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	Good
Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Outstanding
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a follow up inspection between 11 and 14 October 2016 to confirm whether University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) had made improvements to its services since our previous comprehensive inspection, in July 2015. We also undertook an unannounced inspection on 26 October 2016.

To get to the heart of patients' experiences of care and treatment, we always ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

When we last inspected this hospital, in July 2015, we rated services overall as 'requires improvement'. We rated safe, effective, responsive, and well-led as 'requires improvement'. We rated caring as 'good'.

There were seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. These were in relation to staffing, supporting staff, safety and suitability of premises, safe care and treatment, and assessing and monitoring the quality of service provision.

The trust sent us an action plan telling us how it would ensure that it had made the improvements required in relation to these breaches of regulation. At this inspection we checked whether these actions had been completed.

We found that the trust had made the required improvements and rated Furness General Hospital as 'good' overall, with caring rated as 'outstanding' and safe rated as 'requires improvement'.

Our key findings were as follows:

- There had been significant improvements across most services at this hospital since our last inspection in July 2015.
- In medical and end of life care services, there were a number of outstanding examples of compassionate care and emotional support shown by all levels and disciplines of staff, who did not hesitate to go the extra mile to make a difference for patients and their loved ones.
- Leadership of the hospital was good, managers were available, visible, and approachable; staff morale had improved significantly and they felt supported. Staff spoke positively about the service they provided for patients.
- There had been significant investment in leadership within end of lfe services.
- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.
- The hospital had in place infection prevention and control policies which were accessible, understood and used by staff. Patients received care in a clean, hygienic and suitably maintained environment.
- The trust reported no incidences of MRSA between September 2015 and May 2016. Eight cases of clostridium difficile were reported in the same period.
- We saw that patients were assessed using a nutritional screening tool, had access to a range of dietary options and were supported to eat and drink.
- Nursing and medical staffing numbers had improved since the last inspection. However, there were still several of nursing and medical staffing vacancies throughout the hospital, especially in medical care services and the emergency department. The trust had robust systems in place to manage staffing shortfall as well as escalation processes to maintain safe patient care.
- The hospital had improved compliance against mandatory training and appraisal targets in most services. Local support and supervision of junior staff had improved, and many areas had developed their own unit-specific competencies for training and development purposes.
- There had been an improvement in record-keeping standards throughout the hospital, however, we identified some ongoing areas for improvement around legibility and trigger-levels for early warning of deterioration, particularly in in medical care services and the emergency department.

Summary of findings

- The trust's referral to treatment time (RTT) for admitted pathways for surgery services had improved since the last inspection. Information for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks, against the England average of 75%.
- Access and flow, particularly in the emergency department and medical care services, remained a challenge. The emergency department's performance had been deteriorating over the preceding 12 months. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Delays in obtaining suitable community care placements were causing access and flow difficulties, particularly in medical care services.

We saw several areas of outstanding practice including:

- The medicine division delivered outstanding Referral to Treatment (RTT) outcomes across all specialisms despite pressures on the service overall.
- The Listening into Action programme had delivered some clear, effective and significant quality improvements for the organisation and for patients across the hospital.
- There were many examples of public engagement in the development and delivery of maternity services, such as co-designing the new maternity unit, interviews for recruitment of new staff, including midwives and matrons, and the development of guidelines and strategies.
- The service was one of three trusts which were successful in securing funding to pilot a maternity experience communication-improvement project. This was a patient-based training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements could be made for women who were using maternity services.
- The bereavement team, Chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafés. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death cafés for the public as part of 'dying matters week' and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that thosecollecting them had been recently bereaved. In addition, bereavement staff sent out forget-me-not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands. This was a service provided by an external organisation with funding provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- A remembrance service was held by the Chaplaincy every three months for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved oneand support was offered at this time.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

However, there were also areas of poor practice where the trust needs to make improvements.

Summary of findings

Importantly, the trust must:
In urgent and emergency care services:

- Monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department;
- Ensure patients do not wait longer than the standard for assessment and treatment in the emergency department.

Action the hospital SHOULD take to improve

In urgent and emergency care services:

- Ensure observations are recorded appropriately to allow the assessment and early recognition of the deteriorating patient;
- Ensure nursing documentation is completed in accordance with the trust policy;
- Continue to ensure that staff complete mandatory training in accordance with trust policy;
- Continue to ensure equipment checks are completed consistently in accordance with trust policy;
- Ensure the regular update of patient group directions in accordance with trust policy.

In medical care:

- Ensure all nursing and medical clinical documentation is completed legibly, in full and in accordance with recognised professional standards;
- Ensure multi-factorial falls risk assessments are completed in all cases where risk is indicated and that this is evidenced in the electronic patient record or in the medical notes;
- Ensure robust divisional oversight of the respiratory unit at Furness General Hospital (FGH) due to shortfalls in substantive senior medical presence onsite, vulnerability of senior medical staffing and reliance upon senior locum contracts;
- Ensure that, where medicines are stored in fridges, temperature ranges are recorded in accordance with policy to ensure that the safety and efficacy of the medicine is not compromised;
- Ensure all staff complete all elements of their mandatory training requirements and ensure accurate compliance figures are maintained;
- Ensure all staff benefit from the appraisal process and that appraisals are completed on an annual basis in accordance with local policy;
- Ensure action plans put in place to address shortfalls in local and national patient outcome audits findings are monitored and reviewed in a reasonable time-frame to ensure compliance is measured;
- Ensure there is a review of patient comments and Patient Led Assessment of the Care Environment (PLACE) findings regarding food quality, and consider measures which may be implemented to improve nutritional care;
- Ensure staff awareness and knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is underpinned by consideration of procedural competence in making such application, to avoid potential legislative breaches;
- Ensure all patients are aware of alternative treatment options (including risks and benefits) in addition to recommended treatment options;
- Ensure the number of patient bed moves after 10pm is kept to a minimum to avoid patient and family anxiety and distress;
- Ensure the remit of the nurse-led ambulatory care unit is fully understood by all key personnel to ensure its safety and efficiency in delivering patient care;
- Ensure the effectiveness of the new governance framework is measured and adaptationsare made accordingly;
- Ensure the effectiveness of current staff engagement themes and consider other formats which may support divisional strategy and staff harmony;
- Ensure reasonable measures are put in place to support staff wellbeing and ensure all staff know what support is available to them.

Summary of findings

In surgery:

- Continue to improve Referral to Treatment Times (RTT) for patients and continue to implement trustwide initiatives to improve response;
- Prioritise hip fractures (within 48 hours);
- Ensure all transfers between locations are performed in line with best practice guidance and policy. Where practice deviates from the guidance, a clear risk assessment should be in place;
- Continue to engage staff and encourage team-working to develop and improve the culture within the wards and theatre department;
- Continue with staff recruitment and retention;
- Improve the completion of NEWS;
- Improve environmental cleanliness;
- Improve the monitoring of fridge temperature and take action if temperatures exceed the expected range;

In critical care:

- There was no provision for dedicated critical care pharmacy cover at the FGH site, despite recommendation of such by GPICS (2015). The critical care unit should take action to create plans that adhere to this guidance;
- The unit should take action to improve physiotherapy staffing and be clear about how it supports rehabilitation for patients in line with GPICS (2015);
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, planned as part of the appointment of a supernumerary coordinator and in accordance with the GPICS (2015) standard;
- The unit should continue to monitor discharges out of hours, and develop actions to improve (reduce) the number of FGH critical care discharges out of hours.

In maternity and gynaecology:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester and Lancashire NHS Trusts;
- Ensure that care records (including cardiotocograph (CTGs)) are legible, complete, timed and dated;
- Continue to monitor the cultural assessment survey for obstetrics and gynaecology and improve values around organisational culture.

In services for children and young people:

- The hospital should ensure there is a review of all children and young people's mortality and morbidity;
- The hospital should ensure that documentation refers to Gillick competency and that staff are properly trained and confident to assess Gillick competency;
- The hospital should continue to ensure that communication takes place with partner agencies about the placement of CAMHS patients.

In outpatients and diagnostic imaging:

- The trust should continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations to develop a one trust culture;
- The trust should continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, dermatology and allied health professionals;
- The trust should continue work to ensure that all premises used are suitable for the purpose for which they are being used, are properly used, are properly maintained and are appropriately located for the purpose for which they are being used. This is particularly in relation to services provided from medical unit one;

Summary of findings

- The trust should ensure that it meets referral to treatment targets in outpatient clinics and that it addresses backlogs in follow up appointment waiting times.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating
Urgent and emergency services	Requires improvement 

Why have we given this rating?

We rated the emergency department as 'requires improvement' because:

- The emergency department's performance had been deteriorating over the last 12 months. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Bed occupancy levels were 115 -130% across the trust.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the England median in all months over the 12 month period.
- Between June 2015 and May 2016, the trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with handover times of over 30 minutes. The department was continuing to fail to meet the standard. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department to being handed over to the emergency department staff. Between the end of September 2015 and the end of September 2016 the Furness General Hospital had 444 black breaches.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average.

Summary of findings

- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline.
- The department was not meeting the trust's target for staff completing mandatory training. Following our previous CQC inspection, in July 2015, an 'action the hospital must take to improve' was to ensure that staff received appropriate support, training, supervision and appraisal. Although support and appraisal rates had improved, mandatory training remained below the trust target for completion.
- The outcomes of care were not always monitored regularly or robustly, using the National Early Warning Score (NEWS) system. Failue to do this might prevent early recognition of a deteriorating patient.
- Nursing assessments and care pathways were not always completed or regularly reviewed.

Medical care (including older people's care)

Good

The service had been inspected as part of our comprehensive visit in July 2015. Overall, medical care at FGH was then rated as 'requires improvement'. During this inspection we found the service had made significant improvements.

- There had been a reduction in patient harm related incidents, particularly pressure ulcers and falls.
- Although there were still several nursing and medical staffing vacancies, the trust had robust systems in place to manage staffing shortfall and had extended its recruitment reach with the appointment of a number of international nurses.
- The service had improved compliance against mandatory training and appraisal targets. Local support and supervision of junior staff had improved and many areas had developed their own unit specific competencies for training and development purposes.
- Overall, medicines management and medicines record keeping was good, however, we identified that reconciliation was not always completed in a timely manner.

Summary of findings

- There had been a marked improvement in record keeping standards, however, we identified some ongoing areas for improvement around legibility and trigger levels for early warning of deterioration.
- The service had developed an action plan to address and progress areas for improvement that had been highlighted in the 2015 inspection.

During this inspection we rated medical care services as 'good' overall, with caring rated as 'outstanding' and safe rated as 'requires improvement' because:

- Staff understood their responsibilities to raise concerns and report incidents. The division had reported a reduction in patient harm related incidents. Senior staff managed nurse staffing shortfalls proactively and there were robust escalation processes in place to deal with nurse staffing concerns.
- Staff delivered evidence-based care and the division was actively involved in local and national audits. There were some positive patient outcomes recorded in heart failure, diabetes and myocardial infarction audits and there was good evidence of collaborative and effective multi-disciplinary team working.
- The division was passionate about delivering quality, compassionate patient care, and this passion permeated throughout all staff groups and at all levels. Staff cared for their patients' holistic needs and had no hesitation in 'going the extra mile' to make a difference for the benefit of patients and their families. Patients had individual care plans and felt safe. Patients were positive about the care received and would recommend the service as a place to receive care.
- The division reported excellent referral to treatment time figures across all specialisms. The division was responding to the internal and external demands placed upon it by developing a number of services and care pathways to reduce unnecessary hospital admissions. There was a positive drive to engage with partner organisations to both maintain and further

Summary of findings

services for the benefit of the population in the short, medium and long term. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.

- Managers led the service well. The divisional strategy reinforced the trust vision and aligned with ongoing work with partner organisations. Staff felt a real and palpable shift in divisional culture referring to a 'team' approach and an openness, which they described as putting them all "on the same page". New organisational governance structures had been set up within the division and there was evidence to show how these supported divisional governance processes. There were many very good examples of improvement projects and innovative strategies which brought about changes in clinical practice and work efficiencies, improved patient care and delivered organisational benefits.

However:

- Some medicines and record-keeping documentation standards required improvement, in particular, around legibility of written entries, adherence to best practice standards and a consistency in completing records, charts and other documents in full.
- There was vulnerability in registered nurse staffing and a disproportionate reliance on locum senior medical staff to cover the respiratory unit at FGH. Nonetheless, the division actively recruited to vacant posts and was keen to convert locum positions into substantive appointments.
- The division had some static patient outcome measures in stroke and respiratory services at FGH. These findings were across a number of domains and were below national average benchmarks. The division had action plans in place to address areas for improvement.
- Seven day services were not fully embedded and the division fell below national averages on a number of key metrics in the NHS Services,

Summary of findings

Seven Days a Week Four Priority Clinical Standards. The division was involved with the trust task group which was looking at seven day working across the organisation.

- A combination of factors, including extended length of stay, increasing bed occupancy levels and delays in obtaining suitable community care placements, was causing access and flow difficulties at FGH. This had led to significant numbers of patient moves after 10pm and a number of medical outliers encroaching into other services. Divisional managers were working with partners, looking at all variables affecting patient flow.
- To achieve the divisional strategic objectives the service identified staff engagement as one of its key priorities. Clinical leaders recognised that there was a risk of staff becoming fatigued and less resilient to the pressures of working demands in the current climate. Staff considered the division managers could do more in terms of recognition and support for their wellbeing.

Surgery

Good

The overall surgery rating from our 2015 inspection was 'requires improvement'. During the 2016 inspection we found that the actions identified during that earlier inspection had been completed. There were systems in place to identify themes from incidents and near miss events. We saw improved audits for '5 steps to safer surgery' and had discussions with staff about the process and procedure for raising safeguarding referrals. There were risk assessments and escalations plans in place for situations where practice deviated from guidance.

We rated surgical services as good at this inspection because:

- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned. All wards used an early warning scoring system and risk assessments for the management of

Summary of findings

deteriorating patients. Infection prevention and control was managed effectively on most wards. We saw staff treating patients with compassion, dignity, and respect throughout our inspection.

- Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of their induction. All the staff we spoke with had received training and knew about safeguarding policies and procedures. The division had a dementia champion and could access an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients until staffing numbers could be improved. The ratio of qualified nursing staff to patients was one to eight. We reviewed the nurse staffing levels on all wards and theatres, and found that levels of skill mix were appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times, and senior staff attended bed meetings to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used enhanced recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us appraisals were undertaken annually and records for Furness General Hospital showed that 82% of staff across surgical wards and theatres had received an appraisal.
- Allied Health Professionals worked closely with ward staff to ensure a multi-disciplinary team approach to patient care and rehabilitation. We saw that orthogeriatricians had input into the care pathway of elderly patients.
- Evidence-based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures. The National Oesophago-Gastric Cancer Audit (2015) showed patients diagnosed after an emergency admission was 0%, placing the trust within the lowest 25% of all trusts for

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this measure.The Patient Reported Outcomes Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance. Ward managers and matrons were visible and available on the wards so that relatives and patients could speak with them.

- The trust's referral to treatment time (RTT) for admitted pathways for Surgery had been worse than the England average performance between October 2015 and August 2016. However, the latest figures, for September 2016, showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks, against the England average of 75%.
- Complaints were dealt with informally at ward level and escalated as necessary to ward managers and matrons in line with trust policy. Complaints were discussed at monthly staff meetings where training needs and learning was identified.
- There had been concerns about bullying in theatres in 2015. These concerns had been investigated and actions implemented to prevent bullying and harassment in the workplace. Investigations we saw were timely, detailed, and appropriate. Staff told us there was now a higher morale and a better working environment, following resolution of individual behaviours and a change of staffing.
- Staff said that speciality managers were available, visible, and approachable, leadership of the service was good, staff morale had improved a great deal and they felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

Critical care

Good

Following our last inspection, in July 2015, we found that overall the critical care service provided at the Furness General Hospital required improvement.

During this inspection we rated this service as good overall, with good ratings in safe, effective, caring, responsive and well-led because:

Summary of findings

- During our inspection we found that nurse staffing levels were good, with sufficient staffing levels for provision of critical care. Recruitment was underway to provide a supernumerary coordinator and practice educator in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015). Supernumerary induction for new nursing staff was good with an organised approach to nurse appraisal and nursing achievement of competence in critical care skills. This was an improvement upon findings in 2015 when we found that, although nurse staffing levels had improved from the 2014 inspection findings, there were no supernumerary coordinator or funded practice educators in post.
- Medical staff we spoke with discussed the historic shortfalls in anaesthetic staffing levels for out of hours cover. We had noted in 2015 that intensive care services, obstetrics, anaesthetics and emergency surgical services across the trust did not have enough anaesthetic staff to meet the required national recommendations and standards. However, this was well understood by the executive team and clinical staff. An additional five consultants at RLI and three consultants at FGH ha been funded to ensure safe staffing levels and mitigate risks. A recruitment strategy was in place.
- We observed good medical handover and staff we spoke with told us that the system in place for responding to acutely unwell patients outside of ITU was good.
- We had reported in 2015 that medicines were not stored securely in the unit, however, this had improved at the 2016 inspection and we did not observe any breaches in pharmacy storage standards or any poor compliance with regular safe storage of medicines audits. Similarly, improvement in general storage in the unit was observed with well-organised, locked access, storage rooms available on the entrance corridor to the secure main unit. The main unit was tidy and stores were well organised.
- The emergency resuscitation equipment and patient transfer bags were checked daily with a

good system in place as per trust policy. There was good provision of equipment in critical care with robust systems for medical device training. The risks associated with loss of service, should equipment be broken and require replacement, were on the risk register.

- The unit was visibly clean and appeared light and spacious for the four patients in the main bay. Sstaff we spoke with told us that there had been capacity to flexibly increase to five bed spaces in the main area, but recently agreement had been made to close that area to create more floor space. The strategy included future planning for a larger combined critical care unit.
- Standards of infection prevention and control were in line with trust policy. Staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported the assurance that patients with infections received best practice care and, should patients need specialist ventilated isolation facilities they would be transferred. This would apply to only a small proportion of patients. Patients with infections were isolated as per the trust's policy, however, the two isolation rooms were not designed in line with Health Building Note (HBN 04-02) and did not have en suite shower rooms or ventilated lobby areas.
- There was ongoing progress towards a harm-free culture. Incident reporting was good with low incidence of harm and infection. There was a proactive approach to the assessment and management of patient-centred risks, and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. The programme for care of patients with tracheostomy across wards was comprehensive. There was further work ongoing to identify specific admission wards at FGH, in line with work at the RLI site.
- In 2015 we reported that there was no Critical Care Outreach Team (CCOR) across either critical care unit at UHMB. The trust did not have a dedicated CCOR team and this continued to

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be noted on the risk register. However during our 2016 inspection we noted good provision of principles in line with GPICS (2015), NICE CG50 and against the seven core elements of Comprehensive Critical Care Outreach(C3O 2011). Staff we spoke with told us that there was an 'educational model' of outreach embedded across the trust. We observed one occasion of a rapid response to an acute emergency by the team during the inspection.

- Patients were at the centre of decisions about care and treatment. The weight of positive comments gave evidence of a caring and compassionate team. Staff were positive and motivated and without exception delivered care that was kind and promoted dignity, and focused on the individual needs of people.
- The team in critical care services was well-led. A genuine culture of listening, learning and improvement was evident amongst all staff we spoke with. Staff across the team were passionate about their roles and proud of the trust. The investment in leadership programme was good and it was clear that learning from it was shared, staff had a shared purpose and they made an impact in practice. Governance arrangements were embedded in the directorate.
- We found that ICNARC data showed that patient outcomes were comparable to or better than expected when compared with other units nationally; this included unit mortality.
- In line with recommendations by NICE CG83 and GPICS (2015), follow-up clinics were in place H for critical care patients who had experienced a stay in critical care of longer than four days. Emotional support was given as part of the follow-up appointment, and post critical care admission and additional psychological support were assessed on an individual basis. The use of patient diaries had been embedded in practice since our last inspection.
- Patients received timely access to critical care treatment and consultant-led care was delivered 24/7. A low number of critical care elective admissions were cancelled and there was a low

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number of readmissions to the unit. Patients were not transferred out of the unit for non-clinical reasons. Staff worked hard to avoid discharging patients to wards during the night, and there was a low number of out of hours discharges, comparable with other similar units.

