committed to good patient care; however in CCU/HDU support from senior manager's relation to improving staffing levels had been lacking.

Maternity and family planning

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

Information about the service

Furness General Hospital (FGH) is one of three hospital sites where maternity and gynaecological care is provided within University Hospitals of Morecambe Bay Trust (UHMBT). Geographically there are 46 miles between FGH and Royal Lancaster Infirmary (RLI) and 32 miles between FGH and Westmorland General Hospital (WGH). The largest proportion of women receive maternity care provided by teams of midwives within the community setting.

The maternity services provided by the trust have been the subject of scrutiny since 2010. Initial concerns arose after several maternal and neonatal deaths. These have been the subject of an on-going police investigation. In response to these concerns and identified service failings both CQC and Monitor have used their powers of enforcement to secure service improvements. Monitor was assessing progress against the action plan submitted by the trust to secure service improvement. Performance information was submitted to the regulator monthly.

Across UHMBT the Women & Children's Services Division is led by a clinical director supported by a general manager, a head of midwifery supported by an interim governance lead and three matrons for midwifery and one for gynaecology. There is a matron on each of the hospital sites. Each ward has a manager / ward sister who is accountable to the site matron.

In 2011/2012 there were 1150 births at FGH and 1063 in 2012/2013 this is an average of three births per day. There are 40 hours consultant obstetrician cover per week on the labour ward and four consultant obstetricians currently in post. The four bed special care baby unit has been downsized, relocated and is now adjacent to the maternity ward.

The maternity ward has 22 beds for antenatal and postnatal care and there is a Day Assessment Unit (DAU) and a labour ward.

The gynaecological ward at FGH has eight overnight beds and the flexibility to accommodate up to 12 if required. The ward is used regularly to accommodate patients with a medical concern when the medical wards are fully occupied.

During our inspection we visited the antenatal / gynaecological outpatient clinic areas, antenatal and postnatal ward, labour ward and gynaecology ward. We spoke with nine patients, one relative as well as 12 staff which included nurses, midwives, ward sisters / managers, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at care records. We also reviewed the trust's performance data.

Maternity and family planning

Summary of findings

All the women and relatives that we spoke with told us the quality of the care they received was of a good standard and that staff worked hard to ensure that their needs were met.

Maternity and gynaecological services are safe although some improvements were required. The service needs to continue to monitor the safety and quality of the provision at the hospital using a wider range of information relating to performance, incident reporting, workforce and lessons learned.

The high numbers of caesarean section births at the hospital should be reviewed.

The service needs to continue to address the cultural disparity between the hospital sites as there was little evidence of the hospital working closely with the service provided at Royal Lancaster Infirmary.

Are maternity and family planning services safe?

Good 

Cleanliness and hygiene

Patients on both the maternity service and the gynaecology areas were cared for in an environment that was very clean. Staff were provided with appropriate personal protective equipment and there were good supplies of hand washing facilities and alcohol hand gels. Staff observed the 'bare below the elbow guidance' and were seen to wash their hands frequently between patients.

We noted that staff observed safe practice guidance to control and prevent infection.

Staffing

The midwife to live birth ratio at the hospital was 1:28 which meets best practice guidelines and is sufficient to provide safe conditions of care. Since our last visit to the maternity service in October 2013 there had been an increase in the numbers of permanent nursing staff on the maternity wards. Staffing had increased with the addition of two experienced midwives and six newly qualified midwives. This meant there was a large proportion of the nursing team who were less experienced. A lecturer practitioner had been appointed to support student and newly qualified midwives. Newly qualified midwives were provided with a 12 months preceptorship programme with a named mentor to support them.

There was 40 hours of dedicated labour ward consultant cover. National guidelines (Safer Childbirth 2007) recommend that for units with under 2500 births per year, consultant cover on the labour unit should be assessed according to local need rather than setting a specific recommendation. The arrangements for anaesthetic cover met the national standards for the number of deliveries.

Senior managers confirmed that there were minimum safe staffing levels in place in all clinical areas. Workforce data that was sent to Monitor (NHS regulator) as part of an action plan for UHMT to improve in relation to maternity services on a monthly basis confirmed this. However, we

Maternity and family planning

noted that this data was not included in the maternity performance dashboard at a local level. This meant that all data relating to staffing may not be used to inform staffing requirements effectively.

Equipment

Equipment was clean, well maintained and safely stored.

Incident Reporting and learning

All incidents were reported and reviewed by a multidisciplinary team (MDT) on a daily basis. Senior managers report that there has been an increase in reporting rates over the last two years following previous maternity incidents and inspections. Information provided by the trust supported the increase in incident reporting.

The process in place ensured that a response was provided to the person who reported the incident and to explain what actions were to be taken. This response was provided within 48 hours and the content of the mandatory study days was adapted to focus on the additional learning required. Where widespread lessons needed to be learnt had been identified, these were published in a regular newsletter for staff. We found an example relating to 'growth charts' had been reported on in early 2013 and an education package was produced to inform staff. However the same concern was still noted more recently and had now been included in mandatory training.

Mandatory training and safeguarding

Staff were required to attend a three day mandatory training session that they attended annually. Staff reported that there were regular learning sets in addition to the three mandatory days and MDT updates.

The training database on the gynaecology ward showed us that all staff had received mandatory training including cardio pulmonary resuscitation and child protection.

There were systems in place to escalate adult safeguarding and child protection concerns. Staff were familiar with the systems and were confident in escalating issues of concern.

Systems, processes and practices

The labour ward at the hospital does not have its own obstetric theatre and women requiring an emergency caesarean section were taken to the main hospital theatres. We were told that the labour ward used to have this facility but it had been removed some time ago.

Women requiring an emergency caesarean section were taken on a trolley from the labour ward, through the middle of the Medical Assessment Unit (MAU) to the main operating theatre.

In order to access the MAU the staff on the labour ward needed to unlock a connecting door. On the day of the inspection we saw that it took eight minutes for a member of staff to locate the person who had the key. This meant that women who needed an emergency procedure may be left waiting to be transferred to theatre in a timely manner.

During our visit we saw that the handover on the labour ward was attended mainly by obstetric staff. We asked if any paediatric staff attended as standard practice, we were told that because the unit was small communication with paediatricians was on a needs basis. At the time of our inspection there was a woman receiving care that may well have benefitted from the contribution of a paediatrician during the MDT handover.