- Less than half of all discharges to ward areas were delayed beyond four hours due to pressures on hospital beds, with 25% - 40% reported in ICNARC in 2015/16. This did not prevent patients from receiving the care and treatment they needed, and staff paid attention to patient dignity when Department of Health (DoH) single sex accommodation breaches occurred. ICNARC data did indicate that the unit position was comparable nationally with other units against the eight hour reported target in the CMP.
- Staff we spoke with in critical care and theatres did not express concern about the patients when 'outlier' admissions took place and staff had not reported any incidents of harm as a consequence. The FGH unit had reported an increase in annual admissions of around 40 in 2015/16. Staff we spoke with attributed the outliers to bed pressures across the trust. Critical care training had been increased for staff in theatres as part of an LiA project. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as had been previously reported, and all admissions were short stay and rarely level 3.

However:

- There was no provision for dedicated critical care pharmacy cover at the FGH site, despite recommendation of such by GPICS (2015).
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.

- We observed that physiotherapy cover in the unit did not provide enough opportunity to be involved in unit activity, nor did it deliver care that was in line with GPICS (2015) in the cases of six patients, and there was reduced opportunity to develop standards of patient rehabilitation in critical care.

Maternity and gynaecology

Good

At the last inspection, in July 2015, we rated maternity and gynaecology services as 'requiring improvement' for being safe and well-led, particularly in respect ofchecking of equipment, medicine management, assessing and responding to risk, embedding governance and risk processes, and joint working and culture. During this inspection we found good progress had been made in these areas and we rated Furness General Hospital as 'good' because:

- Staff understood their responsibilities to raise concerns and record patient safety incidents. There were processes to ensure reviews or investigations were carried out and action taken.
- Staff were aware of the procedures for safeguarding vulnerable adults and children, and the infant abduction policy had been tested.
- There were processes in place for checking equipment and arrangements for managing medicines.
- Medical, nursing and midwifery staffing levels were similar to or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.
- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.

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- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and coordinated to take account of women with complex needs, and there was access to specialist support and expertise.
- The leadership team understood the challenges to the service and actions needed to address these. Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.
- There were many examples of how people's views and experience were used and acted upon to develop and deliver maternity care.

However:

- Not all care records were fully completed, dated and signed. This included inconsistent recording on cardiotocographs (CTG), which was not in line with the trust fetal monitoring policy. These areas were audited and recommendations made.
- Although there was a plan which set out the principles and governance arrangements for a strategic partnership with Central Manchester and Lancashire NHS Trusts, further work was required to effectively capture and monitor outcomes.

Services for children and young people

Good

Following our previous inspection, in 2015, children and young people's services were rated as 'requires improvement'. Issues were found in respect of the reviewing of incidents, high numbers of paediatric consultant vacancies, and lack of job plans. Consultant paediatricians had also raised concerns about bullying and those concerns not been acted on by senior leaders.
At this inspection we found that these issues had been resolved.
We rated the children and young people's services as 'good' because:

Summary of findings

- Staff were aware of their responsibility to report incidents and appropriate systems were in place. Staff received feedback about incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed. Staff had completed the appropriate level of training in safeguarding and received safeguarding supervision.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition and appropriate transfer arrangements were in place for those children requiring more specialised care.
- Consultant paediatricians were on site 24 hours a day, seven days a week.
- Staff had access to evidence-based policies which were compliant with national guidance.
- There was a programme in place for local and national audit.
- Feedback from children, young people and their parents was positive.
- Services were planned to meet people's needs. Facilities were provided for parents.
- There were governance systems in place to ensure that quality, performance and risks were managed, and that information could be cascaded between senior management and clinical staff.

End of life care

Outstanding ☆

In the last inspection of Furness General Hospital, in July 2015, we rated end of life care services as 'good'. During this inspection we rated the end of life care service as 'outstanding' because:

- The trust had clear leadership for end of life care services, that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.
- End of life care services were very well-led. There was a clear vision and strategy that focused on all people being treated with dignity, respect and compassion at the end of their lives.

Summary of findings

- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- There was very good public and staff engagement.
- There was a commitment by the trust, underpinned by staff, that patients would be cared for in a dignified, timely and appropriate manner.
- There were examples of innovation across the service. During 'dying matters week' the trust had introduced death cafés, aiming to raise the profile end of life care. This also included the development of the bereavement service.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death cafés', where issues relating to death and dying were talked about openly.
- The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely manner, therefore ensuring that individual needs were met.
- Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.
- The Chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.
- The mortuary was clean and well maintained, infection control risks were managed and clear reporting procedures were in place.
- The bereavement service had been nominated for a compassionate care award in 2015.
- The survey of bereaved relatives results were positive in relation to dignity and respect afforded to patients.
- The trust had recently introduced a 'Hospital Home Care Team' service where patients could

be transferred to their own homes and supported by trust staff, in cases in which care packages were difficult to access in the community.
- An 'ease of access to hospital' group had been developed by the trust which included representation from the bereavement and Chaplaincy service, and initiatives were in place to improve access to the mortuary.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust was making use of audits and was learning from incidents in order to drive improvements.
- Mandatory training was in place and attendance at this by the specialist palliative care nurses exceeded the trust target.
- The care of the dying patient (CDP) document was in use throughout the trust.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system). This enabled recording and sharing of patients' care preferences and details about their care at the end of life

Outpatients and diagnostic imaging

Good

We rated outpatients and diagnostic imaging services as 'good' because:

- During our previous inspection we had identified concerns about the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and implemented an electronic records system for most outpatient areas. This was still being rolled out across all departments, but we found that there had been significant improvements in the availability of case notes. Staff were positive about the improvements in efficiency and effectiveness for outpatient services, such as the availability of test results and timely access to information.
- We found that, since the 2015 inspection, there had been some improvements in diagnostic

imaging staffing numbers. When we inspected this time the department continued to work with vacancies but a new rota system enabled the department to make improvements.

- During our last inspection we had noted that there was no information available in the departments for patients who had a learning disability, nor any written information in formats suitable for patients who had a visual impairment. We saw this time that there was a range of information available in different formats and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence-based and followed national guidance.
- Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department along with preceptorship for all new staff to the department.
- We found that access to new appointments throughout the departments had improved.
- Overall, staff felt engaged with the trust and felt that there had been some improvements in service delivery since our last inspection. There were systems to report and manage risks. Staff were encouraged to participate in changes within the department, and there was departmental monitoring at management and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training, and lessons learned.

However:

Summary of findings

- There remained a shortage of some staff groups including occupational therapists, radiographers, and radiologists. Some staff raised concerns about the sustainability of the team under prolonged staffing pressures.
- Some referral to treatment targets were missed, and follow-up appointments continued to suffer backlogs and delays.

Furness General Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to Furness General Hospital

Furness General Hospital (FGH) is situated on the outskirts of Barrow. It has around 268 beds. It provides a wide range of services including Accident and Emergency, medicine, surgery, maternity, outpatients and diagnostic imaging, critical care, end of life care, and children and young people's services, including a special care baby unit.

The emergency department at FGH provides a 24-hour, seven-day a week service to the local population and is a designated trauma unit. However, at the time of our inspection, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre if their conditions allowed them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their conditions allowed. The department had only one resuscitation bay and there was no distinction between the cubicles used for patients with minor injuries and those used for major injuries; they were all nursed in the same area. However, plans were in place to address this through the trust's estates strategy. There were 12 cubicles that could be used for patients with either minor or major injuries or illnesses.

Medical care services at FGH provided treatment for patients requiring cardiology, gastroenterology, general medicine, medical oncology, respiratory medicine and stroke care. There were 132 medical inpatient beds and 23 day-case beds located across seven wards; Acute Medical Unit ("AMU"), Complex and Cardiac Care Unit ("CCCU"), Ward 6, Ward 7, Ward 9 and Oncology. The division also provided an ambulatory care unit, a clinical investigation unit, an endoscopy suite and specialist day case/rapid access services at the Croslands Centre.

FGH provided a range of elective and non-elective surgical inpatient services. There was also a sub-regional service for upper gastro-intestinal surgery. There were six surgical wards, a day case unit and a theatre suite comprising seven theatres. There were 109 inpatient and 22 day case beds.

Critical care services could flexibly admit three level 3 and three level 2 patients; two of the six bed spaceswere single rooms. The service provided intensive and high dependency care for patients who had had complex surgery. It also provided care for emergency admissions.

This hospital offered midwife-led and obstetric consultant-led care for high risk and low risk women, and a range of gynaecology services. Within the Labour Suite at FGH, there were four delivery rooms and two active birth rooms. There were 24 maternity beds for antenatal and postnatal care, and a day assessment unit. The gynaecology ward had 8 inpatient and 2 day case beds.

Services for children and young people at FGH consisted of a children's unit, which included a 14 bed inpatient ward, an eight bed day case unit and a four bed assessment unit; a children's outpatient department; and a four bed special care baby unit (SCBU).

Detailed findings

Patients at the end of life were nursed on general hospital wards at FGH. There was a Specilast Palliative Care (SPC) team in place. There were 1.7 whole time equivalent (WTE) consultant in palliative medicines posts including the lead consultant, who was based at the Royal Lancaster Infirmary (RLI), and a new consultant post based at FGH for two sessions (one day) a week. There were four SPC clinical nurse specialists across the trust as a whole, two of whom were based at FGH, including the lead nurse, who had clinical responsibilities at FGH and managerial responsibilities across the trust as a whole. The trust also had a bereavement team which consisted of a bereavement nurse and a bereavement officer at both FGH and RLI.

Outpatient services were part of the core clinical services directorate. There were nurse-led clinics for dermatology, diabetes, lung clinics, gastroenterology clinics, respiratory and rheumatology clinics. Outpatients offered 'one-stop' clinics for Cardiology, Respiratory, Thyroid and Urology. There were a small number of children's services in Rheumatology clinics.The service had a Community Patient Contact Centre (CPCC) which acted as the patient focal point for correspondence, discussions and planning around bookings for their elective appointments. The patient contact centre dealt with around 12,000 calls each month.

Diagnostic imaging at FGH provided plain film x-rays, ultrasound, CT, MRI, Nuclear medicine, breast screening, including interventional treatments, and a radio pharmacy. The acute clinical work including fluoroscopy was concentrated at the two main trust sites, RLI and FGH,and offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals, CQC

Inspection Lead: Amanda Stanford, Head of Hospital Inspections, CQC

The team included CQC managers and inspectors, and a variety of specialists: Nurse Manager, A&E Doctor, A&E Sister, Critical Care Nurse, Advanced Paramedic, Doctor, Matron, Consultant General Surgeon, Lead Nurse Post Anaesthetic Care Unit, Critical Care Matron, Risk Midwife, Midwife Matron, Consultant Obstetrician & Gynaecologist, Neonatal Consultant, Locum Doctor, Paediatric Nurse, Consultant in Clinical Oncology, EOLC Matron, Outpatients Matron, Board Level Director, Director of Nursing and Quality, and Medical Director.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following core services at Furness General Hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and Gynaecology
- Services for children and young people
- End of life care
- Outpatient and diagnostic imaging services

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the trust. These organisations included clinical

commissioning groups (CCGs), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We staffed public engagement stalls at the hospital sites on 20 and 21 September 2016 to hear people's views about care and treatment received at the hospitals. We used this information to help us decide which aspects of care and treatment to look at as part of the inspection.

We carried out the announced inspection visit from 11 to 14 October 2016 and undertook an unannounced inspection on 26 October 2016.

Facts and data about Furness General Hospital

Between July 2015 and July 2016 the hospital had 35,650 emergency department attendances. This equates to an average of 98 patients per day; 17% of emergency department attendances between April 2014 and June 2016 were children aged up to 16 years old. This had been a consistent percentage for the preceding three years.

Hospital episode statistics data for 2015 / 2016 showed that 11,870 patients were admitted for surgery at this hospital.

Between April 2015 and March 2016, there were 1,054 births at FGH. Across the trust, the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under was slightly higher than the England average.

Between April 2015 and March 2016 there were 8,378 admissions to the children and young people's service across the trust.

Between April 2015 and March 2016 there had been 25,360 inpatient admissions and 1,438 inpatient deaths across the three hospital sites within the trust. Between April 2015 and March 2016 there had been 960 referrals to the SPC. Of those referrals 36% were for patients with a non-cancer diagnosis and 64% were for patients with cancer.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

University Hospitals of Morecambe Bay (UHMB) NHS Foundation Trust has emergency departments on two main hospital sites at the Furness General Hospital (FGH) in Barrow and the Royal Lancaster Infirmary (RLI) in Lancaster. The population served by these hospitals is spread over a large geographical area and journey time between Barrow and Lancaster is approximately one hour and 15 minutes by car.

The emergency department at FGH provides a 24-hour, seven-day a week service to the local population. Between July 2015 and July 2016 the hospital had 35,650 emergency department attendances. This equates to an average of 98 patients per day. Between April 2014 and June 2016 17% of emergency department attendances were children aged 16 years and under. This had been a consistent percentage for the preceding three years.

Between April 2015 and March 2016 25.1% of attendances resulted in an admission. This was higher than the England average of 24.7%.

The emergency department was a designated trauma unit. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their conditions would allow them to travel directly. If not, they were stabilised within the emergency department and either treated or transferred as their conditions dictated. There was a protocol to inform the medical team about patient injuries that would require treatment at a major trauma centre. The department had a nearby helipad within the hospital grounds, and a protocol was in place for the transfer of the patient from there into the emergency department by ambulance.

The hospital department pre-dated current national guidance for compliance in facilities for accident and emergency departments. At the time of the inspection it had only one resuscitation bay and no distinction between the cubicles used for patients with minor injuries andthose used for major injuries; they were all nursed in the same area. However, plans were in place to address this through the trust's estates strategy.

Self-presenting patients with minor illnesses or injuries were required to register with a receptionist on arrival, and were assessed by a triage nurse. There were 12 cubicles that could be used for patients with either minor or major injuries or illnesses.

In order to make our judgements we spoke with seven patients, five carers and 16 staff from different disciplines, including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice and viewed 25 sets of records. Prior to and following our inspection we reviewed performance information about the trust and reviewed information provided to us by the trust.

Urgent and emergency services

Summary of findings

We rated the emergency department at FGH as 'requires improvement' because:

- The emergency department's performance had been deteriorating over the last 12 months. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached the standard between October 2015 and September 2016. Whilst there are multiple factors that impact upon patient flow, it was recognised that the most important factor was bed occupancy. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Bed occupancy levels are were 115-130% on each trust site. The aim was to achieve an 85% average occupancy
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment at FGH was worse than the overall England median in all months over the 12 month period.
- Between June 2015 and May 2016, the trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- Between September 2015 and August 2016 there was an upward trend in the monthly percentage of ambulance journeys with handover times of over 30 minutes. In the previous CQC inspection, in July 2015, an action that we said the hospital should take was to improve the ambulance turnaround times. The department was continuing to fail to meet the standard. A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department to being handed over to the emergency department staff. Between the end of September 2015 and the end of September 2016 FGH had 444 black breaches.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average.
- Between August 2015 and July 2016, the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average.Performance against this metric showed a trend of decline.
- The department was not meeting the trust's target for staff completing mandatory training. Following our previous inspection, in July 2015, an action we said the hospital must take to improve was to ensure that staff received appropriate support, training, supervision and appraisal. Although support and appraisal rates had improved, mandatory training remained below the trust target for completion.
- The outcomes of people's care was not always monitored regularly or robustly using the National Early Warning Score (NEWS) system. Failure to do so may prevent early recognition of a deteriorating patient.
- Nursing assessments were not always completed.
- Patient group directives were overdue for review in January 2016.
- Care pathways were not regularly reviewed.
- Emergency equipment was not being checked daily.
- A key safe which contained keys for medicines cupboards was found unlocked

However:

- The management team had strengthened the 'cross bay' working since our last inspection, and learning from incidents, sharing best practice and cross site working had improved.
- One of the actions we said the hospital should take to improve following our previous inspection was to improve staff engagement, knowledge and awareness of the strategy of the service. At this inspection we found that staff were more engaged, and were provided with information via WEESEE, newsletters, internet updates and email, on trust developments, clinical issues, patient themes and staff recognition.
- The planned and actual staffing levels were met for medical and nursing staff.

Urgent and emergency services

- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than to the England average for the entire period. The trust's performance followed a similar trend to the England average.
- There were governance, risk management, quality measurements and processes in place to enhance patient outcomes, and openness and transparency about safety was encouraged.
- Staff provided care to patients based on national guidance, such as the National Institute for Clinical Excellence (NICE) guidance and the RCEM.
- There were a good level of staffing and a good skill mix for nursing and medical staffing.
- Feedback from patients, relatives and carers was consistently positive. We saw that staff were caring and compassionate in their dealings with patients. Patients felt well-informed and engaged in their care.
- Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and abuse, and where areas for improvement were identified this was acted upon.
- There were systems in place to monitor and improve infection control practices.
- There were clear systems and processes in place to protect children and vulnerable adults from abuse. Services were planned in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people.
- Staff and managers were clear about the challenges the department faced. They were able to clearly tell us about the risks posed to the department and how these were being addressed.
- The emergency department had a clear management structure at both divisional and departmental level. The leaders within the department were knowledgeable about quality issues and priorities; they understood the challenges and were taking action to address them.

Are urgent and emergency services safe?

Requires improvement

We rated the emergency department as 'requires improvement' because:

- Guidance issued by the Royal College of Emergency Medicine (RCEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period.
- The department was not meeting the trust's target for staff completion of mandatory training. Only 38% of medical staff and 33% of nursing staff had received level three safeguarding children training. Advanced paediatric life support training was completed by 42% of medical staff and 62% of nursing staff. Advanced adult life support was completed by 87% of nursing staff.
- The outcomes of people's care was not always monitored regularly or robustly using the National Early Warning Score (NEWS) system. Failure to do so may prevent early recognition of a deteriorating patient.
- Record keeping was variable. Nursing assessments were not always completed.
- Patient group directives were overdue for review in January 2016.
- Care pathways were not regularly reviewed.
- Emergency equipment was not being checked daily.
- A key safe which contained keys for medicines cupboards was found unlocked.

However:

- When something went wrong, people received a sincere apology and were told about any actions taken to improve processes to prevent the same happening.
- Openness about safety was encouraged and staff understood their responsibilities to raise concerns and report incidents. We saw that systems and processes worked together to keep people safe from harm and abuse and, where areas for improvement were identified, this was acted upon.
- There was a strong culture of reporting incidents, which was done using an electronic system. Incidents were investigated swiftly. Feedback and lessons learnt from incidents were shared amongst staff.

- The department was visibly clean, and equipment was maintained in line with trust policies.
- There were systems in place to monitor and improve infection control practices.
- The planned and actual staffing levels were met for medical and nursing staff.
- There were clear systems and processes in place to protect children and vulnerable adults from abuse. Safeguarding of vulnerable adults and children were given sufficient priority, and there was active and appropriate engagement in local safeguarding procedures.
- Plans were in place to respond to emergencies and major situations. Staff understood their roles, and the plans were tested and reviewed.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- To report incidents, staff used an electronic system. Staff were confident about using the system and were encouraged to report incidents. Incidents were appropriately graded in severity from low or no harm to moderate or major harm.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. etween November 2015 and October 2016 the trust reported no incidents which were classified as Never Events for Urgent and Emergency Care.
- In accordance with the Serious Incident Framework 2015, FGH reported three serious incidents (SIs) in Urgent and Emergency Care between November 2015 and October 2016 which met the reporting criteria set by NHS England. There was no particular theme to the serious incidents. However, 'capacity issues' resulting in patients having a long wait for a bed on a ward was the most common category of incidents reported, and these were reported as grade one, no injury, incidents.
- There was clear evidence that these SIs were robustly investigated. Staff told us that they always received feedback following investigations of incidents of harm or risk of harm. Learning from incidents was discussed and cascaded through several forums. Learning was discussed individually, displayed on a notice board in the staff area, and discussed in the clinical governance group meetings.
- Most of the staff we spoke with were aware of the statutory Duty of Candour principles. The department had a system in place to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons. Examples of duty of candour were given and we saw staff were open and honest with the patients and their family.
- Any unexpected deaths or potentially avoidable deaths that occurred in the emergency department (ED) were reviewed within the divisional mortality meetings with medicine. These were attended by a member of the ED who reported any findings or lessons learned at the department meetings.

Mandatory training

- There was a trust mandatory training policy in place. This referenced eight statutory training requirements, mandatory training requirements and training in essential skills. They included such topic areas as equality and diversity, health and safety, infection prevention and control, information governance, basic life support, conflict resolution, general fire safety awareness and manual handling.
- For each training element staff groups were identified, together with the frequency of each training element. Employees had a personal training account, which reflected the mandatory training needs required by them as an individual, and showed whether their training was up to date and when it would expire.
- The trust set a target of completion at 95%. Six of the eight training elements had been completed at above 95% by medical staff, the two not fully completed were 'conflict resolution' and 'health and safety'. It appeared that five of the elements had been completed at above 95% by nursing staff. These were 'conflict resolution', 'health and safety', 'information governance', 'infection

prevention and control', and 'fire safety'. However, from the training figures received this was difficult to ascertain, as there were different level modules for some of the topics.
- In addition, sepsis training was an essential part of training for the emergency department staff; 77% of staff had completed this. There was a sepsis champion in the department.
- Staff completed most mandatory training using e-learning. However, there were some clinical skills that required competency-based classroom sessions.
- Time was allocated in the off-duty periods for face-to-face mandatory training although staff did e-learning in their own time or at work, if time was available.
- New staff undertook a corporate induction programme that included some face- o- ace mandatory training.
- We were told that all medical staff who looked after children were trained in advanced paediatric life support (APLS). However training figures supplied indicated that only 42% of medical staff had trained in APLS. Nursing staff at band 6 and above must be trained in APLS according to trust policy, yet only 62% had completed this training. Two members of staff were booked to complete this in November 2016, and a plan was in place for the remaining three staff to undertake it in the new year. Band 5 nurses must be trained in paediatric life support (PLS) according to trust policy, yet only 40% had completed this training. All nurses band 6 and above should have completed advanced life support adult training according to trust policy, yet only 87% had completed this training. There was a plan in place to achieve 100%: some staff had booked to attend future courses and others were to book in the near future.

Safeguarding

- The department had a clear system and process in place for the identification and management of adults and children at risk of abuse.
- We reviewed ten children's records. Within three of the records it was not documented that the children had been assessed regarding safeguarding, so we could not be sure that they had.
- Nursing, medical and administration staff we spoke with were able to explain the process of safeguarding a patient and provide us with specific examples to show when they would do this.
- We observed staff accessing the trust safeguarding guidelines, which were readily available in a file. This provided information about how to make referrals should staff have concerns about the safety of any child or adult.
- Any safeguarding concerns were escalated to the senior nurse and doctor.
- There was a safeguarding team for adults and children and a robust referral system in place. A paediatric safeguarding lead came to the department each weekday to collect referrals and discuss concerns.
- A domestic violence coordinator was based in the emergency department and would see patients. The coordinator was part of the safeguarding team and was available for advice and support. Staff told us that all domestic violence incidents involving adults with children would trigger the generation of a safeguarding alert.
- Safeguarding audits took place weekly by randomly checking 40 paediatric ED records. If anything was missed, the paediatric nurse would speak with staff. We saw evidence of audits which showed 97% completion between April 2016 and June 2016. We were told that no audits were completed between July 2016 and September 2016.
- Staff were aware of the assessment for child exploitation and female genital mutilation (FGM). This was discussed within the safeguarding children training.
- The ED had a Child Protection Information Sharing System in place which allowed the trust to share and receive information from other authorities responsible for safeguarding children. When children presented to ED the system generated a specific sign on the patient's records if they had already been identified as 'at risk' or had a specific care plan in place having presented to ED a specific number of times.
- The trust set a mandatory training target of 95% for completion of mandatory safeguarding adults and children training level one and two. We found that 98% of nursing staff and 100% of medical staff had completed safeguarding children and young people training. All medical staff and senior nurses should undertake level three training. This would mean that on every shift a senior member of staff with the appropriate safeguarding competencies, in line with national

guidance set out by the The Royal College of Paediatrics and Child Health, would be on duty. However, only 38% of medical staff and 33% of nursing staff had undergone level three training.

Cleanliness, infection control and hygiene

- The emergency department was visibly clean and tidy. We saw cleaning in progress during the visit. Most of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned.
- We reviewed areas including the sluice, administration stations and relatives' waiting areas, and found them clean and tidy.
- Needle-sharp bins in the areas were not overfilled (more than ¾ full), and the bins were dated and signed by a member of staff, as required by the trust's policy.
- Staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
- We observed medical and nursing staff following the trust's policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department, apart from in the triage room where there were no hand washing facilities. Hand gel dispensers were available in each cubicle.
- In the CQC's 2014 A&E survey the service scored 8.6 out of 10 for the question: "In your opinion, how clean was the A&E department?" This was about the same as other trusts.
- Hand hygiene was audited on a monthly basis. The audit results for February 2016 to June 2016 showed between 98% and 100% compliance.
- Staff routinely carried out mattress audits. We were told that mattresses were checked and cleaned between changes in patient occupancy. We checked five mattresses and found them to be clean and without tears.
- There was one cubicle with a door that was appropriate for isolating patients who might have an infectious condition.
- In the children's waiting areas toys were visibly clean. There was a cleaning schedule for toys and evidence that cleaning had taken place.
- Each bay had a cleaning checklist in place and we saw these had been completed daily.
- We spoke with domestic staff whose main role was to assist with the hygiene and cleanliness of the department and they talked about the importance of infection control, and how they contributed to patient safety by ensuring that they followed trust infection control policy. We looked at the cleaning stock room and saw that items of equipment such as coloured mops and buckets were available and stored correctly. The cleaning chemicals had appropriate instructions for storage and usage in line with Control of Substances Hazardous to Health (COSHH) national guidelines.
- Waste was managed in line with effective infection control practices.
- Most ED nursing staff (94%) had up-to-date training in infection control.
- We saw evidence of a sepsis screening tool for the trust. However, the notes we checked did not include any patient with sepsis and during our inspection we did not observe the treatment of any patient with sepsis.
- We were told that sepsis audits had been carried out and action plans discussed in weekly doctor training. Staff were aware of the signs and symptoms of sepsis and had received sepsis training.

Environment and equipment

- The department pre-dated current national guidance for compliance in facilities for accident and emergency departments (HBN 15-01: Accident and Emergency Departments 2013)
- In the Estates Strategy 2015 to 2025 the trust it acknowledged that there were insufficient cubicles at busy periods and that there was no distinction between the minors and major stream. The risks associated with having only one resuscitation cubicle were acknowledged and were noted on the risk register. We were informed that there were plans to expand into the adjacent fracture clinic (which would be relocated) in December 2016. This would be used for the assessment and treatment of patients presenting with a minor illness or injury. We were also informed that there were plans to expand to three adult resuscitation bays, and another specifically for children, by extending the building into the adjoining courtyard, within the following 12 months.
- The department had a nearby helipad within the hospital grounds. Patients were transferred by ambulance from the helicopter into the emergency department.

- Staff in reception sat behind a desk and had access to panic buttons.
- Staff were aware of how to raise a security alert and said they felt safe. Security arrangements were in place. Security was based in the main hospital during the day and in the department between 7pm and 7am. Closed circuit television (CCTV) was in operation.
- Patients with a serious injury or illness and requiring resuscitation arrived by ambulance through a dedicated entrance that led directly into the resuscitation bay. All other patients including those with major injury or illness accessed the department through the main entrance to the emergency department and came through the waiting room.
- Resuscitation equipment for adults and children was readily available on trolleys and could be moved to any cubicle within the department.
- The resuscitation room and cubicles were visibly clean and well organised, although there was limited space for the amount of equipment, which made the department look cluttered.
- The cubicles were similarly set up, which helped staff care for and treat patients in a timely and efficient manner.
- Equipment trolleys were labelled and some were matched with an equipment checklist. We saw evidence that resuscitation trolleys and the difficult airway trolley had not been checked daily as per trust policy.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Safety testing of electrical equipment had been carried out in the department. The medical engineering department serviced all equipment on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- In the CQC's 2014 A&E survey, the service scored 9.7 out of 10 for the question: "While you were in the A&E Department, did you feel threatened by other patients or visitors?" This was about the same as other trusts.

Medicines

- Staff followed systems that demonstrated adherence to relevant legislation.
- The department used an electronic dispensing system for dispensing medicines, which used finger print technology to control access, provided an audit pathway and improved inventory control. Staff told us they felt this system had improved patient safety.
- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- Medicines requiring refrigeration were stored securely and maximum and minimum temperatures had been recorded in accordance with national guidance.
- Patient Group Directions (PGDs) were in use to support patient access to medicines in a timely way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. The paper copies held on the ward were overdue for review in January 2016. Staff who administer from the PGDs should sign each individual PGD. This had not happened and was highlighted to the department manager during the inspection.
- Blank FP10 prescription pads were stored securely.
- We found a key safe on the wall in the main department that was unlocked as the lock was broken. It contained keys to medicine cupboards. This was accessible to patients and relatives. This was pointed out to the nurse manager at the time of the inspection. However, when we conducted an unannounced inspection on 26th October 2016, we found the key safe was still unlocked. We were told that this was going to be relocated to a wall behind the nurses station.
- When we audited 30 records we found there were no medications omitted that had been prescribed.

Records

- Paper records (ED cards) were used within the department. If the patient was admitted a copy was sent to the ward.
- A discharge letter was generated through the IT system. A copy was sent to the patient's GP through the post.
- Access to patients' previous notes was timely and could be accessed via the medical records department 24 hours a day, seven days a week.
- The IT system could interface with the GP's system and doctors could view a GP summary.

- We reviewed 11 sets of adult patients' records fully, and found completion of documentation was variable. For example, we could not tell whether nursing care had actually been given because the record of nursing care was inconsistent. Assessment of pressure ulcers, pressure care given and falls assessment were not recorded fully on three out of the five applicable records which should have had a nursing assessment completed.
- We found dementia or cognitive assessment was not completed for the over 75s.
- We noted pain scores were not completed in seven out of the 10 applicable records; therefore, we could not tell whether patients had been given timely pain relief.
- Writing was legible in all of the records, and they were dated and timed in nine out of the 11 adult records. Out of the 11 paediatric notes we checked all were legible and one was not dated or timed.
- We found one out of the 11 paediatric records had not had allergies recorded, and two out of the 20 adults' notes had not had allergies recorded. This increased the risk that patients may be given inappropriate medicines that could have a harmful effect.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had had a previous infection or safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit and arranged for safe storage of notes.

Assessing and responding to patient risk

- All patients who booked into the ED received a full, appropriate triage based upon their presentation. This was undertaken by an appropriately qualified nurse.
- Patients who walked into the department were registered by the receptionist and directed to the waiting room, where a nurse triaged them.
- The trust used a recognised triage system in the 'minors' area, which categorised the severity of the patient's condition and level of risk. This determined the order in which patients were seen.
- Once triaged, walk-in patients received an initial assessment by a doctor or nurse.
- Patients arriving by ambulance entered through the main entrance to the emergency department unless they required resuscitation, in which case they entered through a dedicated ambulance entrance directly into the resuscitation bay. The ambulance staff handed the patient over to a nurse who was taking over their care, using an electronic device and the nurse signed to confirm handover was complete. At FGHurness General Hospital, there was no separate initial assessment or ambulance triage.
- A National Early Warning Score (NEWS) system had been recently introduced to the department and replaced a similar system used to assess patients. This supported the process for early recognition of those acutely ill patients who were becoming unwell in order to promote early, appropriate intervention from skilled staff. We checked records and found that only three out of 11 adult records, and only one out of 11 paediatric record, showed evidence of the NEWS recording.
- Guidance issued by the Royal College of Emergency Medicine (RCEM) states that a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. The median time from arrival to initial assessment was worse than the overall England median in all months over the 12 month period. In July 2016 the median time to initial assessment was 16 minutes compared to the England average of seven minutes. The trust's performance had worsened over time with the median time increasing.
- During our inspection we examined records for seven patients who arrived by ambulance. We found that the RCEM target was met for only two of these seven patients. These times we found were between seven and 43 minutes.
- We checked notes for 17 patients who had walked into the ED. We found that they waited between three and 43 minutes for an initial assessment by the triage nurse. Ten of these patients were assessed by the triage nurse within 15 minutes.
- During the inspection we tracked the journey of 15 patients through the ED from their arrival until they were discharged from the department. Of those, 10 received an initial assessment within 15 minutes of their arrival at the ED. This ranged from being seen immediately to being seen within 14 minutes. The longest wait was 37 minutes.
- Failure to triage within 15 minutes was noted on the departments risk register.
- The RCEM recommends that the time patients should wait from arrival to receiving treatment be no more than one hour. The trust met the standard for all months over the 12 month period.

- The emergency department was a designated trauma unit and provided care for all trauma patients. However, the most severely injured trauma patients were taken by ambulance or helicopter to the nearest major trauma centre, if their conditions allowed them to travel directly. If not, they were stabilised at FGH and either treated or transferred as their conditions dictated. There was a protocol to inform the medical team about patient injuries that would require treatment at a major trauma centre. The department was served by a nearby helipad and a protocol was in place for the transfer of patients into the emergency department by ambulance.
- A handover process to the wards, describing patients' medical Situation, Background, Assessment and Recommendations (SBAR), was used. This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition.
- The trust performed 'about the same' as other trusts in the 2014 CQC A&E Survey questions for the five questions relating to assessing and responding to patient risk.

Nursing staffing

- The department completed a nurse staffing audit using a recognised workforce planning tool. This tool, developed by the Royal College of Nursing Emergency Care Association and Faculty of Emergency Nursing, was specifically for use in Emergency Departments to allow any disparity between nursing workload and staffing to be highlighted. The tool analysed the volume and pattern of nursing workload and tracked this against the rostered staffing level, calculating the whole time equivalent workforce and skill mix that would be required to provide the nursing care needed in the department during the audit period.
- As a result of the audits and the NICE consultation paper which gave minimum core nursing staffing in emergency departments, a business case was put forward in April 2014 and agreed. We were informed that a re-audit using the same workforce tool had taken place two weeks before the inspection, however, results were not available at the time of the inspection.
- Between April 2016 and August 2016, the planned number of whole time equivalent establishment of registered nurses was 35.1. The actual number of staff in post was between 31.5 and 33.4. Fill rates were between 90% and 95%. The number of planned emergency nurse practitioners was three and throughout these four months, they had three in post, fill rates being 100%. The planned number of unqualified nurses was 4.5; however, there were between 10.2 and 11.9 unqualified staff in post. Fill rates were between 230% and 280% The higher number of unqualified staff would mitigate the risks posed by having a reduced number of qualified staff. However, at the time of the inspection there were no vacancies as four newly qualified staff nurses had recently started. Therefore staffing was adequate. There was four nurses on maternity leave and we were told these posts were filled substantially.
- We reviewed four weeks of nursing off-duty between 12 September 2016 and 3 October 2016. There were only four shifts out of a total of 56 during which staffing was short, and this was due to short-term sickness.
- The department used bank nurses who were their own staff to cover sickness. Agency nurses were rarely used.
- To mitigate risk, nurse staffing was discussed at bed management meetings, which occurred at least four times a day. Senior staff would move staff from other areas to help cover, if they were available.
- Nurse staffing was noted on the department's risk register.
- The trust's sickness levels between June 2015 and April 2016 were higher than the England average for all months except September 2015. The trusts sickness trend was not following the England average and was increasing over time. The trust was unable to provide separate sickness rates for the emergency department
- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- The department had the skill mix and flexibility to deploy staff as demand and workload dictated across the different parts of the department.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. There was one full time paediatric nurse, who was the lead paediatric nurse for the emergency department, and the ward paediatric staff nurses covered the emergency department, providing one paediatric nurse daily between 9am and 10pm. Between the hours of

10pm and 9am the emergency department nurses would care for any children who came to the department. All nursing staff had received training regarding the care of children.
- The department was overseen by a matron, who provided managerial support, and clinical support when necessary.
- Nursing and medical handover occurred separately at the beginning of each shift.
- The handover included discussions around numbers of patients in the department, waiting times, a handover of each patient, any issues that had occurred, any deaths, and any shortfalls in nursing or medical staffing.
- We did not observe a board round and there was no evidence of regular board rounds which include a discussion with the multidisciplinary team.

Medical staffing

- We examined the medical staffing rota and talked with consultants and junior doctors.
- According to the College of Emergency Medicine (CEM) (2015), an emergency department should have at least 10 whole time equivalent consultants to provide a sustainable service during extended weekdays and over the weekend.
- There were two whole time equivalent (WTE) consultants employed in the ED. This was, therefore, below the CEM recommendations. However, there were 10 associate specialists and eight junior doctors in post. There were no vacancies at the time of the inspection.
- In July 2016 the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.
- Consultant rotas demonstrated that consultant presence in the department was between 8am and 10pm Monday to Friday, and 2pm and 10pm on weekends. CEM guidance states that services should ensure that there is 16 hours of consultant presence a day, except in Major Trauma Centres, which should have 24 hour cover. FGH ED provided consultant presence for only 14 hours a day on weekdays and eight hours a day at weekends. However, in the absence of a consultant an associate specialist was always available.
- National guidelines for emergency departments seeing 16,000 or more children a year state that there should be at least one consultant with sub-specialist training in children's emergency medicine. The department saw 7,425 children aged 0 to 16 between April 2014 and June 2016. A paediatric consultant provided paediatric cover if needed and was on site 24 hours a day, 7 days per week.

Major incident awareness and training

- The trust had a major incident policy; this was accessible to staff on the trust intranet.
- The department had a major incident plan with clear guidance and action cards for individual roles in the event of specific incidents
- Staff had an understanding of their roles and responsibilities with regard to any major incidents. Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT), such as chemical, biological or radiological materials.
- There was a designated store for major incident equipment that contained specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials.
- There was a link nurse in the department for major incidents and the emergency planner checked the equipment every three months.
- Staff had undertaken training and practice that included rehearsal wearing protective suits, in July 2016. There was an agreed programme of training in place for 2017.
- Staff had received training in how to care for someone who may have symptoms of Ebola.
- The department could be locked down easily to ensure the safety of patients should the need arise.
- There were appropriate security arrangements in place to keep staff and others safe and protected from violence 24 hours a day. At night security was based in the department. CCTV was in place.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the emergency department as 'good' for effective because :

- Care and treatment was delivered in line with national guidance and best practice.
- The department had an ongoing audit programme that encompassed both local and national audits.
- Staff were qualified and had the skills they needed to carry out their roles effectively, in line with best practice. Staff were supported to maintain and further develop their professional skills and experience.
- Policies and procedures had been developed in conjunction with national guidance and best practice evidence.
- A preceptor supported new staff, and a supernumerary period of time was given, which varied depending on the staff member's previous experience and learning needs.
- There was evidence of good multidisciplinary working.
- The department offered a 24-hour seven-day service, however, out of hours some services were available only as an on-call service.
- Staff were clear about their responsibilities in gaining consent, including for those who lacked capacity to provide informed consent to care and treatment
- All staff (other than staff new in post) had received an up-to-date appraisal.
- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average.

However:

- Documentation of pain scores was not always completed.
- Care pathways were not reviewed regularly.

Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) clinical standards for emergency departments.
- We saw evidence that care was delivered in line with recommended national guidance for emergency departments and medicine. This included specific pathways for patients presenting with stroke, sepsis, venous thrombolytic embolism (blood clot) and fractured neck of femur. We looked at the pathways and found that some did not have review dates, and those that did had passed their review dates. Care pathways aimed to promote early treatment and improve patient outcomes.
- We did see any evidence of the stroke and venous thrombolytic embolism (blood clot) pathway being used.
- The ED provided an acute service for patients who had had a stroke. A specialist nurse attended ED to advise and to support the care of the patient. A stroke pathway was in place 9am to 5am Monday to Friday. Out of hours, the stroke specialist doctor on call was contactable and the care of the patient could be discussed via telemedicine, which is a video conferencing service.
- The trust participated in the national RCEM and Trauma Audit and Research Network (TARN) audits so that it could benchmark its practice against other emergency departments.
- Some guidelines were accessible on the trust intranet page. Junior doctors were able to demonstrate ease of access to guidelines and found them clear and easy to use.