Monitoring safety and responding to risk

There was a maternity performance dashboard in place that identified key activity in maternity services and clinical data. This provided an overview on the safety and performance of the service enabling the monitoring of risks. However we were advised by senior managers that some specific information such as postpartum haemorrhage and unexpected admission of a baby to Special Care Baby Unit (SCBU) was not possible to capture due to the trust's IT systems. We also asked for data in relation to the number of women being diverted to other maternity units within the trust to enable provision of safe care and we were told by staff that this data was not captured. We were informed by the trust that workforce data and patient safety risks that were unable to be captured on the IT system were reviewed weekly in the matrons and managers' meetings. There was a more formal review in the monthly divisional team meeting prior to the corporate performance meeting where workforce data was scrutinised by the executive team. The trust told us that it was assured that staff were actively reporting patient safety incidents in relation to staffing and this data is collated as part of the maternity risk management paper that fed in to Divisional Governance meetings. However these risks should have been included on the maternity dashboard.

We were told by staff that the use of the divert facility within the trust was used more now on the labour ward than in

Maternity and family planning

the past as part of the risk strategy. This meant that women in labour would be diverted to RLI if deemed a high risk which although would be a journey of 46 miles would ensure that the women received the increased support and care that they required.

Are maternity and family planning services effective? (for example, treatment is effective)

Good 

Performance, monitoring and improvement of outcomes

The standardised maternity indicators for puerperal sepsis and other puerperal infections, maternal and neonatal readmissions were all within expected limits. The trust's perinatal mortality rate was significantly lower than expected.

Information made available to the public on Which Birth Choice website indicates that women are more likely to have an unplanned caesarean section at this hospital. Data we looked at provided by UHMBT indicates that the number of emergency caesarean sections performed in the period July 2012 to July 2013 were higher than expected. The maternity performance dashboard indicates that the caesarean section rate has been an average of 30% for the five month period August 2013 to December 2013. This is overall 20% greater than the national average of 25.5%. The numbers of unplanned caesarean sections should be explored by the trust.

The trust had implemented a written maternity risk management strategy that indicated during antenatal care women who were identified as a high risk were cared for by an obstetrician jointly with a community based midwife and their General Practitioner (GP). For the lower risk pregnancies there were a large proportion of midwives with specialisms to provide midwife led antenatal care. This meant that women received care within a good skill mix that promoted their safety and wellbeing.

Are maternity and family planning services caring?

Good 

Compassion, dignity and empathy

Care and treatment was delivered in a caring and compassionate way. Women were well supported by the staff and were positive about their experiences of the service. The trust performed similar to other units in CQC Maternity Survey 2013 in areas such as labour and birth, staff and care in hospital.

Involvement in care and decision making

One woman we spoke with told us that although the plan was that her baby was to be delivered at Westmorland General Hospital (WGH) in the Midwife Led Unit (MLU) she had been transferred during her labour to FGH due to complications. The woman told us that her and her partner were told the risks and accepted the judgement made to transfer her was in the best interest of her and her baby. She also told us that ideally she would have preferred to have gone to Royal Lancaster Infirmary (RLI), however was told that RLI could not accommodate her. At the time of her requiring transfer RLI was on divert alert to other UHMBT maternity services as they had no capacity to admit to the labour wards.

Two patients spoken with on the gynaecology ward praised the staff and the way they had been cared for. They both said they had been involved in their treatment plans by the medical and nursing staff. One patient said that nothing had been too much trouble for staff.

Trust and communication

We were told by one woman that her and her husband were kept fully informed about the labour processes and were never left unattended. One woman said, "Staff looked after my husband just as well as me". During the labour the woman told us she was introduced to the paediatrician, she told us, "He stayed in the room during the birth but luckily he wasn't needed as my baby was alright".

Emotional support

The outpatient's clinic which served both maternity and gynaecology was organised in a way to be sensitive to patient's needs. The clinics were run separately at different ends of the day in order to prevent any crossover of women who were maybe trying to conceive with women who already had conceived in order to prevent any unnecessary emotional anxiety.

Maternity and family planning

The wards also had facilities to ensure where privacy was beneficial that single rooms were specifically designated for that use.

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Requires improvement 

Meeting people's needs

On the day of our visit there were three women receiving care on the main maternity ward and the number of women receiving care on the labour ward increased from two to four as the day progressed.

We saw that following admission where the involvement of other services was required such as, mental health support, this was organised in a timely manner.

We were told by senior managers that, after listening to women who used the service, the introduction of the option of vaginal birth after caesarean section (VBAC) was offered to women where it was deemed a feasible and safe option. However this was a fairly new service and we did not see any significant data to show how effective this was.

We were told by the clinical lead that, "We can't currently offer the choice everyone would want". This was directly related to women not having the choice of accessing the services of a midwife led unit at FGH or RLI when deemed to have a low risk pregnancy.

Access to services

The services for women in maternity at FGH are obstetric led which is normal for high risk pregnancies. There are no midwife led services available for the identified lower risk pregnancies on the site. Women would have to travel to Westmorland General Hospital (WGH) for this service.

There is a Day Assessment Unit (DAU) on site which has a midwife on duty Monday to Friday 7.45am – 6.15pm. The unit is specifically focused on supporting and assessing women who are receiving antenatal care. This service has reduced the need to use a bed on the labour ward for women who are not actually in labour. On the day of the inspection there were two women booked to attend the DAU. Women undergoing an elective caesarean section are assessed prior to surgery in the DAU.

Information about services

We did not see that information about maternity services was available on the trust's website. This meant that women who were looking for information would have to visit the hospital sites.

Are maternity and family planning services well-led?

Requires improvement 

Vision, strategy and risks

Information collated in the maternity performance dashboard was discussed regularly at the divisional team governance meeting to inform risk management. We looked at the data for risks identified across the division of women's services dated September, October and November 2013 all three reports consistently identified medical outliers on gynaecology as being in the top three risks. However we did not see any action plan or strategy in place to address this ongoing risk.

We asked for data in relation to the number of women being diverted to other maternity units within the trust to enable provision of safe care and we were told this data was not captured. We were aware that on the day of our visit and the previous day, the labour ward had used the trust's divert facility. We were told that this is becoming more frequent to ensure safety capacity levels are maintained. However this had a direct impact on two women who had their planned caesarean sections postponed.

We were told by the divisional team that they had worked hard over the last two years as the service had been reacting to the regulatory requirements of both CQC and Monitor. When we asked the team about the vision for the service we were told there was a mixed perception and staff felt that it would likely be dependent on the outcome of "Better Care Together" a current review of local health services.

They said that would need to be combined with the trust's ability to maintain staff and skills along with negotiation with the commissioners. They told us they were, "Still on a continuing improvement cycle and getting on with business as usual".



Maternity and family planning

There was no written strategy in place for maternity care in this hospital.






Governance arrangements

The maternity performance dashboard as a tool was not complete in the current format used and had elements of data missing that may help manage risks and the effectiveness of the service for example workforce data and postpartum haemorrhage data. These are significant omissions that should be included in the performance dashboard to support the safe and effective management of the service. We were told that a governance lead for maternity was appointed two years ago as an interim post.

Leadership and culture

Senior management told us that they had focused on an 'improvement journey'. They said over the last two years their work had been driven by meeting actions set from and responding to, regulatory requirements in response to service failings. They felt that they had now achieved and completed the required actions from the regulators and described their new focus as 'business as usual'.

Services for children & young people

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

Information about the service

The children's ward at Furness General Hospital provides a 22 bedded ward including a four bed assessment unit; an eight bed day case service and inpatient acute beds. The children's service also provides children's outpatient department and a special care baby unit (SCBU) with four cots. There is a paediatric consultant available at all times.

We were informed that there were approximately 120 assessments and 105 admissions each month.

We visited the children's ward; the children's outpatient department and the Special Care Baby Unit (SCBU).

We talked with five parents (or relatives) and their children and 18 staff including nurses, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at five care records. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Paediatric services were safe although some improvements were required. The trust was not flexible in responding to the changing dependency levels of children on the ward and so staff were placed under pressure at times when nursing staff numbers fell below recommended ratios.

Facilities and equipment on the ward were well managed to ensure that they were always clean and properly maintained however action is needed to ensure that this is the case throughout children services.

Staff were caring. This was confirmed via feedback from people using the service, and our observations of care. There was also a play therapist to provide meaningful play for children. This helped allay children's fears and anxieties about being in hospital and prepared them for surgery and other procedures in sensitive and child friendly way.

The trust's ability to respond to people's needs required improvement. Information was not available for people whose first language was not English. There was no obvious consideration of cultural and religious needs with regards to food and nutrition.

Leadership at the ward level was effective and we saw good examples of information sharing and active steps taken to improve services and respond to quality audits.

Services for children & young people

Are children's care services safe?

Requires improvement 

Cleanliness and Hygiene

The domestic staff followed a cleaning schedule that ensured all areas of the ward were clean.

We observed good hand hygiene practices and noted that infection control equipment and measures were implemented by all staff. The trust had completed checks to make sure that there was effective infection control on the ward. Their records showed that in December 2013 the ward scored 90 - 100% success in this area.

Staffing

We found that the current nursing establishment was not based on a recognised staffing assessment tool. We were told that a risk analysis had been completed and the report to justify more nurses was to be presented to the trust board. This analysis had been completed using a recognised staffing risk assessment tool. The Paediatric business case to increase the staffing establishment was presented to the Executive Directors Group (EDG) meeting on 28th January 2014. The business case required further work and when re-presented at EDG on 18th February 2014 it was approved. Recruitment subsequently commenced.

We were told that the current aim of the trust was to have four qualified nurses on duty between 07.30am and 09.00pm. We reviewed the staff roster and saw that for the week preceding the inspection there were three occasions when only three trained nurses were on duty in the afternoon and evening. We saw it was routine for three nurses to be on duty all day at the weekend. There were two qualified paediatric nurses on duty each night. In addition to the qualified nurses there was also a health care assistant on duty at each shift. We also looked at the roster planned for the week following the inspection visit and saw that only three trained nurses were on duty for four out of the seven the late shifts.

We found that this staff ratio was inflexible and indicated a lack of planning because extra nurses were not provided during foreseeably busy periods such as surgery days when there could be up to eight patients admitted for surgery in addition to inpatients.

Members of staff told us they were understaffed in the day surgery bay because two staff were allocated to care for up to eight children. The children required regular observations and care following surgery, but we were told that a shortage of staff meant that observations were sometimes missed and medication administration was delayed. We did not see any unsafe practice at the time of the inspection however the trust had identified that the staffing ratio presented a risk and had sent a business case to the board to increase the staffing establishment.

Despite staffing pressures, on the day of our inspection we saw that nurses were effective in meeting the needs of the children on the ward at that time. We saw that medication was administered on time, clinical observations were completed, care plans were followed and the information was updated as required. We saw positive interaction between patients and staff. Staff took time to talk with patients and parents. Staff responded to requests quickly. Children and young people we talked with said the nurses provided the care and support expected. Nursing staff worked very hard to provide a good service to patients.

On the Special Care Baby Unit (SCBU) the staff allocation was two babies to one staff member; however there was not enough space in the unit to allow for that many staff. We were told by staff, and this was confirmed by the clinical director, that there was a high level of sickness amongst staff allocated to work in the SCBU. Staff told us this was because of the stress associated with working in the unit. Staff also expressed concern that inexperienced qualified nurses were expected to cope with the responsibility of caring for sick babies when they lacked the confidence to do so.

The ratio of qualified paediatric doctors promoted the safety of children using the service. The service is led by consultant paediatricians and so there were 10 consultants working a 24 hour roster and at night there was a consultant resident in the hospital. The rest of the medical team was made up of qualified doctors who were training to become general practitioners (GPs).

Safety Huddles

The trust used a system for updating the nurses on duty about safety issues on the ward called a 'safety huddle' three times each day. At these times nurses discussed the safety issues on the ward including the clinical and nursing needs of patients, safeguarding considerations and staffing. We also saw from the checklist that this was also

Services for children & young people

an opportunity for the manager to review staff conduct such as adherence to the dress code. We attended a 'safety huddle'. The ward was busy and only nurses changing their shift attended. The update was useful for the nurse coming on duty because they were informed about the progress of the children on the ward including the nursing needs of a child returning from another hospital and those waiting for specialist assessments.

Management of the deteriorating patient

A paediatric early warning tool was used to aid recognition of sick and deteriorating children. This made sure children were seen as quickly as needed. We also saw that the Children's physiological observation track and trigger (Cpotts) system had been completed for each child. The Cpotts is currently one of the best-practice vital sign assessment tools for use with children and young people.

Incident reporting and learning

Incidents were electronically reported and the ward manager confirmed that all incidents and concerns were logged onto a centralised computer system. We saw that the system recorded detailed information about the type of concern. There were a number of headings that included complaints; concerns; safeguarding; and incidents. Each heading was split into subheadings so that precise information could be recorded. We reviewed recent concerns that had been recorded. We saw that when these were fully investigated the record was closed down. We also noted that reports were highlighted 'red' if an investigation was ongoing. It was unclear whether the data from this system was reviewed and analysed so that trends could be identified and appropriate action taken.