Nutrition and hydration

- Patients were offered food and drinks. Snack boxes were available 24 hours a day. Hot food was available from the hospital canteen if requested.
- There was no set mealtime regime. Patients told us they were offered food and drinks and we observed patients eating and drinking.
- We noted that, of 22 sets of patients' notes, only one documented that food and/or drinks were given.
- We saw evidence in patient's records that there was a section on nutritional status and body mass index. This was only completed on patients being admitted.
- Baby food could be accessed from the children's ward if needed.
- In the CQC's 2014 A&E survey, the service scored 7.08 out of 10 for the question: "Were you able to get suitable food or drinks when you were in the A&E Department?" This was about the same as other trusts.

Pain relief

- A pain score tool was used to assess patients' levels of pain. Pain was scored as zero for no pain, up to 10 for severe pain.

- We reviewed 11 sets of adult patients' notes for the completion of pain scores. Only three records documented the patient pain score. However, we did find evidence that pain relief had been given in all but one of the adult patients' prescription charts and all but one of the paediatric prescription charts.
- Patients told us that staff asked about their pain; nearly all of those patients who had pain said they were treated quickly. Patients were happy with the pain relief they had received.
- In the CQC's 2014 A&E survey, the service scored 6.40 out of 10 for the question: "How many minutes after you requested pain relief medication did it take before you got it?" and scored 7.50 out of 10 for the question: "Do you think that the hospital did everything they could to help control your pain?" Both scores were about same as for other trusts.
- The paediatric notes we checked received pain relief within 20 minutes of arrival and those in severe pain were reassessed every hour (RCEM management of pain in children 2013).

Patient outcomes

- The Royal College of Emergency Medicine (RCEM) has a range of evidence-based clinical standards to which all emergency departments should aspire to achieve optimal clinical outcomes.
- The RCEM invites emergency departments to take part in national clinical audits annually, which evaluate care based against agreed standards. The emergency department had participated in a number of audits to benchmark its performance against the RCEM standards.
- Recommendations were made as a result of the audits and these were discussed in the medical division quality and governance meetings and in the emergency department meetings, emailed to staff, and displayed on notice boards in the department.
- We saw action plans as a result of these audits, and evidence that findings were acted upon.
- There were several audits ongoing at the time of the inspection. These included asthma, sepsis, paracetamol overdose, consultant sign-off and unplanned re-attendance within seven days.
- There was a clinical audit and effectiveness steering group, which was held monthly and at which doctors responsible for the audits discussed their findings
- The department closely monitored its performance against a range of clinical indicators. This presented a detailed and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of patients, and the effectiveness of the care they received.
- Between August 2015 and July 2016, the trust's unplanned re-attendance rate to A&E within seven days was generally worse than the national standard of 5% and generally better than the England average. In latest periodthe trust's performance was 6.8% compared to an England average of 7.9%. The trust's percentage had been higher than the standard for the entire period and the unplanned re-attendance rate had shown a steady increase, almost in-line with the England average.

Competent staff

- Medical and nursing staff had an annual appraisal and they spoke positively about the process.
- At the time of our inspection 87.5% of nursing staff had received an up-to-date appraisal. The five who had not been appraised were new members of staff. The trust target was 100%.
- All medical staff had received an up-to-date appraisal.
- New nursing staff received a preceptor package which included a local introduction to the department and detailed competencies that they must achieve. New staff who we interviewed spoke highly of the package and felt well supported.
- New staff had a supernumerary period of time that varied depending on their previous experience and learning needs.
- Revalidation is the new process that all nurses and midwives in the UK must follow from April 2016, in order to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practising. Staff were aware of the requirements and how to register online.
- Medical staff have been required to undergo a revalidation process with the General Medical Council (GMC) since 2012. The trust had a process in place to support medical staff who were in the revalidation procedures.

Multidisciplinary working

- We observed very good working relationships between medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency department.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if necessary.
- A mental health liaison nurse provided timely assessment to patients with mental health needs between 8am and 8pm, seven days a week. Out of these hours, a crisis team was available. This was a community-based service and we were told that patients often had to wait for a long time before being seen.
- A GP out of hours service was based in the hospital, and links had developed with the department allowing the referral of appropriate patients to that service.

Seven-day services

- The adults and children ED was operational 24 hours a day, seven days a week. Consultants or associate specialists provided cover 24 hours a day. A paediatric on call consultant was available 24 hours a day, seven days per week.
- The emergency department had x-ray facilities within the department, which could be accessed 24 hours, seven days a week. CT scans were available within one hour. The department had an ultrasound scanner available.
- Pharmacy services were available seven days a week and 'out of hours' an on call service was provided.
- Physiotherapy services and occupational therapy were provided six days a week, with an ad-hoc service on Sundays. There was an on call physiotherapist available if needed.
- There was sevenday access to pathology services.

Access to information

- Patients' hospital notes were kept on site and were easily and quickly available from the medical records department.
- In the department there were electronic screens that displayed the status and waiting times of all patients in the department.
- By using the trust's intranet, staff had access to relevant guidance and policies.
- A GP letter was generated from the IT system, printed off and posted to the patient's GP practice.
- The IT system could interface with the GP's system and doctors could view a GP summary, which included patients' current problems, current medications, allergies and recent tests.This information could be accessed securely, following verbal consent to do so from the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with nursing and medical staff, who had a good understanding of the Mental Health Act (MHA) and code of practice. Staff were able to explain how patients detained under the MHA were being treated for their mental disorder and that, if they required treatment for a physical illness, consent would still have to be sought in line with current legislation.
- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examinations and perform tests.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards was included within the mandatory safeguarding training; 100% of medical staff and 98% of nursing staff had completed the training.
- We spoke with nursing and medical staff, who were able to describe the relevant consent and decision-making requirements in place relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Standards (DoLS) to protect patients. Patients' consent was obtained as per trust procedures.
- Staff were clear about their responsibilities in gaining consent from people, including those who lacked capacity to provide informed consent to care and treatment. Staff used Fraser guidelines and Gillick competency principles when assessing capacity and decision-making, and when obtaining consent from children. The 'Gillick Test' helps clinicians to identify children aged under 16 years who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the

risks and alternative courses of actions. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Are urgent and emergency services caring?

Good

We rated caring as 'good' because:

- The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.
- Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in decisions about their care and treatment.
- Patients were well informed about decisions about their care, treatment and conditions.

However:

- Due to the layout and size of the department privacy was difficult to maintain, especially as patients arrived by ambulance through the main waiting room.

Compassionate care

- We observed patients being treated with dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors were closed. However, privacy was difficult to maintain due to the size and layout of the department. As ambulances arrived they brought patients through the main waiting room unless they were seriously ill.
- We observed a number of interactions between staff, patients and relatives. Staff were always polite, respectful and professional in their approach.
- We observed staff responding compassionately to patients' pain, discomfort, and emotional distress in a timely and appropriate way.
- Confidentiality was respected in staff discussions with patients and those close to them.
- In the CQC's 2014 A&E survey, the trust scored about the same as other trusts for all of the 24 questions relating to caring. The question " Were you told how long you would have to wait to be examined?" had the lowest score (3.74) and the question "Did doctors or nurses talk to each other about you as if you weren't there?" had the highest score (9.16).
- In the CQC's 2015 A&E survey, the service scored 9 out of 10 for the question: "Were you treated with respect and dignity while you were in the A&E department?" and scored 7 out of 10 for the question: "If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?" Both scores were about same as for other trusts.
- In the CQC's 2015 A&E survey, the service scored 7 out of 10 for the question: "Were you given enough privacy when discussing your condition with the receptionist?" and scored 9 out of 10 for the question: "Were you given enough privacy when being examined or treated?" Both scores were about same as for other trusts.
- We spoke with seven patients and five carers. They were complimentary about the staff.
- The trust's Urgent and Emergency Care Friends and Family Test performance (% recommended) was generally better than the England average between September 2015 and August 2016. In latest period, September 2016, the trust scored 87.9%, compared to an England average of 85.7%. The trend for the percentage recommended at UHMB follows the England average.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology, and they were given literature about their condition when required.
- Most patients who used the service felt involved in planning their care, making choices and making informed decisions about their care and treatment.
- Staff generally communicated in a way that people could understand and was appropriate and respectful.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition and treatment options.
- We observed staff modifying their language, tone and pace of speech to communicate with patients and their relatives to help them understand their care and treatment.

Urgent and emergency services

- Patients and relatives told us they were generally kept informed of what was happening and understood which tests they were waiting for.
- We observed that patients were given a clear explanation at discharge and were advised about what to do if symptoms re-occurred.

Emotional support

- There was a room for relatives to use if needed. Access was available to a telephone, and drinks were available.
- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the Chaplaincy service and the bereavement service.
- The spiritual needs of patients were provided for by a 24-hour Chaplaincy support, which provided sacramental care in the trust chapel and at the bedside, and supported patients at the end of life.
- Staff showed an awareness of the emotional and mental health needs of patients, and were able to refer patients for specialist support if required.

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

Requires improvement

We rated responsive as 'requires improvement' because:

- The emergency department's performance had been deteriorating over the 12 months preceding our inspection. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached this standard between October 2015 and September 2016. Whilst there are multiple factors that impact upon patient flow, it was recognised that the most important factor was bed occupancy. Lack of beds in the hospital resulted in patients waiting longer in the emergency department. Bed occupancy levels were 115 -130% on each site. The aim was to achieve an 85% average occupancy.
- Between June 2015 and May 2016 the trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department to being handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. It reported 157 black breaches in July 2016. There was an upward trend in the monthly number of black breaches reports over the period.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average.
- Between August 2015 and July 2016 the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline. In July 2016, the trust's median time in A&E was 151 minutes versus the England average of 146 minutes.

However:

- During our inspection we did not witness long waits in the emergency department that impacted upon patient safety.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving its urgent and emergency care services before being seen for treatment was better than the England average for the entire period. The trust's performance followed a similar trend to the England average.
- Services were planned in conjunction with a number of other external providers, commissioners and local authorities, to meet the needs of local people.
- There was clear evidence of learning shared and improvements made as a result of listening to complaints and concerns.
- Between October 2015 and October 2016 the proportion of patients leaving before being seen was better than the England average of 3.3%. Between June 2015 and May 2016, the trust's unplanned re-attendance rate to the emergency department within seven days was generally worse than the national standard of 5% and generally better than the England average.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- Planning for service delivery was made in conjunction with a number of other external providers, commissioners and local authorities to meet the needs of local people. For example, the service worked with external partners, including general practices, in a programme named 'integrated care communities'. The aim was to proactively plan care for both frail and vulnerable patients and frequent attendees, to prevent unnecessary attendances to the emergency department. There were a number of schemes, supported by community paramedics and a telehealth project.
- During our visit the department was not overcrowded and there was a sufficient number of treatment rooms and cubicles available.
- Due to changing demands on emergency care services, the department was not large enough to meet the increasing patient numbers and to support new models of working. For example, there was no initial assessment area for patients who arrived by ambulance and there were no separated areas for patients with minor and major illness or injury; they were all nursed in the same part of the department.

Meeting people's individual needs

- Separate male, female and accessible toilets, and baby change facilities were available in the waiting room. The department was accessible for people with limited mobility and people who used a wheelchair.
- The reception area had a designated hearing loop.
- Within the waiting room there were plenty of seats, vending machines which sold hot and cold drinks and snacks, and a cold water machine.
- There was a separate waiting area for children, which had toys and books.This provided good segregation for children from the adults' waiting area.
- There were cubicles that were used for children with minor and major illness or injury. These had colourful pictures and distraction features such as a glitter ball.
- The IT system had a flagging system. This included identifying patients with dementia or a learning disability.
- Staff told us that, if they had a patient with a learning disability, they would encourage that patient's carer to stay with him/her to help alleviate any anxieties, and would try to see the patient as soon as possible. During the time of inspection we did not see a patient with a learning disability.
- There was not a specific 'dementia friendly' cubicle. Staff said they would nurse patients who had dementia in a cubicle near the nurses' station so that they could easily be observed, and staff would encourage the patients' carers to stay with them.
- We were told that the 'Butterfly Scheme' had been implemented. This scheme created discreet, at-a-glance identification, via the butterfly symbol, of patients who had dementia-related memory impairment and wished staff to be aware of that.
- All trolleys in the department were usable for patients with a weight up to 35 stones. A hoist, bariatric wheelchair and bed were available if needed within the rest of the hospital. We were told that the department was due to purchase new trolleys, including a bariatric trolley.
- A range of information leaflets was available for patients to help them manage their condition after discharge. However, leaflets were available in English only.
- Interpreting and translation services were available. These could be either face-to-face or by telephone.
- A private room was available for relatives and those accompanying acutely unwell patients, to discuss sensitive situations. Relatives could access a telephone. Hot and cold drinks were offered and available on request
- A mental health liaison team was based in the department from 8am to 8pm each day and provided assessment for patients with mental health problems. Out of these hours the community based crisis team was contactable. Nurses told us that patients often had to wait for a long time to be seen by the crisis team.
- There was no dedicated cubicle or room used solely for patients with mental health issues. Patients would be looked after in the cubicle opposite the nurses station, as this cubicle was most easily observed by staff. The nurses told us that they would remove any ligature points, including monitoring cables, in such circumstances.

Access and flow

Urgent and emergency services

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in A&E. The trust breached this standard between October 2015 and September 2016.
- The trust had been performing worse than the England average for all but three months of the preceding 12 month period. Prior to June 2016 the trust's performance followed the England average trend, from June 2016 the trust's performance showed a downward trend, whereas the England average showed a slight increase.
- Between August 2015 and July 2016 performance against this standard showed a trend of improvement. In July 2016 the median time to treatment was 55 minutes compared to the England average of 62 minutes. Trends showed that the time to treatment had been slowly increasing over the time period and was in line with the England average.
- Between August 2015 and July 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average for the entire period. The trust's performance followed a similar trend to the England average.
- A 'black breach' occurs when a patient waits over an hour from ambulance arrival at the emergency department to being handed over to the emergency department staff. Between August 2015 and July 2016 the trust reported 1210 black breaches. The trust reported 157 black breaches in July 2016. There was an upward trend in the monthly number of black breaches reported over the period.
- Between August 2015 and September 2016 the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted for this trust was worse than the England average. The trust's performance improved in May and June 2016 but then declined from July 2016 onwards.
- Between August 2015 and July 2016 the trust's monthly median total time in A&E for admitted patients was consistently similar to the England average. Performance against this metric showed a trend of decline. In July 2016, the trust's median time in A&E was 151 minutes versus the England average of 146 minutes.
- In the CQC's 2014 A&E survey the service scored eight out of 10 for the question: "Overall, how long did your visit to the A&E Department last?" This was about the same as other trusts.
- During the inspection we observed flow of patients and reviewed current information on waiting times. We observed the time patients waited in the waiting room. The longest that patients waited was 25 minutes.
- We observed ambulance handovers. There were no delays in ambulance handover times during our visit.
- The bed management team observed flow within the emergency department, and meetings took place at least four times a day (more frequently if needed) jointly with Royal Lancaster Infirmary to understand the bed situation and enable planning for expected admissions and discharges, ensuring patient flow throughout the hospital was timely.
- An escalation process and policy was in place, giving staff actions for managing the department during periods of extreme pressure. This would involve help from the wider hospital teams, including bed managers, matrons and service managers, improving the patient flow throughout the hospital, and specialist teams reviewing patients in the ED.
- Patients who were referred by their GP with a medical problem, went straight the acute medical unit for assessment, this reduced the number of patients attending ED.

Learning from complaints and concerns

- The department had a complaints response process that addressed both formal and informal complaints,including those which were raised via the Patient Advocacy and Liaison Service (PALS). Complaints were investigated by either the matron, the unit manager or the clinical lead and discussed, if appropriate, with the concerned patient/family as soon as possible after receipt, with the aim of rapid resolution of the problem. All complaints were answered fully with an assessment of root causes made.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.
- Between 27 October 2015 and 27 October 2016 there were 56 complaints about urgent and emergency care services. The trust took an average of 23.02 days to

investigate and close complaints; this is in line with their complaints policy that states that complaints will be addressed within within 35 working days of receipt, unless another timescale has been agreed with the complainant. There were 14 complaints about urgent and emergency care services at Furness General Hospital. The overriding theme was patients being unhappy with the care and treatment they received.

- Learning from complaints was discussed individually, displayed on a notice board in the staff area, and discussed in the clinical governance group meetings and departmental meetings.
- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with complained about the department.
- Within the waiting room there wase a number of notice boards. There was a 'you said we did' board. This contained information from patients who had complained regarding communication on waiting times.

Are urgent and emergency services well-led?

Good

We rated well-led in the emergency department as 'good' because:

- There was a clear statement of visions and values across the trust, driven by quality and safety. These mirrored the aims and objectives of the trust.
- Divisional managers expressed their overreaching vision to deliver a high quality and safe service.
- There were governance, risk management, and quality measurements and processes in place to enhance patient safety and outcomes.
- Staff and managers were clear about the challenges the department faced. They were able to clearly tell us about the risks posed to the department and how these were being addressed.
- The emergency department had a clear management structure at both divisional and departmental level. The leaders within the department were knowledgeable about quality issues and priorities; they understood the challenges faced and were taking action to address them.
- Staff described the culture within the service as open and transparent. Staff were able to raise concerns and felt listened to, and leaders were visible and approachable.

Vision and strategy for this service

- Senior staff spoke positively about the board's vision and strategy, 'Better Ccare Ttogether', which outlined new plans for delivering health care. The strategy aimed to reduce the number of patients needing to attend hospital by working collaboratively with GPs and local health and care providers to review how services were delivered.
- The vision and strategic goals for the division mirrored the aims and objectives of the trust, 'to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience by involving patients, staff and partners.'
- Divisional managers expressed their overreaching vision to deliver a high quality and safe service.
- The divisional strategy had short, medium and long-term projections. In the short to medium term, the division was keen to improve patient flow, through a number of options by working with partner organisations. In the medium to longer term the division wase working with the collaborative to develop and further the 'Better Care Together' agenda, aligned to the NHS Five Year Forward View.
- The division's ambitions, service priorities and principles of working for the coming year were incorporated in the trust's priorities for 2016//17 of strategy, engagement, quality and safety, partnership and performance.
- The majority of staff understood the vision and it was well presented around the trust, and staff were able to tell us about the trust's values.
- Staff were aware of the trust's values and felt that patient safety and quality care should be at the heart of everything they do; we heard this from staff at all levels.

Governance, risk management and quality measurement

Urgent and emergency services

- Urgent and emergency care was part of the medicine division. Each clinical division was headed by a clinical director, supported by a divisional general manager and an assistant chief nurse.
- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician-driven with multi-specialism input.
- The governance and assurance framework permeated all levels within the division and was well embedded throughout, despite the recent creation of the governance directorate.
- A governance system was in place and the agenda items of the emergency department's governance meetings included discussions of incidents and complaints.
- A monthly emergency department senior team meeting took place. Items discussed comprised performance data, staffing and training. These meetings reported into the divisional governance and assurance group, the divisional management board and the divisional performance meeting.
- Staff were clear about the challenges the department faced and they were committed to improving patients' journeys and experiences.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department. Seven risks were recorded on the department register at the time of our inspection. Each risk was graded in accordance with severity. These included nurse staffing and failure to triage in 15 minutes. The risks present on the register reflected the views of the staff we spoke to at all levels.
- There was a divisional risk register, on which seven risks scored 16 to 20. These included staffing, missed fractures and patients staying in the department for longer than four hours.
- When we spoke with the senior management team members were able to clearly tell us about the risks posed to the department and how these were being addressed. For example, those risks relating to the recruitment of nursing staffing and patient flow through the department to the rest of the hospital. There was consistency and alignment in what the division was concerned about and what appeared within the risk register. Senior managers were open and honest about those and about their plans to address perceived shortfalls in areas of concern.
- The division monitored risk register key performance indicators. Managers completed 90% of risk reviews on time, 79% of risks had ongoing or open actions and 98% of open actions had progress reported.
- The division wase actively working to address areas previously highlighted for improvement, and progress was monitored in the CQC action plan. The division also had a 'journey ahead' plan which brought together the organisation's objectives, divisional strategy, key priorities and governance framework.
- The department took part in RCEM audits and other locally agreed audits.
- The department had operational performance and quality dashboards .
- The department had a clear plan for internal audits in relation to continuously improving performance in key areas such as sepsis treatment and managing major trauma patients.
- The divisional dashboard was compiled monthly and reported key performance indicators, which were discussed at performance review meetings
- The matron's dashboard was used to measure and monitor quality and safety performance on a monthly basis, and was used as a basis for clinical governance meetings, with focus on continuous improvement of the service.

Leadership of service

- The management team had strengthened 'cross bay' working since our previous inspection, and learning from incidents, sharing best practice and cross-site working had improved.
- The division had a clear management structure defining lines of responsibility and accountability. The division was led by a clinical director, a divisional general manager and a chief nurse.
- The division had recently brought together medicine and acute medicine under one management structure cross-bay. A deputy chief nurse, deputy divisional general manager, six matrons, five service managers and a designated divisional governance lead further supported the divisional management structure.
- The emergency department had a clear management structure at both divisional and departmental level.
- The nursing team was established with experienced staff who provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear

lines of accountability. From our discussions with staff, we found that local leadership was strongand supportive, and staff felt they were listened to and felt valued.
- The medical team had responsibility for audits in the department.
- Staff were motivated and described a supportive, team-working environment.
- Staff commented that the matron was visible, and staff we spoke to said that their leaders were approachable and visible, and they felt confident that they could voice concerns openly and they would be listened to.
- During our interview with the leaders of this service they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service.

Culture within the service

- We found the culture of the department open and inclusive. The majority of staff that we spoke to felt that they were valued and respected by their peers and leaders.
- The majority of staff told us that FGH EDwas a good place to work. They felt supported in their work and there were opportunities to develop their skills and competencies, which were encouraged by senior staff.
- There was a desire from all staff we spoke with to provide effective care and treatment to patients.
- We observed staff working well together and there were positive working relationships with the multidisciplinary teams
- We observed staff being flexible and helping in the different parts of the department which were busy to provide a better and more responsive service for patients
- We asked staff at all levels about the morale of the department and they all said that morale was generally good and they worked as a team. There was a consensus that morale tended to be lower when the department was full and staff were under pressure.
- We saw evidence of how the service is working towards meeting the requirements related to Duty of Candour, and examples of where this had been carried out. Staff we spoke to felt that identifying when something went wrong could help them to improve patient safety, and that, when this did occur, individuals involved were well supported through reflection, supervision and training, and learning was shared.
- The department's meetings and notice boards highlighted improvements and changes made through learning from complaints and incidents, and also provided information to support the health and wellbeing of staff.
- Staff at all levels also told us that, although achieving targets was important, they were not afraid of breaching a target if it meant that the patient was safe and received the correct care, including admission to an appropriate speciality.

Public and staff engagement

- Patients and those close to them were given the opportunity to provide feedback through the friends and family survey.
- The trust had an initiative in which 'mystery customers' visited the departments and provided feedback on standards of care and service delivery.
- There was a quality board in the waiting room, which displayed information about the department's audits. This included ' you said we did,' giving examples of suggestions the public had made and what actions the department had taken as a result of those suggestions.
- Staff were encouraged to share experiences and comment on changes and ideas for improvement through the 'theme of the week' initiative. This allowed staff to say how they thought something might work better.
- We spoke to a patient flow coordinator. This was a new role being trialled to improve the flow of patients through the department, and enhance communication with the rest of the hospital. Thisrole was being trialled as a result of listening to staff.
- We saw evidence of staff receiving recognition for their contributions to the service, through internal annual awards ceremonies.
- The division provided staff with information, via WESEE, newsletters, internet updates and email, on trust developments, clinical issues, patient themes and staff recognition.
- In the NHS Staff Survey 2016, the trust performed worse than other organisations in the question 'staff experiencing harassment, bullying or abuse from other staff in the last 12 months' (29% compared to England average of 26%). Staff we spoke with did not report any incidents of this nature to us during the inspection.

Innovation, improvement and sustainability

Urgent and emergency services

- There was much improved cross-departmental working with Royal Lancaster Infirmary since our previous inspection, allowing the sharing of best practice, education and lessons learnt.
- There had been partnership working with the local prison, which allowed the medical team at the prison to speak to doctors in the department directly via video link, to avoid unnecessary transfer to the emergency department.
- We were told of partnership working with GPs in Millom, a rural community, some distance away from the hospital. They could video link and speak to doctors in the department to avoid unnecessary transfers to the hospital.

Medical care (including older people's care)

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

Information about the service

The medicine division ("the division") incorporated acute medical services, emergency care, elderly care and speciality medicine cross-bay with a combined management team. The division provided 330 inpatient beds. The division reported over 36,500 admissions into the service from April 2015 to March 2016, an increase of 2% from the previous year. These admissions can be broadly broken down into emergency admissions (56%), day case (43%) and elective (1%). Admissions for the top three medical specialisms were general medicine (19,206), gastroenterology (5,393) and medical oncology (3,606).

The division at FGH provided treatment for patients requiring cardiology, gastroenterology, general medicine, medical oncology, respiratory medicine and stroke care. There were 132 medical inpatient beds located across seven wards; Acute Medical Unit (AMU), Complex and Cardiac Care Unit (CCCU), Ward 6, Ward 7, Ward 9 and Oncology. The division also provided an ambulatory care unit, a clinical investigation unit, an endoscopy suite and specialist day case/rapid access services at the Croslands Centre.

During our inspection we spent time at FGH visiting all wards, the medical assessment unit, ambulatory care, endoscopy suite, clinical investigations unit and the Croslands centre. We spoke with 38 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed 13 reviews. Our team met with 10 patients and relatives, observed shift handovers, multi-disciplinary team meetings (MDT), safety huddles, meal times and care being delivered at various times of the day and night.

Medical care (including older people's care)

Summary of findings

The service had been inspected as part of our comprehensive visit in July 2015. Overall, medical care at FGH was then rated as 'requires improvement'. A number of areas for improvement were highlighted and the service was told to take action to:

- Ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patient;
- Ensure staff received appropriate support, training, supervision and appraisal to enable them to carry out the duties they are employed to perform;
- Ensure staff followed policies and procedures around managing medicines, including intravenous fluids; and
- Ensure there is a secure, accurate, complete and contemporaneous record for each patient, including food and fluid charts.

During this inspection we found the service had made significant improvements.

- There had been a reduction in patient harm related incidents, particularly around pressure ulcers and falls.
- Although there were still a number of nursing and medical staffing vacancies, the trust had robust systems in place to manage staffing shortfall and had extended its recruitment reach with the appointment of a number of international nurses.
- The service had improved compliance against mandatory training and appraisal targets. Local support and supervision of junior staff had improved and many areas had developed their own unit specific competencies for training and development purposes.
- Overall, medicines management and medicines record keeping was good, however, we identified that reconciliation was not always completed in a timely manner.
- There had been a marked improvement in record-keeping standards, however, we identified some ongoing areas for improvement around legibility and trigger levels for early warning of deterioration.
- The service had developed an action plan to address and progress areas for improvement highlighted in the 2015 inspection.

We rated medical care (including older people's care) as 'good' overall because:

- Staff understood their responsibilities to raise concerns and report incidents. The division had reported a reduction in patient harm related incidents. Senior staff managed nurse staffing shortfalls proactively and there were robust escalation processes in place to deal with nurse staffing concerns.
- Staff delivered evidence-based care and the division was actively involved in local and national audit. There were some positive patient outcomes recorded in heart failure, diabetes and myocardial infarction audits, and there was good evidence of collaborative and effective multi-disciplinary team working.
- The division was passionate about delivering quality, compassionate patient care, which permeated throughout all staff groups and at all levels. Staff cared for their patients' holistic needs and had no hesitation in 'going the extra mile' to make a difference for the benefit of patients and their families. Patients had individual care plans and felt safe. Patients were positive about the care they received and would recommend the service as a place to receive care.
- The division reported excellent referral to treatment time figures across all specialisms. The division was responding to the internal and external demands placed upon it by developing a number of services and care pathways to reduce unnecessary hospital admissions. There was a positive drive to engage with partner organisations to maintain and further services for the benefit of the population in the short, medium and long term. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.
- Managers led the service well. The divisional strategy reinforced with the trust vision and aligned with the on-going work with partner organisations. Staff felt a

Medical care (including older people's care)

real and palpable shift in divisional culture referring to a 'team' approach and an openness, which they described as putting them all "on the same page". New organisational governance structures had been encompassed within the division, and there was evidence to show how this supported divisional governance processes.

- There were many very good examples of improvement projects and innovative strategies, which brought about changes in clinical practice, work efficiencies, improved patient care and delivered organisational benefits.

However:

- Some medicines and record-keeping documentation standards required improvement, in particular, around legibility of written entries, adherence to best practice standards and a consistency in completing records, charts and other documents in full.
- There was vulnerability in registered nurse staffing and a disproportionate reliance on locum senior medical cover on the respiratory unit at FGH. The division actively recruited to vacant posts and was keen to convert locum positions into substantive appointments.
- The division had some static patient outcome measures in stroke and respiratory services at FGH. These findings were across a number of domains and were below national average benchmarks. The division had action plans in place to address areas for improvement.
- Seven day services were not fully embedded, and the division fell below national averages on a number of key metrics in the NHS Services, Seven Days a Week Four Priority Clinical Standards. The division was involved with the trust task group looking at seven day working across the organisation.
- A combination of factors including extended length of stay, increasing bed occupancy levels, and delays in obtaining suitable community care placements were causing access and flow difficulties at FGH. This had led to significant numbers of patient moves after 10pm and a number of medical outliers encroaching into other services. Divisional managers were working with partners looking at all variables affecting patient flow.
- To achieve the divisional strategic objectives, the service identified staff engagement as one of the key priorities. Clinical leaders recognised there was a risk of staff becoming fatigued and less resilient to the pressures of working demands in the current climate. Staff considered the division managers could do more in terms of recognition and support for their wellbeing.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- There was inconsistency in the completion of the multifactorial falls risk assessment compounded by the transition from paper records to the electronic patient record. Therapists coordinated such assessments and discussed these at daily board rounds and multi-disciplinary team meetings. Nursing staff however could not provide evidence in the electronic patient record to confirm the assessment had been completed in all cases.
- Medicines reconciliation across the unit was poor. Warfarin prescribing standards were variable and not fully compliant with regional standards. The division had implemented recommendations to address the detailed findings and planned further audit to review compliance against key indicators.
- Documentation audits identified some shortfalls in legibility, entries not including GMC/NMC numbers should there be a need to later refer back to the write and partial completion of medical clerking templates where fields ought to have been annotated. Trigger levels used to support escalation of care for a deteriorating patient were not adjusted for those patients with an elevated baseline or receiving oxygen therapy.
- The division had a considerable number of registered nurse vacancies across the wards at FGH. Despite escalation processes, support from ward managers and matrons working clinically and recruitment drives, a number of registered nurse shift gaps remained unfilled. Where all avenues were exhausted, wards had taken to backfilling shifts with care support workers and closing beds. This was reflected in shortfalls of planned and actual staffing, ratios, skill mix figures and fill rates.
- The division was reliant upon the goodwill of staff and locum use to cover the medical rota. Senior medical staffing in respiratory services was led by locum consultants and registrars, which would become more vulnerable and at risk if further depleted or locum support reduced.

However:

- Staff confidently reported incidents and had an awareness of the Duty of Candour regulations. There were no never events in the division and a low number of serious incidents.
- The division recorded safety thermometer data and displayed results on wards; there had been a reduction in patient harm incidents related to falls and pressure ulcers. The prevalence of catheter acquired urinary tract infections had also reduced over time.
- Staff were conversant with infection prevention and control guidelines. Staff used personal protective equipment appropriately, isolation nursing procedures were followed, and waste and sharps disposal was in accordance with trust policy. Ward cleanliness and hand hygiene audit findings were consistently good.
- Overall, medicines management and medicines record-keeping was good.
- The division was progressing from paper notes to the electronic patient record. Wards were at various stages of transition. Compliance with documentation standards was generally good.
- Staff responded to patient risk promptly, using a combination of clinical judgment, early warning trigger tools and treatment pathways. Audit compliance against key observation recording indicators was good.
- Nurse staffing requirements were calculated using a recognised acuity tool. The division also cross-referenced staffing ratios and qualified-to-unqualified skill mix. The division increased staffing levels in high dependency areas according to recognised multipliers. The division advertised nurse vacancies and was actively recruiting registered nurses from overseas. The division had clear escalation criteria for staffing concerns and, where managers considered patient safety was compromised, beds were closed.
- Medical staffing vacancies and rota gaps were covered by existing medical personnel in post with support from a number of locum appointments. Medical staffing out-of-hours and at weekends was appropriate for the unit at FGH,and junior grades felt supported by senior colleagues and consultants.

Incidents

- The division reported incidents through the trust electronic reporting system.

Medical care (including older people's care)

- The division graded incidents according to risk rating and severity of harm in accordance with the trust's policy on 'Reporting and Management of Incidents including Serious Incidents'.
- Such reported incidents were then categorised according to severity ranging from no harm, to low, moderate, sever, and fatal. Ward managers, matrons and the patient safety team reviewed submitted incidents and grading of harm. Managers reviewed all incidents graded moderate or above at the weekly patient safety summit (WPSS).
- Between September 2015 and August 2016 the division overall reported 2,952 incidents; a third of all incidents recorded by the trust. Of incidents recorded across the division, 1,911 (65%) were no harm, 927 (32%) were recorded as low harm, 52 (2%) were rated moderate and fewer than 1% were classed as severe. The division reported to fatal incidents.
- Ward managers, matrons and divisional leads all monitored incident trends and themes. The most common incident type within the moderate harm severity category related to slips, trips and falls accounting for 39% of all reported. Slips, trips and falls were also the highest contributor to the severe harm category accounting for 50% of all reported.
- We reviewed five incident investigation reports/root cause analysis (RCA) documents. We found the investigation reports to contain relevant history, detail surrounding the scope and level of investigation, timeline, findings and areas of good practice/concern. Investigators identified actions and evidence of lessons learnt.
- In accordance with the Serious Incident Framework 2015 medical care services at FGH reported two serious incidents (SIs) which met the reporting criteria, set by NHS England, between September 2015 and August 2016. One incident was reported as a 'medication incident meeting SI criteria' and the second incident was reported as a 'medical equipment/devices/ disposables incident meeting SI criteria'.
- Staff confidently reported incidents and provided examples of incidents they would report. These primarily focussed on patient safety matters such as falls, pressure ulcers, near misses and medication errors.
- Between September 2015 and August 2016 FGH reported no incidents which were classified as Never Events for medical care. Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event. (Strategic Executive Information System, STEIS).
- Staff we spoke with explained that they received feedback on incident outcomes by e-mail, at 1:1 sessions, at ward meetings and at safety huddles.
- Staff reported all Pressure Ulcers (PUs) irrespective of grade or classification. The tissue viability nurses (TVNs) received all reported PU incidents. The TVNs completed a further assessment of the incident and graded according to severity. The TVNs aimed to respond to all PUs classified as category two or above within 48 hours, however, it was not currently possible to meet this timeframe on all occasions due to the need to provide cross-bay cover, annual leave and workload generally. The TVNs worked with medical photography to obtain images, which they reviewed remotely when not on site.
- Staff we spoke to knew of the Duty of Candour (DoC) requirements and of the trust policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to those persons.
- Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- Staff discussed incidents where DoC applied with the WPSS team. The Patient Safety Team monitored the completion of the DoC requirements monthly.
- The division completed a quarterly audit of DoC completion, which it presented to the serious incident review and investigation panel, then onward to Quality Assurance Committee and the Board as part of the quarterly incident report.
- The division shared learning from incidents and when things went wrong at all levels. Management discussed outcomes at divisional meetings, and matrons and ward

managers shared learning and cascaded key information to their staff at ward meetings, safety huddles, by email, and through bulletins and newsletters.

- The division held monthly mortality review meetings. Staff considered data relating to all deaths in the preceding month and audited a number of cases (between April and June 2016, 64% of all medical deaths were audited by the group). The group discussed individual cases such as unexpected deaths, relevant factors and comorbidities, considered preventability and identified issues and actions to support learning. The group reviewed feedback from national enquiries (NCEPOD) to improve care and reinforce good practice. Staff shared learning from the mortality group at ward governance meetings, for example, cautions and indications in the use of antiplatelet medication, and early identification of the most appropriate care environment to avoid unnecessary hospitalisation.

Safety thermometer

- The division recorded safety thermometer information to monitor the prevalence of patient harms at the frontline, and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline was intended to focus attention on patient harms and their elimination.
- Data collection took place one day each month – a suggested date for data collection was given but a ward could change this. The trust was required to submit data within 10 days of the suggested data collection date.
- Data from the Patient Safety Thermometer showed that the division reported 36 pressure ulcers, 18 falls with harm and 17 catheter urinary tract infections (CUTIs) between September 2015 and September 2016. The prevalence rate of (PUs rose between August 2015 and March 2016, after which the rate started to fall. Both prevalence rates for falls and CUTIs saw a reduction over time.
- From August 2015 to August 2016, the proportion of patients who received harm free care averaged 92.6%, slightly worse than national figures for the same period (NHS Safety Thermometer).
- Senior nursing staff considered PUs and falls reduction to be a key priority.
- Between July and September 2016, the trust reported 326 PUs. Seventy-two (22%) of all recorded PUs during this period were hospital acquired. Compared to figures in the first quarter of 2016 (April – June), the trust had seen a 26.5% reduction in the number of hospital acquired PUs. During this period there were no category three or category four PUs recorded.
- Staff at FGH reported 13 hospital acquired PUs (18%) across all medical wards.
- Ward six reported two category two hospital acquired PUs in September 2016. Ward seven and ward nine reported none.
- The division monitored falls prevalence and classified falls according to harm. The National Audit of Inpatient Falls (NAIF) 2015 showed that the number of falls per 1000 patient occupied bed days (OBDs) was higher than national average (9.96 against 6.63) and, within the North West region, the trust reported the second highest prevalence. The trust reported falls with moderate or severe harm to be 0.17 per 1000 OBDs, lower than the national average of 0.19, and regionally rated 15 out of 20 trusts.
- The NAIF also collected data on whether patients had been assessed for all the risk factors and whether there had been appropriate interventions implemented to prevent falls. They reported compliance using a 'red/amber/green' (RAG) rating. At FGH, NAIF auditors found that all patients had access to their nurse call bells and the use of a mobility aid, however, they identified areas for improvement in relation to the assessment of delirium, blood pressure, medication, vision and continence factors.
- Between July and September 2016, the division reported 291 falls, a reduction on the previous quarter and a 13% reduction for the same period in 2015. Of those falls, 106 (36.4%) happened at FGH, the majority from ward 6 and ward 9. Records showed that 83% of the falls resulted in no harm, 16% were reported as low harm and 1% were moderate. There were no major or severe classified falls.
- Matrons remotely monitored clinical indicators and risk assessment completion across their unit on the electronic patient record (EPR). This showed when individual risk assessments were last completed, which staff member had completed them and when they were next due for assessment. Matrons attended units where risk assessments were incomplete, due or late, to ensure immediate completion. Matrons also attended ward meetings and safety huddles to discuss risk assessment

completion and compliance. Matrons were unable to confirm the completion of the multi-factorial risk assessment by remote review and confirmed this would necessitate a review of the full record.
- We found safety thermometer information displayed clearly and consistently in an accessible and readable format on large whiteboards situated at the entrance of all wards.