We were informed by the clinical director that no serious incidents were currently being investigated.

Environment and Equipment

The children's ward was bright and airy. The bays were clean and comfortable. There were also side rooms which were used for babies or when children or young people needed isolation. There were three bathrooms one of which had an assisted bath.

We looked at the system for checking the resuscitation equipment and other equipment on the ward and in the outpatients department.

The records showed that the resuscitation trolley was checked each day to ensure all the required equipment was available and safe to use. We noted that the items on the trolley were left on display and so could be removed during the day without being noticed.

The SCBU had recently been moved from its own large ward to a smaller area in order to facilitate more flexible and better integrated working. This had followed considerable concerns last year over being able to adequately staff the SCBU at FGH because of recruitment and sickness and absence difficulties. We saw that there was insufficient space to allow an emergency team full access to give rapid clinical attention if a baby's health deteriorated. The unit did not have the facility to isolate babies if there was a risk of infection.

Safeguarding

There was a clear safeguarding policy was in place. This policy confirmed good links with the local authority and met with the Royal College of Nursing best practice. There were named safeguarding liaison nurses who had excellent links with the local authority and had a good knowledge of safeguarding procedures. Staff we talked with understood their responsibilities in relation to protecting children from abuse and responding to concerns of this nature. The electronic training record confirmed that all nursing staff had completed either level two or level three safeguarding and child protection training. The ward manager told us that this training had been provided to all hospital staff and gave the example of a hospital porter raising a concern as evidence that the training had been effective in promoting child protection throughout the hospital.

The quality checks carried out on the children's ward showed that in December 2013 the ward underperformed and scored a 'red' rating in relation to completing a safeguarding trigger checklist for each child. We saw that in response the service made a statement promising that nurses would complete the record from December onwards. We looked at the nursing records for a sample of children and found sustained improvements because the safeguarding checklist had been completed for each child. The result of the checklist was used to trigger completion of an in-depth safeguarding risk assessment if required. We saw from referral letters and reports that the service had

Services for children & young people

effective systems in place to ensure collaborative working with statutory services including schools, the police and the local authority. Therefore appropriate action was taken if it was suspected that a child was at risk.

Consent

When consultants and nurses talked with the child or young person in the presence of their parent, we could not see when the young person had agreed to this. It was not possible to check whether the trust's written consent and capacity guidelines were compliant with the Fraser guidelines concerning consent and children under 16 years old. We saw that in keeping with good practice, it was assumed that the young person was able to understand the care and treatment unless it was previously found or became clear that there might be a limit to their capacity. We saw that children who were capable of doing so had signed their consent forms along with their parents. Young people were able to access out-patient appointments without parents and consent to treatment where they were Fraser competent.

Mandatory and role specific training

The ward manager told us that all staff had completed paediatric life support training but information on the electronic training record did not confirm this. It is essential that the trust is able to confirm that all staff are up to date with the paediatric life support training to ensure that children have the best chance of recovery if they should collapse or become acutely ill while on the ward.

Staff on the SCBU said that training had been provided. Qualified staff had completed advance paediatric life support training and also basic paediatric life support training. Staff also confirmed that they had completed specialist paediatric courses including new-born resuscitation, extra vigilance for new-borns, paediatric and neonate development, conflict resolution and the safer disposal and use of 'sharps' such as needles.

Staff had not received formal mental health training, placing young people and staff at potential risk. This meant that staff did not feel confident or competent to deal with children and adolescents with mental health problems. At a ward level the matron had worked closely with the CAMHS team and a worker from this team provided training to the ward staff. The matron told us that training had focused on mental health care pathways, eating disorders and self-harm. The matron also stated that the plan was for the CAMHS service to run a monthly study day.

Are children's care services effective? (for example, treatment is effective)

Good 

Using evidence-based guidance

Paediatric care pathways for common childhood illnesses such as viral infections were in use and were based on up to date NICE guidance.

Use of clinical audits

On the children's ward we saw that some clinical audits were completed by the ward manager. The quality assurance audits completed for October, November and December 2013 showed that the ward scored a green rating in the majority of areas assessed. We saw that improvements were sustained from one month to the next. An action plan for improving areas that had not met the required standard was displayed along-side the dashboard that gave the results of the audit. The clinical director for children services confirmed that the major improvement made as a result of safety audits was the provision of a 24 hour onsite paediatric consultant.

Neonatal re-admissions

The trust's performance data indicated that the trust had a higher than expected re-admission rate for neonates (between June 2012 and June 2013 there were 152 readmissions when the expected rate was 138.7). This number covered readmissions for Furness General Hospital and the Royal Lancaster Infirmary. We discussed this matter with the clinical director. It was explained that the figure could be due to the use of the assessment unit to triage children and so these counted as admissions, whereas this would not be the case if they had been triaged and sent home through the emergency department. However we were not provided any information to support this assertion.

Multidisciplinary working and support

There was effective multidisciplinary working. Children with long term and complex medical needs were often treated at larger children hospitals, most usually at Alderhey Hospital in Liverpool or the Manchester Royal Children's Hospital. The transfer of these children was completed by the North West Transfer Service (NWTs). We interviewed a qualified advanced paediatric nurse from this team. The NWTs nurse confirmed that transfer processes were

Services for children & young people

smooth and well-rehearsed and so children were given the best chance of a good recovery because they received specialist treatment as quickly as possible. Children were also transferred back to the ward following treatment at these hospitals.

Are children's care services caring?

Good 

Compassion, dignity and empathy

Medical and nursing staff treated patients with respect and dignity. We saw that time was taken to listen to children and their parents. Requests were met with a favourable response and nurses offered additional help and guidance as required. Patients told us they were treated with respect. Their comments included: "the nurses looking after me today have got time to be kind and caring" and "the staff are really great and explain things to you"

We read through medical and nursing records. We saw that reports were written in a considerate and respectful manner. Reports included an overview of the emotional condition of the child and description of anxieties which may have been raised. Staff also recorded the conversations and action taken to try and reassure patients and their relatives.

Involvement in care and decision making

Information in medical and nursing records confirmed that children and young people were involved in planning their care.

Trust and communication

Correspondence and records in the patients' medical and nursing files showed that there was effective communication and staff followed instructions about investigations, treatment and discharge planning.

Staff communicated with patients and their parents /carers in an open and honest way. It was evident that parents had confidence in the staff team and staff worked hard to establish a rapport with the children and young people being cared for.

Are children's care services responsive to people's needs? (for example, to feedback?)