Cleanliness, infection control and hygiene

- The division followed the trust healthcare associated infection (HCAI) prevention and control strategy underpinned by national guidelines and IPC policies to manage and monitor infection, essential for patient and staff safety.
- All wards we visited were visibly clean and tidy.
- The division was involved in the trust wide QAAS (Quality Assurance Accreditation Scheme) to support in the measurement of quality and effectiveness of care. This included monitoring of ward cleanliness and infection prevention and control procedures such as hand-washing and compliance with cleaning schedules. Auditors rated wards according to compliance against national and best practice standards on a scale of good to inadequate. There were no wards at FGH rated inadequate. Where wards were rated 'requires improvement', auditors implemented action plans and revisited the following month to ensure full compliance.
- All clinical and non-clinical areas had specific cleaning rotas and all equipment checked was visibly clean. All clean utility areas and treatment rooms were visibly clean and tidy. We observed clinical waste and sharps been disposed of appropriately. Commodes had green stickers placed on them to indicate the time and date they had been cleaned. Staff told us the correct procedure for cleaning the commodes.
- Wards we visited displayed the number of and date of last case of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile). There had been no reported cases of c.difficile across the division between July and October 2016.
- The division supported the trust's agenda to ensure effective prevention and control of healthcare associated infections (HCAI) including CUTI's. Staff referred to infection prevention and control team (IPC) procedure and policy when providing care for patients with indwelling catheters.
- The trust monitored hand hygiene compliance during monthly audits. Overall, division compliance between May and October 2016 averaged 97.5% against the trust target of 96%. In September, all medical wards at FGH reported ward cleanliness and hand hygiene audit scores in excess of 95%.
- All staff completed an annual aseptic non-touch technique (ANTT) practical assessment and e-learning module. Managers reported that compliance across the division at FGH was in excess of 95%.
- The wards displayed clear instructions and signage to encourage staff and visitors to wash their hands on entering the ward. The signage was repeated throughout the ward environments and there were numerous washbasins for hand-washing. Wards provided wall-mounted gel and soap for ease of use. Each patient had personal bedside hand cleaning gel.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. Staff used PPE appropriately.
- We observed patients requiring isolation nursing being cared for in side rooms. Staff displayed appropriate signage advising staff and visitors not to enter without appropriate protective clothing. We observed staff using appropriate protection when entering the room and disposing of the same appropriately when they left.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "Bare below the Elbow" protocol.
- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required. Records showed that 93% of staff in the medical division at FGH had completed this training so far this year.
- The endoscopy suite had disinfection facilities on site.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the cleanliness category the trust scored worse than the national average (95% compared to 98%).

Environment and equipment

- The hospital opened in 1984, however, there had been considerable investment to improve internal facilities in a number of areas across the medical division at FGH, such as the Coniston Suite and CCCU.
- Where ward doors were not closed or secured by way of remote monitoring, staff greeted us and asked us to provide identification.

- All patients had designated bed space, which included a personal locker, table, call bell and access to gender-specific toileting and bathing facilities.
- The division was involved in the trust-wide QAAS (Quality Assurance Accreditation Scheme) to support in the measurement of quality and effectiveness of care. This included '15 steps' (an assessment of the environment from the patient's perspective), monitoring of the ward environment and equipment such as oxygen, suction and resuscitation equipment. Auditors rated wards according to compliance against national and best practice standards, on a scale of good to inadequate. There were no wards at FGH rated inadequate. Where wards were rated 'requires improvement' action plans were implemented and revisited the following month to ensure full compliance.
- We checked the resuscitation trolleys on all the wards we visited, and found that these contained correct stock. Staff checked the electrical equipment daily (defibrillator and portable suction/oxygen) and after use. Staff completed fuller weekly content checks of all stock including emergency drug expiry dates. We saw that each resuscitation trolley had a log attached to it for staff to complete. We found all checks completed accordingly. Trollies were fitted with tamper-proof tag.
- Staff told us that the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. We reviewed service and maintenance schedules provided by the medical engineering department, which were all current and in line with trust target capture rate for all devices. All equipment we checked had safety-testing stickers in date, which assured staff the equipment used was safe and fit for purpose. Staff confirmed that, where equipment had not been routinely checked, they ceased to use it until they received medical engineering department approval.
- The CCCU had undergone considerable change since the last inspection. The unit had moved site to provide more room for patients and new equipment. All patients had bedside monitors and the unit provided telemetry monitoring for up to nine patients on adjacent medical wards.
- The division provided weekday endoscopy services at FGH. The unit was not JAG accredited (Joint Advisory Group on GI Endoscopy providing formal recognition of competence to deliver services against recognised standards). In the preceding six months, the service had decommissioned a number of endoscopes due to equipment wear and tear. The unit had secured replacement endoscopic equipment with other endoscopes shared cross-bay with their JAG accredited units at Westmorland General Hospital (WGH) and Royal Lancaster Infirmary (RLI). Decontamination of endoscopic equipment was carried out on-site by central sterile services and equipment was returned to the unit in sealed vac-packed trolleys.
- Staff provided patients who were at risk of developing pressure sores with appropriate pressure relieving support surfaces, such as mattresses and cushions, in accordance with their assessed risk.
- Staff provided patients who were admitted into hospital with pressure sores, or who eveloped skin damage whilst in hospital, with higher specification mattresses. Staff obtained these through TVN or equipment stores. The TVN team had developed a PU equipment pathway to assist staff in identifying the most appropriate pressure relieving equipment for their patient, and how to access it.
- The TVN team purchased additional pressure relieving equipment to support patient comfort and skin integrity such as the 'Repose Wedge' (air filled wedged used as a pillow, for foot support or to aid positioning).
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the facilities category the trust scored worse than national average (90% compared to 93%).

Medicines

- Medicines on the divisional wards at FGH, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Staff managed controlled drugs appropriately and maintained accurate records in accordance with trust policy, including regular balance checks.
- Nursing staff were aware of local policy and professional standards for medicine management, and for the storage and administration of controlled drugs.
- Staff we spoke with knew how to report incidents involving medicines. There was an open culture in respect of incident reporting, and staff received support from ward managers to learn from incidents.
- We found medicines reconciliation was not always completed in a timely way. For example, we saw one patient on ward six who had been in hospital for nine

days, and another on ward seven who had been in hospital for six days, neither of whom had had their medicines reconciled by a member of the pharmacy team.

- Medicines requiring refrigeration were stored securely. The completion of daily fridge temperature checks to ensure the safety of the medicines was variable across the wards at FGH. On AMU, ward six and ward seven some fridge temperatures were reported outside the recommended guidelines, however, there was no evidence to confirm that action had been taken on these occasions. Staff informed us that, when a temperature reading was outside the upper or lower limit, they would immediately contact the pharmacy department for guidance about ongoing storage, and medical engineering to make any repairs.
- We reviewed 13 medication charts and overall documentation was good. Medical and nursing staff completed the charts legibly with the names of the prescribed medication clearly written,along with accompanying start and end dates where appropriate. On ward seven we noted three medication omissions where the reason for this was not clearly stated. All prescription charts had patient allergies recorded. Doctors prescribed antibiotics detailing the reason for the prescription, the duration and a review date specified in accordance with guidelines.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately.
- We observed, and were informed of, the processes involved for the safe handling, management and disposal of cytotoxic medications on the oncology day unit.
- In April 2016 the division completed an analysis of warfarin prescribing at FGH. The Regional Management Guidelines (2012) require 100% documentation completion of patient details, indications, relevant PMH, relevant medication history and target range. Additionally, they recommend that 100% of patients have INR testing performed every 5 days with doses adjusted accordingly. Audit findings at FGH varied with key documentation compliance ranging from 35% for medication history to 92% for fully completed patient details. INR monitoring was 100% compliant. However, recommended dose adjustments had not been always made. The audit recommended further guidance to junior medical staff, the devising of local trust warfarin documentation and prescribing guidelines, and the completion of a follow-up audit.
- The division completed a monthly QAAS documentation audit against 12 key standard indicators, which included a review of medication charts, legibility, patient demographics, allergy status and omissions. Between July and September 2016 auditors reported average compliance to be 90%. Auditors highlightedthat the legibility of some written entries required improvement.

Records

- The division was going through a transition from paper to electronic patient record (EPR). Wards were at various stages of implementation, with nurse documentation and medical records remaining in the written form.
- Where paper records were being used, staff stored these safely in portable locked cabinets or in staffed areas.
- We reviewed 13 sets of nursing and medical records. Overall, the records were up-to-date. However, it was not always clear, due to illegible written entries, whatwere the names and/or grades of the clinician/ nurse/other healthcare professional who had made the notes. Senior medical staff documented daily reviews along with a clear diagnosis and treatment plan. Staff recorded discussions, following MDT meetings, detailing on-going treatment, input from therapies, discharge plans and dialogue with families. This was consistently good across all wards.
- We found nursing records overall to be up-to-date with evidence of regular care reviews. We found appropriate risk assessments within care plans. Some nursing staff had not grasped the full functionality of the EPR in a way that would allow themto timely locate key documents for review.
- Nursing staff were complimentary about the new computerised care planning documentation and, in particular, the risk assessment bundle, which covered falls, nutrition, pressure ulcers and sepsis.
- Three sets of records (23% of those reviewed) were deficient to varying extents. Our review highlighted two particular themes: partially completed medical clerking documentation and inconsistency in the completion of a multi-factorial falls risk assessment.
- The division completed a monthly QAAS documentation audit against 12 key standard indicators such as legibility, demographics, care bundle and paper record

(fluid charts, observation charts, food charts and risk assessments) completion. Between July and September 2016 auditors reported variability in compliance against criteria. Legibility overall was very good (96%) and completion of care bundles was good (88%). However, a number of entries failed to include NMC numbers, showing poor compliance (40%). The main issue appeared to relate to the completion of the electronic patient record (EPR) which had recently been implemented in the division. There had been reported improvement, which ward managers and matrons considered to be due to staff becoming more familiar with the transition to the electronic platform.

- Many clinical areas had speciality-specific care bundles, for example, these were provided for patients on the respiratory ward with chronic obstructive pulmonary disorder (COPD), in accordance with best practice and British Thoracic Society (BTS) guidelines.

Safeguarding

- The trust had a designated lead for safeguarding, supported by a specialist team with responsibility for children.
- All staff we spoke with knew the trust safeguarding policy, how to access relevant information using the trust intranet, and where to seek guidance for any out-of-hours concerns.
- Staff used 'flags' or icons on the EPR to highlight adults who were vulnerable or who had particular needs.
- The trust set a mandatory target of 95% for completion of mandatory safeguarding adults and children (level 1 and level 2) training, and at July 2016 the trust completion rate was 91% for level 1 and 92% for level 2. Across the division at FGH level one training compliance averaged 95%; level two training varied on wards between 60% and 100%. All staff who were required to complete level three had met the trust's target.

Mandatory training

- Generic mandatory training modules covered eight core subjects, namely conflict resolution, equality and diversity, fire, health, safety and welfare, IPC, information governance, moving and handling, and resuscitation.
- The division adhered to the trust's mandatory training target of 95%. In July 2016, four of the eight core modules met or exceeded the division target with the remaining four ranging from 82% to 92% completion overall.
- Mandatory training figures at FGH varied considerably from ward to ward and from topic to topic.
- Ward six provided us with sight of mandatory training figures, which confirmed the unit to be up to date with all core modules with the exception of safeguarding adults (60%). The ward manager had arranged for all staff to attend future sessions to ensure compliance against the trust's target by the year end.
- Wards seven, nine, CCCU and AMU each reported mandatory training figures to average 90%, and basic life support training to be in line with the trust's target. Safeguarding mandatory training was reported at 70% complete.
- Ward managers also showed us mandatory training figures for their respective wards, which showed a slight variance from division figures. Generally, ward based capture of mandatory training was higher than reported.
- Ward managers kept an internal ward-level list of key mandatory training dates.
- Staff that we spoke with understood they were up to date with mandatory training requirements in the current year. Staff accessed some mandatory training modules via the trust's electronic learning system. This allowed staff to monitor training due dates when they logged onto the system.
- Ward managers confirmed that, where shortfalls in mandatory training occurred, staff were booked to attend the relevant session.

Assessing and responding to patient risk

- Staff used various tools to assess, monitor and respond to patient risk.
- All patients admitted into FGH had a standard risk assessment bundle completed. This included falls, pressure ulcer, nutrition, sepsis and VTE. Staff reviewed all risk assessments on at least a weekly basis or as patient circumstances dictated, such as changes in mobility or if infection developed.
- The division audited compliance of key risk assessment documentation under its monthly Quality Assurance

Accreditation Scheme (QAAS). The standard required all entries within the care bundle to be completed within four hours of admission. The division reported compliance at 97%.

- Of 13 records reviewed we found risk assessment completion in line with recognised quality standards in the majority of cases. We found that 92% of patient records reviewed had a full PU risk assessment completed within six hours of admission and 85% of patient records reviewed had a venous thromboembolism (VTE) assessment completed on admission with re-assessment within 24 hours. We also observed that, for all patients who required VTE treatment, staff prescribed the relevant prophylaxis. The division engaged with the newly set up Patient Safety Unit team to support its priority objectives in the coming year around VTE and sepsis management.
- Staff completed an initial falls risk assessment in 100% of patient records reviewed. Where the falls risk recommended the assessor complete a multifactorial falls risk assessment, staff were uncertain where this appeared in the EPR. It was not immediately clear during our review, even with direction from staff, when or if these assessments had taken place. Staff confirmed that, where patients were at risk of falling and a multifactorial falls risk assessment was required, this was generally coordinated by therapy services, discussed during board rounds, and discussed at multi-disciplinary team (MDT) meetings
- The division highlighted patient safety as a key concern within the trust and had increased resources to address particular areas of priority, such as falls reduction. A senior divisional nurse was leading on falls reduction across the trust. All wards had purchased new equipment such as low beds, falls monitors and crash mats. Ward-based staff had increased engagement with patients at risk, with greater family involvement where appropriate. Staff also used cohort nursing techniques and MDT approaches with support from therapists and others to assess and respond to risk.
- All patients had clinical observations (blood pressure, pulse, temperature, respirations) recorded at a frequency appropriate for their clinical need, which was altered from the four hourly benchmark in accordance with their presentation.
- Staff told us they previously used the Physiological Observation Track and Trigger System (POTTS) as an Early Warning Score (EWS) tool along with professional judgement as a trigger to escalate concerns. Staff confirmed they were moving away from POTTS onto the National Early Warning System (NEWS), in which six observational parameters are scored: respiratory rate; oxygen saturations; temperature; systolic blood pressure; pulse rate; and level of consciousness, to identify a variance from the norm.
- The trust monitored compliance in the use of POTTS as an early warning tool to aid in the identification of the deteriorating patient. Between April and July 2016 compliance across the medical division at FGH was better than trust target of 90% on all wards with the exception of April 2016 where ward 6 achieved only 88% compliance.
- In the 13 sets of records reviewed we found observations accurately recorded in accordance with the desired frequency. We did not see any varied trigger thresholds for those patients with a higher than norm baseline or for those on oxygen therapy.
- In the event of a patient deteriorating and requiring senior medical input, staff confirmed they could always get a consultant promptly in and out-of-hours. If a patient required level 2 or level 3 critical care (for example on an intensive care unit with full ventilator support), FGH had an intensive care unit (ICU).
- Where a patient was admitted due to concerns around sepsis, the division followed the trust sepsis screening tool (adapted from the Sepsis 6 tool) to screen and identify vital high risk factors within an hour. The sepsis care pathway flowchart provided guidance in treating severe sepsis, management plan documentation, critical care considerations and observation monitoring.
- At the time of our inspection, stroke patients were being thrombolysed in A&E and then transferred to CCCU for monitoring as opposed to the stroke unit due to nurse staffing levels.
- Other divisional wards had adapted their clinical areas to respond to patient risk.
- On CCCU staff described how easy it was to have a consultant review a patient of concern in a timely manner. Although not a designated level two unit, CCCU was staffed accordingly and provided care for patients with severe AKI, severe sepsis, thrombolysis or who required Bilevel Positive Airway Pressure (BIPAP).
- The division at FGH provided telemetry (a remote cardiac monitoring system) for up to nine patients on adjacent medical wards. At the time of our inspection only two of the nine telemetry units were functioning.

Staff on CCCU monitored the patient cardiac rhythm periodically and provided updates to the ward staff at each shift change. In addition, CCCU also provided a direct contact function (a voice-activated unit which allowed immediate contact with the ward nurse caring for the patient) for use in the event of an urgent query or emergency, for example, an unusual cardiac rhythm or if the telemetry unit failed. The division had developed a standard operating procedure for the use of the system, however, staff found the unit often picked up background noise interfering with verbal instructions. We observed this issue during our inspection. Where the voice-activated direct contact was ineffective CCCU staff used the ward telephone and attended the ward in person to check on the patient. The division monitored the effectiveness of the voice-activated unit and planned to roll out further training to improve its use.

- CCCU had close links with the cardiac transfer waiting list coordinator in Blackpool. Staff on CCCU used an on-line system (L-CISS) which detailed patients and provided clinical background information about those awaiting transfer for further cardiac care (PCI/surgical intervention) which was not available within the trust. Staff were aware of the retrieval process for stable and unstable patients.
- The division provided a number of cardiac services at its Cardiac Centre based at Westmorland General Hospital in Kendal. This allowed in-patients requiring cardiac interventions, such as cardioversions, pacemakers, angiograms, loop recorders, box changes, transoesophageal echocardiogram, dobutamine stress echocardiogram and adenosine challenges, to have these interventions completed safely during the current period of hospitalisation, thus avoiding transfer, maintaining care continuity and reducing risk.
- Staff provided patients who were discharged from AMU requiring repeat tests or early follow up with priority discharge summaries, copied to all relevant personnel involved in care, such as GPs, district nurses, pharmacies, and therapists, and copies were included in the patient record. Additionally, the AMU administrator maintained a running spreadsheet for all of those patients to ensure that o patient "slipped through the net" in often tight timescales, and to ensure that all test completion was within the timeframe requested by the AMU consultants.
- In dealing with risks posed by a patient who was aggressive, staff had access to a security firm to support them in providing 1:1 observation, if they were unable to use additional staff. Whilst staff recognised that this was not an ideal option, it was helpful for responding to the risk quickly, and for ensuring the safety of the patient, others on the ward and staff.

Nursing staffing

- Division managers confirmed the service had used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. The funded staffing establishments for all the general medical wards were based on "red rules", which they confirmed to be a minimum of a 60:40 qualified:unqualified split and a minimum of 1:8 registered nurse:patient ratio. Managers confirmed that, in higher dependency areas, multipliers were used to vary nursing establishment figures aligned to acuity and dependency measurement, for example, in CCCU.
- Senior nursing staff also informed us that they used their own internal professional judgment along with safe nursing indicators to reinforce SNCT findings and determine staffing numbers/skill mix as an ongoing concern.
- The management team had identified nurse staffing as an issue within the medical division and this appeared on the services risk register. Staff on all wards we visited (with the exception of CCCU) confirmed that there were vacancies.
- The trust provided us with data detailing qualified nurse and unqualified staffing vacancies across the medical division at FGH. Between April and July 2016, the number of whole time equivalent (WTE) registered nurse vacancies increased from 12.9 to 26.3. Wards six, seven and nine showed the greatest number of vacancies. Actual unqualified nursing staff in post exceeded planned by 20 WTE. The divisional quarterly performance review dated July 2016 reported 85 WTE registered nurse vacancies across the whole division (inclusive of emergency medicine,) with further shortfall due to sickness and maternity leave.
- Trust-wide registered nurse vacancy rates were reported at 4.1%. The division registered nurse vacancy rate at FGH varied from ward to ward, however, overall it was in excess of 5%. Turnover rates in the division were 9.2% and sickness rates were 4.6%.
- Managers acknowledged that existing staff worked significant additional hours to support the unit, which in

the medium- to long-term would have a negative impact on health and wellbeing. Managers had reduced bed capacity at FGH, with the closure of 12 across the wards, to maintain safe staffing.