Requires improvement 

Access

We reviewed the records for three children and young people. The children had been admitted through three different pathways: - directly onto the ward following a phone call; via the emergency department; and from a direct referral from a community based practitioner. We saw that the assessment process, observations and subsequent care plans were in keeping with the reason for admission. Initial care plans matched the referring doctor's plan of care in full.

Meeting people's needs

A telephone advice line for children with diabetes run by ward staff had been introduced. The success of this advice service had been audited. The findings were that although effective, staff required additional training, more comprehensive guidelines and awareness raising around medical support to ensure the service was as effective and safe as possible.

We saw that a hospital play specialist was employed and effective at providing distractions for the younger children and also allowed some respite for parents. This service was only available Monday to Friday and no annual leave or sickness cover was provided.

We reviewed the menu on the children's ward. Matron told us that as a result of consultation with patients and ex-patients the menu had been revised. We were able to compare the old menu with the new. The new menu had improved because now there was a choice of different meals at lunch and supper time where as previously the menu had been the same. Although the menu had codes for special diets such as 'high energy' or 'low fat' there was no option or information about meeting religious needs such as a kosher or halal option. We also noted that the assessments for dietary preference did not prompt staff to ask questions about cultural needs.

Environment

The physical environment was child friendly and a room for older teenage children was in development.

The SCBU unit did not have a designated office as this room was used to store some equipment. Staff felt it was difficult to maintain confidentiality because discussions

Services for children & young people

could be easily over heard. We saw that on average two babies were treated on the unit each day with one parent's room where a mother and father could stay close to the unit and their baby.

Support for children with life limiting illnesses

We discussed the management and support provided to children with a life-limiting illness with the matron. We were informed that this was a clinically led discussion which would be ongoing. The management of care and treatment was reviewed with the parent and child as required. The matron told us that the current policy was based on the 'Together for a short life' care pathway. The matron said that policies and procedures in relation to end of life care including the 'do not attempt cardio-pulmonary resuscitation' (DNAR CPR) policy was being reviewed by the trust wide resuscitation committee. The revised policies which included those for children and young people were based on nationally recognised guidelines.

We were informed that the ward had access to an 'end of life' nurse and families were supported through appointments with senior doctors. The service was flexible because sometimes, despite the attention of palliative care nurses and an initial choice about remaining at the family home, sometimes these plans changed. The matron said that children with life-limiting illnesses were generally well known and the staff and family worked closely with the children's Macmillan team from Manchester.

It was felt that there was good support from the community nurses but ideally 24 hour support from a paediatric palliative care nurse would improve the service and make it more effective.

Vulnerable patients and capacity

There was insufficient children and adolescent mental health service (CAMHS) cover to meet the needs of children and young people who were admitted to the ward with these needs. There was no service at the weekend and so children admitted on Friday had to wait until Monday for a mental health assessment and therefore an appropriate treatment plan. If no medical treatment was required ward staff described their role as providing children with a 'place of safety' during the wait for a CAMHS assessment. This meant there was a delay in assessment and treatment for children with mental health needs.

We were told that there had been a significant increase in the number of children admitted to the ward with mental

health needs. We saw that referrals were made to the Child and Adolescent Mental Health Services (CAMHS). There were no mental health specialists available during the weekend, which meant sometimes children had to wait for a few days before an assessment from the CAMHS service. We saw from the governance newsletter for January 2014 that the deficit in the CAMHS service was identified as a departmental risk.

When members of the CAMHS team visited children on the ward. We saw that they were well known to staff and that staff took time to meet with the CAMHS team member and supported patients and their parents to have private consultations.

We discussed the use of interpreters and leaflets available in different languages. We were informed that a telephone interpreter service was available but this was rarely used. The clinical director accepted that leaflets in languages other than English should be considered.

We saw joint working with the community learning disabilities nurse, who supported the play therapist and also supported families to complete a passport of care, providing clear details of how people needs should be met if they required admission into hospital.

Leaving hospital

We saw that the discharge plan was a part of the admission plan. The discharge plan was comprehensive and included confirmation that advice had been given about aftercare and recovery and also that referrals had been made to outpatient clinics and other community based specialisms as required.

Learning from experiences, concerns and complaints

We reviewed complaints and incidents specific to the children's ward at FGH at ward level.

The paediatric governance newsletter included a section called 'lessons learned.' This information was mainly a description of gaps in processes such as the availability of guidelines and lack of a comprehensive audit programme. There was also a brief report about staff not fully following the medication protocol; in response staff were reminded to follow the medication policy. No other information about concerns, complaints or incidents concerning the clinical or medical wellbeing of the patients was mentioned in this document.

Services for children & young people

We reviewed information in the 'Children and Young People leaders- experience assurance' report, dated January 2014. There was no information about current complaints and it was written that the group had relatively recently received the complaint report from November 2012.

Are children's care services well-led?

Good



Vision, strategy and risks

We found examples of good leadership at ward level. We received positive feedback about the level of consultant support available to trainee GP's. Ward staff confirmed they felt well supported by the matron and senior nurses. Nurses we talked with were clear about the new strategies in place to provide a better service. They felt able to voice their opinions and concerns, and said they usually felt listened to by their direct line manager. There was a sense from staff that some changes took a long time to arrange between being agreed at ward level and actioned by the trust board that meant risks were prolonged unnecessarily.

Nurses in the SCBU however felt that though they were supported by the matron and able to voice their opinion they were not listened to by the trust board. This was because no detailed and clear response had been made with regards to their concerns about the safety of the SCBU environment, the confidence of nurses to provide safe care and the request for additional specialist clinical support.

Leadership and culture

There was a positive culture on the ward and in the SCBU and the children's outpatient department. All the staff we talked with was positive about their colleagues and direct leaders.

Comments from staff included: "Good team to work with- we pull together and help each other. We're friendly to patients and have built up a good relationship.

And:

"Lovely team to work for and I love contact with the children and families."

We spoke to a range of nursing and medical staff, all of whom were passionate about their role and committed to providing a good service to children and young people. All of the staff we spoke with were keen to develop the service further.

Patient experiences and staff involvement and engagement

The trust has commissioned the "iWantGreatCare" independent quality assurance company to collect information about the patient experience and provide outcomes data. This was a newly introduced scheme. The information and questionnaires were 'user friendly' and would encourage children and young people to participate.

We saw 'I Want great care' posters, questionnaires and suggestions boxes throughout the hospital and on the children's ward. Children, young people and their parents were given the opportunity to be completely honest about their care and treatment because the questionnaires were anonymised.






The trust had involved patients and ex-patients in the 15 Step Challenge for children and young people in acute inpatient services. This process helped staff and patients to work together to identify improvements that could enhance the patients experience.

The ward was now working towards the Department of Health 'You're welcome' standards for making health services for children and young people user friendly. We were told that this initiative had resulted in young people being involved in changing the menus, designing a 'chill-out' room and also the colour scheme for new bedding on the ward.

Learning, improvement, innovation and sustainability

The wards quality dashboard provided evidence that when improvements were made they were sustained. However it is a concern that, in relation to the SCBU, staff feel that their concerns and risks do not receive prompt consideration and appropriate responses from the trust board.

End of life care

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

Information about the service

End of Life/ Palliative care services are provided throughout the trust across the three sites, Royal Lancaster Hospital (RLI), Furness General Hospital (FGH) and Westmorland General Hospital (WGH). Patients requiring radiotherapy have to travel to Preston where the service is provided by the regional cancer centre hosted by Lancashire Teaching Hospitals NHS Foundation Trust.

People with palliative / end of life needs that required in patient care were nursed on the general wards across the hospital.

There is a network of nurses across the three sites within the trust that have training in palliative care. The trust has a bereavement team that can provide care and support to relatives following the death of their loved ones. There are also well organised links with charitable and voluntary organisations providing hospice care and counselling and bereavement support.

During our inspection we spoke with ten patients, three relatives, four nursing staff, two receptionists, three consultants, two senior doctors, and the dementia nursing lead, three department managers, one palliative care educator and the bereavement support staff.

We observed care and treatment and looked at care records on oncology, medical and orthopaedic wards in the trust. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the data provided to us by the trust.

Summary of findings

The trust has a dedicated palliative care team who provided good support to patients at the end of life. Care and treatment was given in a sensitive and compassionate way. Staff worked hard to meet and plan for patient's individual needs and wishes. Staff were very motivated and committed to meeting patients' different needs and were actively developing their own systems and projects to help achieve this.

We found many examples of good compassionate care for patients and patients were very positive about the service from the specialist team.

The multi-disciplinary team worked well together to ensure that patients care and treatment was planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place of care.

We found variation in the standard of records in relation to DNACPR documentation.

End of life care

Are end of life care services safe?

Requires improvement 

Safety and performance

There was a clear policy in place on DNACPR forms approved in January 2014. This policy and procedural guidance was in line with current good practice and legislation.

However we found variation in the standard of records in relation to DNACPR documentation that included a lack of comprehensive information about multidisciplinary team and patient and relative involvement in decision making. There were occasions when the decision had not been endorsed by the most senior clinician. This is important because the overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician in charge of the patient's care.

Equipment

The hospital had its own syringe drivers for people needing continuous pain relief. A syringe driver is an alternative method of administering medication and may be used in any situation when the patient is unable to take oral medication. A range of syringe drivers were being used in different areas of care across the trust. Having different types and makes of equipment within the hospital can cause confusion. It may present a hazard when patients' and staff move from one area of care to another as staff may not be familiar with each different type of equipment.

The palliative care team and staff we spoke with were aware of the importance of consistency with equipment to ensure there was no interruption or delay in treatment. As a result a business case for the replacement of syringe drivers across the trust had been submitted to the trust board. This would enable the trust to standardise this type of equipment in use and reduce potential hazards and delays in relation to patient's pain management and administration of medicines.

Training for staff

Electronic educational packages were in place for staff and learning modules on palliative care and oncology were readily available. This was considered mandatory training

for junior doctors and Band 5 nurses involved in caring for oncology patients. The e learning system recorded when training had been completed so senior staff could monitor training uptake.

Not all eligible staff had completed the training as yet. Staff who had completed the training had found it useful in developing their practice in caring and treating patients requiring palliative care.

The palliative care and end of life team had developed clinical and educational strategies to improve the experience, quality and effectiveness of the service provided to patients. The strategy covers the period March 2013 until March 2016 and its implementation is being monitored by the palliative care team through formal reviews.

The strategy is very new and not yet fully implemented; therefore we could not evaluate the impact of the strategy at the time of our inspection.

Are end of life care services effective? (for example, treatment is effective)

Good 

Using evidence-based guidance

The trust had set targets for achieving the Gold Standards Framework (GSF) This is national, accredited training initiative aimed at enabling frontline staff to provide a gold standard of care for people nearing the end of life. The trust had made progress in this area although staff informed us that the trust had not yet met 100% of the targets set. This trust envisages that when all elements of the GSF had been implemented staff will be better skilled to meet the needs of patients requiring palliative and end of life care. This will also help staff on general wards to care for and support people at the end of life.

Following an independent review by The National Institute for Health and Clinical Excellence (NICE) was rewriting guidance for patients at the end of life. The trust had published guidance for staff regarding the review. The palliative care consultant and senior managers were aware of these change and confirmed that the trust was no longer using the Liverpool Care Pathway (LCP) to support care and treatment decisions.

End of life care

Some nursing staff we spoke with still referred to the pathway and felt that following the withdrawal of this guidance there was less structure now to the planning of individual care for people at the end of their lives. Staff confirmed that they had been given information and training on the Gold Standard Framework (GSF). In addition, the palliative care team had issued information to staff in 'Guidance to Health Care Professionals Caring for Patients in the Last Days of Life'. This summarised the key elements of caring for the patient who was dying. This was to support staff until the revised recommendations from NICE were available for implementation.

Multidisciplinary working and support

The Multi-disciplinary team worked well together to ensure that patients care and treatment were planned and coordinated. People were positive about the care they received and the support they were given. There were effective working relationships with local hospices to coordinate people's end of life care where the hospice was their preferred place to die.

Elderly care consultants and dementia care leads were also positive about the GSF and felt that the GSF approach had improved the care of older people as well as improvements in the way the multi-disciplinary team worked together.

Are end of life care services caring?

Good 

Compassion, dignity and empathy

There were very good examples of person centred, compassionate care. Patients and those close to them were positive about their interaction with both the palliative care team and the oncology team. Patients felt that care and communication was good and that their individual needs were met in a sensitive and respectful way. One patient said "The nurses and doctors have been helpful and very compassionate" Another person told us that they had appreciated their relative being cared for in a single room as this allowed the patient and the family privacy as their condition deteriorated.

Patients and those close to them were less positive about the care given on the medical wards. They said that staff were rushed and did not always have the time to spend with them.

Patients felt staff were, "kept busy" and that more staff were needed. Despite that, staff came quickly when they were called and were "respectful and kind" when they were delivering care.