- Ward six was a 36-bedded stroke unit. Due to the nurse staffing deficit on the unit of 16 registered nurse vacancies, managers closed nine of the 36 beds. Staff used the closed bay to provide additional therapy services on the unit. Review of historic nurse rotas back to July 2016 showed a significant number of gaps. We found one week, in July 2016, during which there were over 60 registered nurse shifts available (a shift comprising an early day, a late day or a night shift). The ward was only able to cover one third of the registered nurse rota gaps, however, managers increased the unregistered nurse complement to support the unit. The number of deficient shifts improved into August and September, however, the unit continued to have difficulty filling registered nurse rota gaps. Registered nurse fill rates in September averaged 57% during the day and 70% during the night, with average care support worker figures being 109% and 150% respectively. On the day of the inspection, the ward was short against establishment of one registered nurse shift providing ratio of 1:5 on the early shift (skill mix 45:55), 1:7 in the afternoon (skill mix 40:60), and 1:7 overnight (skill mix 50:50).
- Ward seven was a 36-bedded respiratory and rheumatology unit. Managers had closed six beds due to inadequate staffing, however, at times of high demand, three of those beds were reopened. Registered nurse staffing ratios on the day of inspection were 1:5 on the early shift (skill mix 60:40), 1:6 in the afternoon (skill mix 70:30), and 1:11 overnight (skill mix 50:50). The historic nurse rotas from July to October 2016 showed registered nurse staffing below planned figures on approximately 20 shifts each week. September fill rates showed registered nurses at 76% during the day and 100% overnight. Care support worker numbers were in excess of establishment at 111% and 143%, day and night respectively. The unit had nine registered nurse vacancies and the ward was under establishment for registered nurses on the day of the inspection. The ward manager planned to employ four overseas nurses and was involved in the upcoming cohort interview process. The ward manager had appointed additional care support workers and managers considered reducing bed numbers further until the newly appointed registered nurses started.
- Ward nine (a 22-bedded gastroenterology/cardiology unit) and the Coniston suite (an 11-bedded haematology/oncology unit), reported 1.4 registered nurse vacancies at the time of our inspection, recently improved by a number of new appointments. Historical nurse rotas showed significant deficits in registered nurse numbers. One week in July and August, over 30 registered nurse shifts were unfilled. The ward was staffed in accordance with establishment at the time of our inspection with ratios of 1:6 during the day (skill mix 60:40) and 1:11 (skill mix 60:40) overnight. We viewed improved staffing figures following recent appointments which correlated with September fill rates showing 89% registered nurse fill during the day and 100% overnight, supported by increased care support worker establishment of 144% and 93%, day and night respectively. The ward also planned to appoint three new qualified nurses to further enhance staffing figures.
- The CCCU (an eight-bedded complex and cardiac care unit) had a full complement of nursing staff, however, the ward manager confirmed staffing numbers did still vary to address patient acuity. The rota was established to provide minimum cover at a ratio of 1:2 registered nurse:patients. There was always a senior nurse on duty and a care support worker to support. This coincided with registered nurse fill rates, reported in September 2016 at 99%.
- On AMU the ward manager reported nurse staffing to be good with only one registered nurse vacancy. The unit was one registered nurse short during the evening of our inspection, however, all other planned nurse staffing levels were met. The nurse rotas from August to October showed actual registered nurse staffing met planned in over 90% of shifts in line with September fill rates of 83% during the day and 100% overnight. The unit was supported by care support workers at 131% and 193%, day and night respectively. Where some shifts remained deficient, the ward manager explained these tended to be filled by care support workers. The ward manager monitored staffing skill mix and planned to have band 6 or band 7 nurses on all shifts, however, this was less achievable on the night rota.

- Oncology Day Unit reported two nurse vacancies, however, the ward manager confirmed there were usually no difficulties in filling vacant posts. Staffing at time of inspection was in line with establishment.
- Overall, ward managers confirmed they had difficulty in filling registered nurse shifts, which they put down to a lack of nurses generally, and the geographical location of the trust. Managers relied on the goodwill of their own nurses to work additional hours and be flexible in their working patterns. Ward managers confirmed their supervisory and management shifts were often converted into clinical shifts to support staffing levels.
- Where existing staff could not cover shifts, nurse managers liaised with matrons to secure staff from the nurse bank and external agencies. Ward managers confirmed even accessing external resource did not ensure all registered nurse shifts were filled. Where registered nurses could not be obtained, ward managers requested care support workers to assist the unit. Additionally, the matrons and some specialist nurses worked on the wards during periods of increased activity.
- The division had appointed a number of international nurses and there was an ongoing recruitment campaign to bring registered nurses to the trust from overseas. The division was up-skilling a number of clinical support workers.
- Ward managers closed beds where staffing levels compromised patient care.
- The trust provided us with data on the use of bank and agency nursing staff between July 2015 and March 2016. The use of agency nurses at FGH varied across the division wards. There was a decreasing reliance upon bank and agency staff. However wards six, seven and nine reported agency use every month ranging from 6% to 26%
- Despite nurse staffing shortfalls, we obtained consistent evidence from all wards to confirm that there was a process in place for managing staffing levels, and should there be a need to escalate due to a change in patient need. All staff confirmed patients were safe and not at risk.
- Ward staff acknowledged the vulnerability of nurse staffing with one ward manager describing the situation as a "finely stacked deck of cards".
- The nursing handover took place at shift change and was very thorough. The handover was timely, efficient and comprised a review of each individual patient followed by discussion of any overall safety issues or other matters of concern.

Medical staffing

- In July 2016 the medical staffing skill mix showed the proportion of consultant staff to be in line with England average and the proportion of junior (foundation year 1 and 2) doctors to be higher that England average. Consultant staff made up 38% of the medical staff group, registrar grades made up 23%, middle grades were 9% and junior grades equated to 30%.
- The division provided information on out-of-hours medical cover at FGH.
- The division provided one Consultant on call 24 hours from 8am and on site for up to 12 hours during weekdays. Cover at weekends varied. The on-call arrangements included one registrar grade, one middle grade and one junior grade (foundation year – FY1/2) doctor on call on site from 09:00 to 21:30, and then the same covering the night shift hours.
- Shift patterns across the divisional wards at FGH for ward cover varied from ward to ward. There was always a senior doctor covering the medical wards (at specialist trainee level three or equivalent) on site with up-to-date advanced life support competencies.
- Ward six staff confirmed that there was always a minimum of one consultant on the ward all day during weekdays with out-of-hours cover being provided by two FY1, one FY2 and a specialist registrar. The unit managers confirmed that they were currently interviewing for a specialist registrar (SpR).
- Ward seven confirmed a minimum of one consultant on ward for the morning or afternoon during weekdays. The unit had two permanent rheumatology consultants in post, two registrars, one middle grade and one foundation year doctor. In respiratory, however, the two consultants and two registrars in post were locums. A middle grade, two junior grades and two advanced nurse practitioners (ANPs) supported the remainder of the team. Managers acknowledged the extent of senior locum cover in respiratory at FGH and were actively looking to recruit to substantive posts.

- Ward nine confirmed there was always a minimum of one consultant on ward for the morning or afternoon during weekdays. In the evening, after 9pm, the unit was covered by a registrar and a middle grade doctor on site, with the consultant on call from home.
- On CCCU consultants provided seven-day cover and were supported by registrars, middle grade and foundation year doctors. The consultant of the week ("COW") rota also supported the unit.
- The FGH AMU was a 19-bedded unit, which took patients referred from general practitioners, clinics and A&E. The unit had at least two consultants on duty during the day, who completed twice-daily ward rounds, supported by two middle grade doctors. Junior doctor positions were only recently established. Out-of-hours and weekend cover was provided by the acute on-call team, however, daily consultant-led ward rounds took place at the weekend.
- There was a consultant trained in general internal medicine or acute internal medicine on call at all times for AMU at FGH. Additional consultant support could be called upon and consultants were able to attend the unit within 30 minutes.
- In July 2016 the trust reported a vacancy rate of 4.6% in Consultant Medical Staff. The trust reported that a major recruitment programme was underway to address the gaps in Consultant Medical Staff.
- The service had recently appointed two haematology consultants (expected to be in post in January 2017) and an associate specialist in respiratory medicine, and planned interviews for positions in endocrinology and cardiology.
- During April 2015 to June 2016 the division reported increasing locum costs across senior medical grades. The division aimed to reduce these costs across the second half of 2016-17 with new substantive appointments. Acute medicine reported average monthly agency and locum use between July 2015 and March 2016 of 39%, in elderly care this was 29% and in gastroenterology 24%. Junior grade locum positions were reported as lower, at 7%.
- Sickness rates for all medical grades across the division at FGH were below the trust average of 4.5%, however, turnover rate figures were reported to be significantly higher (the data was considerably skewed due to relatively low numbers being considered).
- Medical handovers at shift changes were comprehensive with detailed and relevant information shared. Medical handovers ran succinctly and timely prior to post-take ward rounds. Although invited to attend, senior nurses did so intermittently due to pressures and workload on their respective wards.
- The trust performed within expectations for all questions on the 2015 General Medical Council (GMC) National Training Survey.

Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken, and key contact information to assist staff in dealing with a major incident.
- Staff we spoke with knew how to access the major incident policies for guidance.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust.

Are medical care services effective?

Good

We rated effective as 'good' because:

- The service was actively involved in local and national audit activity and followed recognised guidance, which provided a strong evidence base for care and treatment. Staff reflected on audit outcomes and there was evidence of action plan development and changes in practice.
- There were very good patient outcomes recorded in the heart failure audit and some good outcomes noted in diabetes and myocardial infarction audit findings, showing improvements from the previous audit window.
- Staff confirmed internal and ward-based learning opportunities were good. The Tissue Viability Nurses had driven forward an educational programme to reignite awareness of pressure area care to support harm reduction and improve preventative treatments.
- Staff had an awareness and understanding of the importance of considering consent, capacity and safeguarding issues in delivering healthcare under the Mental Capacity Act ("MCA").
- We found very good multi-disciplinary working (MDT) working across the division. Medical and nursing

handovers were thorough, timely and considered key clinical, nursing and risk elements. There was a real strength of working relationships between nurses and therapists. The division had developed a seven-day ambulatory care service.

However:

- Improvements in patient outcomes in some national audits were static. These tended to focus around key performance indicators in stroke and respiratory services. The division implemented action plans to improve in areas highlighted by audit findings.
- The quality of food to support patient's nutritional status was variable. Patients were unenthusiastic and unhappy with food presentation, temperature and timings. These comments were supported by findings from the CQC In-Patient Survey 2015 and the Patient Led Assessment of the Care Environment (PLACE) 2016 survey where food was rated worse than the national average.
- The division had not fully embedded seven-day working. Benchmarking against the NHS Services, Seven Days a Week Four Priority Clinical Standards was variable, and overall it fell below national averages on a number of key metrics. The division was involved with the trust task group looking at seven day working across the organisation.
- There was some frustration amongst staff about the efficiency and workability of the trust referral process, and uncertainty about the most suitable pathway for patients when a safeguarding application had been rejected.

Evidence-based care and treatment

- Staff referred to a number National Institute for Health and Care Excellence (NICE) Guidelines/Quality Standards, Royal College, Society and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site, reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet and all were current, identified the author/ owner and had review dates.
- The division was actively involved in local and national audit programmes, collating evidence to monitor and improve care and treatment. The division compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and ongoing evidence-based reviews.
- In accordance with NICE Quality Standards, the division was involved in data collection activity for numerous national audit, such as chronic obstructive pulmonary disease (COPD), cardiac rhythm management (CRM), cardiac arrest, Parkinson's, pneumonia, heart failure, diabetes, acute coronary syndromes, falls and fragility fracture audit programme (including hip fractures) and gastrointestinal bleeding.
- The division had developed a number of evidence-based, condition-specific care pathways to standardise and improve patient care and service flow. In ambulatory care, for example, there were pathways for low risk pulmonary embolism and low risk upper gastrointestinal (GI) haemorrhage.
- The division had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. For example, in respiratory care staff were re-educated on the content of the trust antibiotic policy for the first-line management of respiratory infections. In stroke services action plans were in place to improve timeliness and reduce delays in accessing CT scanning. There were also a number of action plans for cardiology services.
- In December 2015 the division completed an audit of acute kidney injury (AKI) care looking at prevention, detection and management in accordance with NICE Clinical Guidance. The cross-bay study retrospectively sampled 38 case notes, and reported areas of good practice and recommendations for improvement. The auditors highlighted good practice in identification of risk, monitoring of creatinine, AKI treatment plans and recording of urine output. The auditors identified the need for a more timely referral to nephrologist and to scanning when criteria met. In the sample considered, the auditors noted a high mortality rate and high readmission rate. The trust devised an AKI action plan to progress and implement an AKI care bundle, to update AKI training and to improve nephrology referrals.
- The division had adapted guidance for sepsis screening and management.
- All endoscopic procedures were carried out in accordance with recognised best practice and professional guidelines.

- The division had a designated audit lead and was active in the trust clinical audit and effectiveness steering group. We reviewed the clinical audit progress report for the period April 2015 to March 2016, which showed the division was on schedule to complete, or had completed all audit requirements. There were no delays or causes for concern which required measures to be put in place to get back on track.

Pain relief

- We found all patients had access to prescribed analgesia. We found analgesia prescribed both on a regular basis and on an as required basis.
- Staff considered the use of analgesia alongside the patient's clinical condition and particular need.
- Staff informed us that they monitored pain and assessed effectiveness of pain relief using a number of techniques,such as direct questioning, by observation, anticipatory ahead of procedures and with reference to observations and pain assessment tools, such as a severity scores from '1-10'.
- Patients confirmed staff recognised when they were distressed or uncomfortable, and responded to their requests for pain relief in a timely manner.
- The trust had a number of pain management policies, such as use of sedation, pain management on fractured neck of femur cases, and in endoscopy.
- Staff on the oncology day unit spent time with patients to understand how they were managing symptoms in order to provide optimal care.
- The FGH endoscopy survey published in August 2016 confirmed 12% of patients found the procedure more painful than expected.

Nutrition and hydration

- The division recognised the importance of good nutrition, hydration and enjoyable meal times as an essential part of patient care.
- The division monitored nutritional documentation compliance by auditing nutritional screening, risk assessments and care plans. In April 2016 compliance scores averaged 73%. Matrons used audit findings to re-inform staff about the importance of nutritional assessment for all patients.
- Of 13 records reviewed during inspection, we observed all patients had a malnutrition universal screening tool (MUST) risk assessment (equating to 100% compliance). Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us they accessed support from dietetics and the speech and language therapy service (SALT) for those patients who required additional input to maintain their nutritional status.
- We observed nutrition and hydration information recorded on fluid and food charts, which were kept by the patient bedside and summarised periodic intake during the course of the day. Overall, the completion and accuracy of these charts was good.
- The medical division engaged with trust monitoring of nutritional standards against various national stakeholder benchmarks, such as the nutritional alliance, the diabetic association, Public Health England and Department of Environment, Food and Rural Affairs (DEFRA). The trust rated performance against these standards as 'green'.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- Staff used visual signage on the patient name board, alert symbols on the e-whiteboard and identifiers on jugs/glasses/trays to highlight patients who required assistance with eating and drinking.
- We received variable comments from patients regarding food quality and menu choice. Of the 10 patients we spoke to, six confirmed the food choice and quality to be "acceptable", however, four felt presentation, temperature and timeliness of meals was poor. There were various menu options for individual dietary requirement, such as halal and vegetarian foods.
- We observed staff of all levels (doctors, ward managers, staff nurses, care support workers, therapists, volunteers, and support staff) and family membersassisting patients with eating and drinking. This included the process of feeding, supporting with drinks, offering snacks during the course of the day, providing distraction therapy, opening packets, and ensuring all personal items were in reach. Where encouragement was required this was given in a supportive way and at a relaxed pace. Staff updated care plans when a patient refused to eat.

- Staff provided snacks (sweet and savoury options) in between meals for those patients who preferred lighter options during the course of the day.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the food category, the trust scored worse than national average (84% compared to 88%).

Patient outcomes

- Furness General Hospital took part in the quarterly Sentinel Stroke National Audit Programme (SSNAP). On a scale of A-E, where A is best, the trust achieved grade D in the most recent audit, which covered April 2016 to June 2016. Furness General Hospital overall scores had remained static for the preceding three quarters. The patient- and team-centred performance domains improved in scanning, occupational therapy and physiotherapy, however, there were reduced scores in the stroke unit and discharge processes domains.
- The divisional stroke team had developed an action plan to review and progress improvements in stroke services following the recent SSNAP outcomes report. At FGH, the nurse specialists had improved relationships with the scanning department and stroke patients were, at the time of our inspection, given priority status for scanning investigations. The team had cascaded training to A&E staff to improve early identification of stroke patients who would benefit from prompt access onto the stroke pathway. The service had extended the role of the advanced nurse practitioner to sign CT requests therefore progressing scanning investigations more efficiently. Staff worked closely with therapy colleagues to improve referral pathways and therapy activity with speech and language, physiotherapy and occupational therapy. Staff at FGH have introduced a 'mini' audit meeting to improve documentation in stroke services. The stroke team worked closely with network colleagues to share best practice and to improve patient outcomes across the region.
- Ward six displayed stroke data on a designated board on the unit. The board detailed findings from the SSNAP annual report and contrasted trust achievements, benchmarked against national average ratings, such as time to scan, average time to see consultant, access the therapy services within 72 hours and time to see specialist stroke nurse.
- FGH's results in the 2015 Heart Failure Audit were better than the England and Wales average for three of the four of the standards relating to in-hospital care and six of the total seven standards. Received echo and received discharge planning both scored particularly well at 100%. Cardiology inpatient scored low at 36.2% versus the England and Wales average of 48.1%.
- FGH took part in the 2013/14 MINAP audit and scored better than the England average for one out of the three metrics. This metric was 'nSTEMI patients who were referred for or had angiography (including after discharge)'. The metric 'nSTEMI patients seen by a cardiologist' scored particularly low compared to the England average. However, there was improvement in all three metrics compared to 2012/13 site level results.
- FGH took part in the 2015 National Diabetes Inpatient Audit (NaDIA). They scored better than the England average in 11 metrics and worse than the England average in six metrics. The metrics relating to foot risk assessment scored particularly low.
- In the National COPD Audit Programme 2014 FGH scored a total of 24 points across the five domains (less than the national median score of 33). The respiratory service received full recognition for non-invasive ventilation services and scored well in managing respiratory failure/oxygen therapy. However, poor scoring was recorded against senior review on admission, access to specialist care and integrated care. The service also received a red-flag alert defined as a unit without an ICU outreach service for critically ill cases requiring ICU management.
- The division reported findings following the British Thoracic Society Emergency Oxygen Audit 2015. The summary showed 46% of patients at FGH had oxygen prescribed with target range against national average of 57.5%. The audit found 24% of patients were maintained within target range (compared to 63.5% nationally) and 41% greater than 2% from target range (compared to 9% nationally). There were excellent compliance results in the monitoring of oxygen saturations of 122% against national average of 102%. The division developed systemic and ward based action plans for areas of improvement covering training, modifying prescription charts, updating oxygen policy and implementing regular internal audit. These actions were ongoing at the time of the inspection.
- The division participated in the 2015 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 16.8%, which was worse than the audit minimum standard of 90%. The 2014 figure was

23.8%.The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 3.9%; this is significantly worse than the national level. The 2014 figure was 32.4%.The proportion of fit patients with advanced Non-Small Cell Lung Cancer (NSCLC) receiving chemotherapy was 62.0%; this is not significantly different from the national level. The 2014 figure was 89.5%. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 90.9%; this is not significantly different from the national level. The 2014 figure was 100.0%. Case ascertainment was 136% which was higher than the national aspirational standard of 95%.The division was involved in collating data for the Cancer Patient Experience Survey 2015. The trust was in the top 20% of NHS trusts for seven of the 50 questions and in the middle 60% for 43 questions. The trust received no responses in the bottom 20% of NHS trusts.

- The division was involved in the trust-wide sepsis working group agenda to promote improvements in the identification and management of sepsis. The audit considered sepsis screening (emergency patients), antibiotic prescription within an hour and a 72 hour antibiotic review. The audit compared baseline figures recorded in 2015. In quarter two of 2016/17, the division reported increased compliance against all indicators ranging from 75% to 100%.