Involvement in care and decision making

Patients and those close to them were actively involved in care planning and decision making. Patients were actively encouraged by the Palliative Care and Oncology Teams to ask questions, to discuss their treatment and share their concerns. Care records were well maintained with patients preferences clearly documented. One patient told us "I have always received excellent care and attention and have been kept well informed of my condition and progress. Staff have always reassured me that I can ring them any time should I feel the need to discuss any concerns or doubts I might have about my condition. Reports by the relevant hospital departments are also sent to my GP to enable him to monitor my condition".

Trust and communication

Staff understood the importance of effective and sensitive communication for patients who were receiving palliative or end of life care. Staff worked hard to establish a good rapport with patients and those close to them so care and treatment could be managed in an environment of trust and transparency. Time was spent explaining care and treatment including benefits and possible side effects and complications. Staff were open and honest with patients and those close to them. Difficult messages were given in a compassionate and sensitive way.

Staff were taught and assisted with communication skills through the 'Sage and Thyme' programme. This is a foundation level communication skills workshop developed by a multidisciplinary team at the University Hospital of South Manchester NHS Foundation Trust in response to the publication of NICE guidance for Supportive and Palliative Care for Adults with Cancer (2004). The specialist palliative care staff had all attended advanced communications training. They were coordinating the training and monitoring its progress as was rolled out to their colleagues across the trust.

Information and guidance was also available for people to be able to contact other support services such as local hospices, Morecambe bay cancer information guide, the Marie Curie service and the Hospices at Home service.

End of life care

Emotional support

Staff encouraged an atmosphere of open and honest communication between staff and patients. One patient told us that “I feel I can ask anything when I go for treatment”.

Prior to our inspection of the hospital we held a focus group with local voluntary and support organisations who had contact with the trust services or supported people who did.

A positive comment was made about the bereavement service. People felt that the team were working well and offering good support to people who were bereaved.

Are end of life care services responsive to people's needs?
(for example, to feedback?)

Good 

Meeting people's needs

Patients had access to generic support from occupational therapy, physiotherapy, and speech and language therapy. There was access to a specialist lymphedema service, complimentary therapies and breathlessness management at the hospital; however, there was no dedicated team to make sure people had timely access to these services.

The trust has reviewed its performance against National Institute for Health and Clinical Excellence (NICE) guidance on opioid prescribing in palliative care. As a result of this the need was identified to provide more information for people using this medicine. A patient information booklet had been developed and was in use as well as standard procedures for staff to follow.

There was a dedicated bereavement team working across the trust with an office in each site to provide a point of contact for people recently bereaved. The bereavement specialist nurse was able to see families in privacy and to direct them to other support services. Bereavement support was offered immediately to help people with cope with the difficulties of being bereaved.

Vulnerable patients and capacity

The palliative care team provided support and information to the patient, their families and the care team working on the ward. However, as the service was not available over a

24-hour period and at weekends, there were times when patients could not easily access specialist support when required. Telephone support lines were available from 5pm until 8am the following morning and at weekends. Preston hospital takes the helpline calls to help support patients out of hours.

The inpatient wards were introducing a dragonfly symbol that would alert staff to patients who as a result of their illness needed more time and support.

Leaving hospital

The trust was aiming to develop a seamless process for discharging patients that would enable a patient to be discharged home safely and quickly with all necessary support. It is emotionally and psychologically important for patients at the end of life to return to their chosen place of care and the provision of a rapid and well supported discharge is a key feature of good end of life care.

This service was already working well at this hospital.

The percentage of summaries provided to GPs within forty-eight hours of discharge from hospital remains low. The trust has made some progress and has implemented an electronic solution to secure further improvements never the less current performance remains a concern as General Practitioners are informed in a timely way of changes in a patient's condition and this means that a patients care and treatment could be compromised as a result.

Learning from experiences, concerns and complaints

Staff working in the services were very keen to take up training and development opportunities to provide a good service to patients. They were learning from patient experiences and using them to support service development.

Are end of life care services well-led?

Good 

Vision, strategy and risks

The specialist palliative care consultant and the specialist palliative care nursing team demonstrated great enthusiasm and commitment to developing good palliative care for their patients.



End of life care

They had developed clinical and educational strategies to help them be clear about their objectives and focus and to continuously develop their knowledge and skills.

An aim of the palliative care clinical strategy is to establish a fully integrated palliative and end of life care service that offers patients both specialist and non-specialist care over a 24 hour period for seven days a week by 2017. Staff providing palliative and end of life care on the medical wards were keen to improve the care they provided and appreciated the support they received from the specialist palliative care nurses and bereavement team. They acknowledged that the specialist teams were visible and present on the wards; however, support was limited to 'office hours'. This meant that there were times when patients and staff may have benefitted from specialist advice and such advice was unavailable.

Leadership and culture





Local leadership at service level was good. There was a shared commitment within the palliative care and

oncology teams to provide the best for patients. There was a culture of collaboration and improvement. Staff were keen to develop and expand the service so that patients received the best care possible. Staff were positive about their colleagues and direct line managers. Staff supported each other and worked extra shifts to try to provide cover on the wards to provide continuity of care and support to patients and their colleagues. They were less confident in senior managers and felt that responses and actions to concerns lacked pace.

Patient experiences and staff involvement and engagement

Patient experiences of this service were largely positive. Staff worked well together to facilitate and secure service improvement. Patient's individual needs and wishes were respected and planned for. If care was necessary within the hospital environment, the palliative care team provided support and information to the patient, their families and the care team working on the ward.

Outpatients

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

Information about the service

The trust provides a range of outpatient clinics, and had seen a steady increase in required appointments over the last three years. In 2012-13 there were 481,862 outpatients seen at the trust's hospital sites, up from 448,314 in 2011-12 and 416,912 in 2010-11. (Source: HES data 2010/11, 2011/12 and 2012/13.)

We inspected four of the outpatient clinics and we spoke with 11 patients, four relatives and 19 staff both nursing medical and support staff. We visited the oncology unit, breast screening clinic, dermatology, gynaecological and antenatal clinics across the three hospital sites.

We received comments from our listening events and from people who contacted us about their experiences. We also reviewed the trust's performance data.

Summary of findings

The outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a professional and caring staff team

Staff working in the department respected patient's privacy and treated patients with dignity and respect.

However, we found that waiting times for appointments were long in some departments and there will still be difficulties in securing case notes and test results for patient's appointments.

Outpatients

Are outpatients services safe?

Requires improvement 

Cleanliness and Hygiene

Clinics and departments were clean throughout and gloves, aprons and other items of protective clothing were readily available in the clinics. There was a good supply of accessible hand wash basins and alcohol gel dispensers. Staff used the facilities in accordance with good practice guidance for the prevention and control of infection.

Availability of patient records

We found that all the outpatients departments across the trust continued to experience some operational difficulties as patient records were not always available for outpatient clinics and diagnostic results were not always returned in a timely way so that they were available for the patient's next clinic appointment. In some clinics a number of patients had temporary notes as their case notes were not available. There are still issues regarding the provision of case notes for short notice clinics and the medical records team not being informed of a patient's appointment. The trust's current percentage for case note availability in the outpatients department is 90% and is monitored on a monthly basis. The trust has initiated a Paper Lite project to have electronic information available for patients and to improve the efficiency and effectiveness of outpatient services. This would benefit patients and reduce the reliance on paper records

Safeguarding

We saw that safeguarding policies and procedures were in place. Staff we talked with in the outpatient's clinics had completed safeguarding training and understood their responsibilities in relation to protecting people from abuse and responding to concerns.

Consent

Staff were competent in seeking and obtaining patient consent for treatment, clearly explaining benefits and risks in a way that patients understood.

Monitoring safety and responding to risk

Performance in the Breast Screening Unit was closely monitored to ensure good practice in relation to reducing the numbers of repeat x-rays and mammography required

as a result of poor imaging. There are quarterly reports highlighting any trends and performance issues. The reports inform remedial and, management actions to address performance and risks.

The management of patient safety and active follow up was monitored at board level for this service due to the historical concerns relating to a serious untoward incident in 2010. Further investigation highlighted that over 1400 patients had been affected by the poor implementation of an electronic booking system that had not been actively or appropriately managed by the board prior to 2011. This has now been resolved.

Are outpatients services caring?

Good 

Compassion, dignity and empathy

The patients we spoke to said that staff had been polite and caring towards them. Staff spoke with patients respectfully and were open and friendly in their approach. Difficult messages were given to patients and those close to them sensitively and privately. Patients were given time to understand the messages and ask questions.

Involvement in care and decision making

Patients we spoke with told us they were well aware of their condition and that the doctors and nurses had explained this clearly to them. Patients told us they felt well informed about their care and treatment and could make informed choices.

Diagnostic tests were explained and patients consent sought as appropriate.

Emotional support

Patients gave varying accounts regarding the level of emotional support from staff that differed from clinic to clinic. The majority of patients felt that staff were supportive and offered reassurance and emotional support. However one patient commented that staff had shown little consideration for her feelings after a difficult consultation.

Are outpatients services responsive to people's needs?

(for example, to feedback?)

Outpatients

Requires improvement 

Meeting people's needs

Outpatient's clinics were, in the main, comfortable and patient friendly. There were ample seating areas and facilities for patients to purchase drinks and refreshments nearby. Clinics were well sign posted and members of staff were able support and guide patients around the departments and diagnostic areas escorting patients to their destinations in a helpful and supportive way.

Vulnerable patients and capacity

Vulnerable patients were managed sensitively in outpatient departments. Staff were responsive in meeting patient's individual needs. Patients who suffer from dementia were managed in a thoughtful way and staff tried to make sure that they were seen quickly.

Staff were aware of their responsibilities in relation to people who lacked mental capacity and they sought advice, guidance and support for patients from appropriate professionals to support best interest decision making.

There is limited information available in the departments for patients who have a learning disability We could not find information available in easy read formats; similarly we could not find written information in formats suitable for patients who had a visual impairment.

We asked staff about what was available for people when English was not their first language so they could understand their treatment and care. The trust used 'language line' that could be used for interpretation or support. Staff told us that they had used this service and had not encountered any significant problems nor had not received any complaints from patients about the service. We did not see this service in use during our inspection. In addition patient information leaflets were available in different languages and an interpreter could be booked in advance of their appointment if required.

Patient transport

Transport arrangements were sometimes difficult for patients attending the out patients department. Transfer arrangements led to some people arriving very early for appointments and were then subject to long waits and patients also experienced long waits for transport to take them home afterwards.

Patients felt that the difficulties with transport arrangements for outpatient attendance led to a poor experience that required better organisation and support.

Access to services

From our performance information the trust is meeting expectations in relation to referral to treatment times.

Reception staff told us that their biggest problem was the waiting times in outpatients. Staff said that they told patients if the clinics were running late. Staff told us if people wanted to complain about their appointment they were directed to the team leader. The team leader would discuss the issues with them and look into their complaint and try and resolve things "face to face" first.

Learning from experiences, concerns and complaints

Following a serious untoward incident regarding the lack of follow up on a patient in outpatients, there was an investigation into the trust's outpatients department by an independent consultant. The investigation report was completed in January 2011 and made a number of recommendations for action on the part of the trust. Since that time the trust has worked to improve its management of the outpatient department and strengthen the governance arrangements for managing the department and the escalation of risk.

Systems and management arrangements have improved, however staff and patients are still experiencing difficulties in scheduling and arranging appointments for example, in early 2013, there were two pain clinics with no patient attendance as the system had failed to generate letters to patients informing them of their appointment and so patients did not attend.

Environment

Patients were seen in private consultation rooms where conversations could not be overheard. Patients had private areas to undress and wait, if this was necessary.

Staff told us that if they had to give patients 'bad news' this was done in the privacy of the clinic rooms and that staff were prepared before the patient came into the consultation room so that appropriate support was available for the patient.

Are outpatients services well-led?

Outpatients

Good



Governance arrangements

The outpatients department was part of the trust's core clinical support division which was led by the Clinical Director. The executive nurse chaired the outpatient improvement group, that was linked to the patient experience committee to get feedback from patients about the outpatients department. The trust was currently developing a Patient Experience and Public Involvement Strategy. The objectives were being monitored, along with current patient experience initiatives, on a quarterly basis by the Clinical Governance and Quality Committee. Initiatives had included a 'customer care champion day' and the "I Want Great Care" service. This was currently being piloted within the trust and therefore we were unable to see any evaluation of these initiatives.

There were systems to report and manage risks. Staff were encouraged to participate in the change programme for the

department and there was departmental monitoring at board level in relation to patient safety. This was a recommendation of the investigation into the outpatients department reported in January 2012.

Leadership and culture

Staff in Outpatients exhibited strong teamwork and an obvious desire to make systems work.

We spoke with staff who told us that they met representatives of the outpatient's improvement group regularly and that they were aware of who was leading the service.

We were told by staff that not all specialities did things the same way that caused inconsistencies in the delivery of services.

Some staff said that when they had presented alternative views to trust management they had not been listened to and the systems in place did not support them. This view had been expressed to us before and during our inspection of the trust.