Competent staff

- All staff employed by the trust and working in the division were required to meet their continual professional development obligations.
- The division provided a number of electronic on-line courses and specialist courses in-house for staff to attend. The division also had strong links with network colleagues, higher education establishments, medical schools and universities.
- All newly qualified staff employed by the trust and working in the division were subject to a period of preceptorship and supervision, which varied in length according to the area of work, and subject to competency sign-off.
- Ward managers discussed formal learning and training needs with individual staff members at 1:1 sessions and during appraisal. Informally staff identified their own areas of interest and proposed study for consideration at a local level.
- Junior medical staff maintained close links with the Deanery as part of their clinical placements and post rotations. The junior medical staff stated that the division was extremely supportive with their learning, training and developmental needs. They added that the clinical exposure they received fully underpinned the classroom and clinical skills training.
- Senior nursing staff were recently supported by the division to access higher education, leadership and management courses.
- Staff received formal engagement sessions with their ward supervisor or academic lead. These took the format of 1:1 meetings, clinical supervision sessions, attachment to specialist practitioners, mentoring and observation, reflective practice and revalidation.
- A number of specialist areas had developed their own competencies aligned to national guidelines, training programmes and recognised best practice. In CCCU, for example, new staff followed critical care competencies in view of the complex nature of the patients cared for. In oncology staff were required to meet key performance indicators prior to dealing with chemotherapy. These competencies were monitored over a period with the designated preceptor and signed up when competency had been achieved.
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
- Appraisal rates reported in the quarterly performance review dated July 2016 showed the division to be below the trust's end of year target of 95% across all staff grades. There was an improving and upward trend in appraisal completion across the period April to June 2016, with overall completion being in the region of 80%.
- Junior nursing and medical staff were supported by their senior colleagues who they described as approachable and willing to share. Many junior staff were involved in audit and in improvement projects, and were invited to attend senior staff meetings.
- The directorate provided an on-line clinical guidelines resource accessed by all grades of staff, which gave information/guidance/information/flowcharts/ treatment protocols on various clinical conditions such as sepsis management.
- Sepsis training was monitored locally and overseen by the divisional governance and assurance group (DGAG).

- The trust TVN's were visible in the division and provided comprehensive training packages for staff. TVNs advertised training dates on the intranet, on bulletin boards and via newsletters circulated to wards. The TVNs set up a link nurse champion group and ran various courses, such as categorisation and wound management. The TVN team also ran an annual event – STOP Pressure Ulcer Day -- every November. The TVNs also took opportunities to provide bedside teaching to patients, families and junior staff members when attending wards to review patients.
- Where staff were having performance difficulties at work, ward managers discussed actions that could be put in place to support them at ward level or wider support that could be offered by divisional managers and human resources.
- Ward staff completed induction checklists with agency staff and ensured they were familiar with ward protocols before delivering any patient care.

Multidisciplinary working

- We observed formal and structured multidisciplinary team meetings (MDT) throughout our visit. These meetings considered patient assessment, discharge planning and care delivery in hospital.
- We observed physical therapies being provided by the MDT on the stroke unit, in Croslands and at the Dunmail Centre, where facilities were suitable for multi-agency coordinated interventions.
- We also observed informal discussions between professional colleagues at safety huddles and ward meetings.
- Formal documented input from the MDT collective was not always noted in the medical records within 14 hours, nor was a management plan always in place within 24 hours of admission, which was not in accordance with national standards. There was, however, evidence of MDT input in care and treatment planning, albeit fragmented at this early stage, in all 13 sets of records reviewed. All records reviewed had formal documented MDT screening within 48 hours from admission.
- MDT working on all wards was good and involved multiple services such as doctors, nurses, therapists, pharmacists, social workers, discharge co-ordinators, patients and their family members. Medical records recorded MDT involvement with a detailed record of discussions, plans for ongoing care and discharge arrangements.
- There were clear internal referral pathways to therapy and psychiatric services. Many wards had developed strong links with community colleagues when implementing discharge plans and care packages. This was particularly apparent on the respiratory unit, with embedded working with community specialist nurses and primary care colleagues.
- On AMU the daily MDT held at midday was well established and well attended. The meeting was led by the AMU consultant with input from the MDT. The meeting was thorough, efficient and progressive. In attendance at the time of our inspection were four AMU consultants, one elderly care consultant, three therapists, three senior nurses and the discharge coordinator. Other ward MDTs and board rounds were equally well attended.
- All attendees had a sound understanding of the needs of each patient, care priorities, clinical history and social considerations. Staff spoke about their patients with empathy, compassion and courtesy. Many referred to discussions they had had with the patient and family members.
- Actions from the MDT were reported to patients and their families at the appropriate time. Most often the consultant in charge of the care took responsibility to update them, however, when it was clear to the MDT that another individual was better positioned to update, this was duly delegated.

Seven-day services

- The trust monitored its current working scheme against NHS Services, Seven Days a Week Clinical Standards. The division was the greatest contributor to the March and September 2016 seven day service (7DS) survey with approximately two-thirds of all case notes reviewed.
- The division provided evidence to address the four priority clinical standards, namely time to first consultant review, diagnostics, interventions and ongoing review.
- On average, based on March 2016 data, 60% (slightly worse than national average and in line with regional average) of emergency admissions during weekdays were reviewed by a consultant within 14 hours. At weekend, the figure increased to 65% (slightly better than national and regional average). Based on September data, the figures were reported at 49% during weekdays and 40% during the weekend.

- Of the 13 sets of notes we reviewed, we found 85% of patients were reviewed by a consultant within the 14-hour standard.
- Figures in March 2016 showed over 60% of patients were made aware of their diagnosis, management plan and prognosis within 48 hours from admission. This figure improved in September 2016 to over 70%.
- Of the 13 sets of notes we reviewed, we found all patients were informed about the plan of care and treatment goals within the 48 hour standard.
- The division confirmed that there were formal arrangements in place to review patients admitted as an emergency where the trust offered no provision for that particular service, for example, neurology.
- With the exception of AMU and CCCU, the division confirmed that there was no formal provision in consultant's job planning to hold a consultant-led ward round on every ward, every day of the week. CCCU provided a weekday clinical lead round followed by a speciality-led ward round later in the day. Weekend ward rounds were covered by the acute physician of the day and/or the consultant of the week (CoW).
- The trust confirmed that access to diagnostics (CT, echocardiography, histopathology, MRI, microbiology, upper GI endoscopy and ultrasound) was available during weekdays. There was a shared plan for MRI cover with a neighbouring trust at weekends, and there was an ad-hoc arrangement in place for urgent upper GI endoscopies at weekends due to a lack of cross-bay GI bleed rota. The endoscopy unit had increased training for a number of consultants and nurse endoscopists to progress this cover.
- The service confirmed it is able to access interventions for critical care, primary percutaneous coronary intervention ("PCI"), thrombolysis, emergency surgical services, and renal replacement therapy as the patient requires, however, cardiac pacing and interventional endoscopy were not usually available for emergency admissions as quickly as would be liked. The division was involved in a network arrangement to address the shortfall in weekend interventional services.
- The service did, however, have 24 hour access to consultant directed interventions seven days a week, either on site or via formal network arrangements.
- The percentage of patients in high dependency areas such as AMU who were seen and reviewed by a consultant twice daily was between 40 and 45%, broadly in line with national and regional averages, in March 2016. The proportion of patients reviewed as part of a consultant-delivered ward round at least 24 hours after transfer from an acute area to a general ward varied considerably during weekdays and at the weekend. Weekday figures from March 2016 reported less than 50% (worse than regional and national average) and at the weekend averaged 30% on Saturday (worse than regional and national average) and 80% (better than regional and national average) on Sunday.
- Of the 13 sets of records we reviewed, and of those patients who remained on AMU in excess of 24 hours, we found 6 out of 8 (75%) were reviewed by a consultant twice daily. All patients were reviewed by a consultant within 24 hours, following transfer from the acute area.
- The division was involved in the trust-wide project steering group established to drive work to address gaps in the 7DS provision. The multi-organisational group devised action plans to address areas of shortfall and improve coverage.
- Ambulatory care services at FGH were available every day until 9pm on weekdays and until 2pm at weekends. The nurse-led service provided care to patients from multi-specialisms,who met specific referral criteria, with a view to providing safe care, avoiding unnecessary admission and improving flow elsewhere in the division.
- The oncology day unit provided patient access to a 24 hour helpline. Out-of-hours the helpline service was staffed by triage nurses based in Blackpool.

Access to information

- Staff we spoke with raised no concerns about being able to access patient information in a timely manner.
- Medical staff informed us they received investigation results in a timely manner.
- Staff informed us that discharge-planning considerations commenced on admission with input from the discharge coordinators.
- Staff informed GPs of discharge in writing by way of a discharge summary, which tended to follow the patient on the day of discharge. The division was moving to full electronic patient records and this would provide more efficient communications with stakeholders.
- Staff identified which community services or ongoing care needs would be required for the patient on discharge. Staff involved the patient, his or her family and the service providers in discharge planning.
- If GPs had any queries or concerns regarding ongoing patient care needs on discharge they could call into the

service, where they would be able to speak to a relevant member of staff. Staff on AMU informed us that a member of the medical team (not necessarily the consultant) would always avail themselves to take the call or respond at the earliest opportunity to answer any queries.
- Staff accessed records electronically and refered to policies, clinical guidelines and current trust information via the intranet.
- Staff on the stroke unit gave patients and their families discharge booklets, which provided medical information, treatment details, contact information and signposting for further support and guidance.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- We observed staff asking patients for their consent prior to care being delivered and procedures carried out.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues, and included guidance on the Mental Capacity Act.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- We observed safeguarding and MCA guidance on all wards. Staff referred to the DoLS flowchart to detail the steps to follow to progress an application. Staff also referred to the trust intranet pages that were designated for safeguarding issues.
- Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. We saw evidence of mental capacity assessments completed in medical records.
- Staff on AMU and general wards confirmed that they were making more DoLS referrals than ever before, however, they found the process to be overly burdensome, especially on busy units with an already considerable workload. Staff commented that they had had a number of requests returned due to insufficient information being provided, or rejected with instruction to exercise powers under the Mental Health Act. Staff stated that this led to frustration and confusion as they often had to make such applications with limited information and minimal knowledge of the patient.
- Staff accessed the Safeguarding Team if concerned about a patient, and confirmed that responses from that team were prompt.
- We found completion of MCA/DoLS documentation to be good overall.
- The division had access to trust specialist nurses who had particular expertise in dealing with vulnerable groups such as those with learning disabilities and those living with dementia.

Are medical care services caring?

Outstanding ☆

We rated caring as 'outstanding' because:

- The divisional strategy to deliver quality compassionate care was echoed by all staff across the division. There was a real desire and determination from staff at all levels to ensure patients received the care they needed.
- Feedback from patients and their family members was consistently very positive about the care received and there were a number of examples highlighting staff going 'the extra mile' to deliver.
- Staff considered physical, emotional and social elements of wellbeing equally and without exception. Care was person-centered and holistic. Patients and family members were included when discussing care decisions and treatment plans. Staff considered patient and family involvement in care delivery to have significant benefits, however, they also accepted when this was unachievable due to patient choice or family hesitancy.
- We observed staff delivering care with sensitivity, clinical staff interacting with patients respectfully and non-clinical staff providing emotional support.
- There was a very good response rate in the NHS Friends and Family Test and excellent recommendation rates for the service. The service reported very good outcomes from the National Cancer Experience Survey 2015, the Patient Led Assessment of the Care Environment (PLACE) 2016 survey and the endoscopy survey.

- All patients had individual care plans relevant to their particular care needs, which were reviewed and evaluated as an ongoing concern and, as a minimum, at the end of each shift.

Compassionate care

- Staff stressed to us that their primary concern was to ensure all patients and their families received excellent care throughout their stay at FGH. Staff added that they did everything in their power to ensure all patient needs were met.
- Staff confirmed that when they assesed patient needs they always took into account personal, cultural, social and religious needs. Staff considered this as important as the physical assessment.
- Staff showed an awareness of the 6 Cs (care, compassion, courage, communication, commitment and competence - an indicator of values underpinning compassionate care in practice), and we noted wards had posters displaying the core values.
- During our inspection, we observed care being delivered by nursing, medical, therapy, and non-clinical staff and volunteers interacting with patients in a genuinely caring manner. This included addressing patients by name, introducing themselves by name, actively listening, speaking politely and respectfully, recognising each patient as an individual, and coming to the patient's level when they were in beds and chairs. We found all patients had nurse call bells within reach and these were answered in a timely manner.
- Prior to our inspection we attended a number of listening events with patients and family members. Overall, the feedback received on the care across the division at FGH was consistently good.
- Among the 10 patients and relatives we spoke to, there was consensus, supporting the findings from our listening events, that care was good. Some comments received described the care as "excellent" and said "staff can't do enough for you".
- On CCCU a patient described staff as "really looking after me", confirming that buzzers were answered quickly an, when he required pain relief, this was provided promptly.
- Patients attending the Croslands and Dunmail Centres described the care as "first class".
- A family member on ward six told us how her grandmother was "spoken to with the greatest respect" and said that "the end of her days will be peaceful".
- On ward seven, a patient commented that she "couldn't thank staff enough for everything they had done" for her.
- A patient on the oncology day unit described the nursing staff as "angels", adding, "Nothing is too much bother for them".
- The division captured feedback from patients on how likely they would be to recommend the service, and their experience of the care delivered. The feedback was scored and benchmarked against national standards.
- The FGH response rate to the NHS Family and Friend Test (FFT) between October 2015 to September 2016 was better than national average (30% compared to 25%). The monthly recommendation scores by ward ranged from 88% to 100%, however, overall 'likely to recommend' scores improved from 91.9% to 94.9% with 'unlikely to recommend' scores reducing from 3.7% to 2.1%. The five star score marker from April to June 2016 showed an improvement from 4.67 to 4.76 (out of five).
- In the National Cancer Experience Survey 2015, patients rated their overall experience of the service on a scale of 1-10. The trust reported a score of 8.8 out of 10 in line with national average. We saw that 81% of patients stated that they were involved in decision making, 89% were given the name of their specialist nurse, 93% confirmed they were treated with dignity and respect and 92% stated they received contact information.
- In the Endoscopy Survey at FGH, published in August 2016, 91% of patients rated the care provided by the service to be eight (out of 10) or above, with 80% rating the service 10 out of 10. There were no experience scores below 6 out of 10. All patients confirmed privacy and dignity was maintained.
- The division contributed to the Patient Led Assessment of the Care Environment (PLACE) 2016 survey. In the privacy, dignity and wellbeing category the trust scored better than the national average (86% compared to 84%), and in the dementia care category, the trust scored 75%, in line with national average.
- Patients explained to us that staff maintained their privacy and dignity, and always informed them about any care delivery or procedure in advance.
- The majority of the wards we visited had set visiting times to ensure meal times were protected. Staff authorised visiting outside these hours to assist in individual circumstances.

- Staff enjoyed telling us about positive feedback received from patients and family members, and most wards we visited displayed 'thank you' cards.

Understanding and involvement of patients and those close to them

- Staff informed patients and their family members (where permission had been given to do so) of proposed treatment plans, the reasons for the treatment, the anticipated benefits and risks, and the likely time to be spent in hospital.
- Staff ensured patients understood proposed care and treatment plans by way of direct questioning. Staff provided time for the patient and family to ask any questions or address concerns. One patient on ward seven described how she requested time to consider and discuss care options with her family before responding to her doctors. Staff provided that patient with a en and paper so she could write down her questions for the medical staff to answer.
- Staff kept patients informed of test results, however, the timeliness of the update following such investigations was variable.
- One patient on CCCU described how staff made every effort to accommodate his family visiting times due to their residing some distance away from the hospital, especially his frail wife, who was "always provided with a cup of tea" when she arrived. Staff took time out to update the family when they attended the ward, as only limited information could be provided over the phone.
- A patient on AMU described staff as "wonderful". He added that they paid particular attention to the needs of his disabled wife when she attended the unit to visit. He said, "They made sure she knew exactly what was going on and handled her very well". Staff asked the patient's wife how best they could partner and integrate with her, however, she made it clear she wanted them to lead on all cares.
- At short notice, staff on ward nine arranged for a patient to spend the last days of his life with family overseas. Staff spent considerable time and effort liaising with the family members, coordinating ongoing care arrangements, speaking to airlines, and arranging safe transport services to the departure point.
- Staff on ward six supported patients and their families with the transition in care from hospital to home by simulating the arranged community care package in the safety of the hospital environment: A patient was moved to a self-contained area where a family member could also reside. Staff only provided interventions during a given timeframe in accordance with the community care package. An MDT meeting with the patient and family followed the trial,to evaluate how well it had worked and to make any necessary care adjustments.
- In the bereavement survey a number of patients on ward nine had expressed a desire to have their final care provided on the unit. Staff had therefore decided they would need to identify and develop a suitable area for this purpose. Staff secured funding, engaged with their patients and reclaimed a side-room and storage area to make a new self-contained area with bedroom, living area and kitchen facilities, to provide the best possible environment for their patients and family members choosing to receive final care on the unit.
- In the endoscopy survey at FGH, published in August 2016, all patients surveyed confirmed they were treated courteously and were adequately informed about the procedure. However almost half of the patients surveyed felt that they were not informed about alternative treatment options.
- Staff assessed patients and used clinical judgment to identify those who might require additional support to understand care and treatment plans. Staff gave examples of interpreters and specialist practitioners used, and of support given by way of family presence.

Emotional support

- Staff acknowledged that admission into hospital could be very distressing for some patients. Staff considered the emotional and social impact this could have on their wellbeing. Staff empathised with patients who were frightened and concerned about their health and being hospitalised. We observed genuine warm and caring interactions.
- We observed emotional support being provided by nurses, and indirect care being provided by non-clinical personnel, such as porters and housekeeping staff. We heard a porter introduce himself to a patient, explain why he had attended the ward (to take the patient for an x-ray), ask if this was agreeable to her, and add that he was there "to make her smile".

Medical care (including older people's care)

- A patient on ward seven found her inability to progress her recovery as quickly as she wanted to be particularly frustrating. She described how the therapy staff "wiped away my tears" and continued to provide positive reassurance and encouragement during sessions.
- Staff on ward nine coordinated and delivered a wedding at very short notice. Staff arranged everything. The trust Chaplain held the ceremony, the catering department provided food, and staff arranged flowers and presents. Staff ensured the patient was suitably dressed and made up for the day by bringing in make-up and hair products from home.
- A patient on AMU described how frightened she felt when she was admitted. She told us how the nurses and the housekeeper spent time with her; "they reassured me".
- Staff at the Croslands Centre noticed a change in one of their regular attenders and were concerned about her low mood. They spent time listening to the patient and identified that a loved one had moved away and there had been difficulties in maintaining good communication links. The team, with support from volunteer colleagues, arranged for the use of a tablet device to facilitate email exchanges and video contact.
- Staff recognised the best person to provide emotional support at a particular time could come from a variety of sources, and they did not discourage non-clinical staff from supporting patients within given boundaries. We observed cleaning and housekeeping staff taking time to spend with patients who wanted to talk.
- Staff informed us that patients received emotional support from the Chaplaincy and bereavement services, support groups, and charity and volunteer staff.
- Staff offered patients and relatives private areas if they wanted time away from their bed area to discuss personal matters.

Are medical care services responsive?

Good

We rated responsive as 'good' because:

- Overall, we found the facilities and premises appropriate to meet patient needs.
- The division planned, developed and adapted services, in conjunction with partners and stakeholder input, to meet the needs of the local people across its significant geographical reach.
- The division had excellent results against 18-week standards across all specialisms.
- To assist with pressure on inpatient services and bed occupancy, the service made use of ambulatory care services, rapid access clinics and telemedicine.
- Divisional managers closely monitored access and flow through the division and were involved in a number of initiatives to identify problems within patient pathways that led to blockages in care progression, increasing unnecessary length of stay and discharge planning. The division had appointed a number of discharge coordinators to support the patient transition from hospital.
- Ambulatory care services had developed to implement care pathways for specific medical conditions under strict criteria, thus avoiding the need for hospitalisation and inpatient treatment. Rapid access clinics were also being increasingly utilised to facilitate prompt access to consultant decision-making.
- The division actively looked at strategies to improve patient experience for vulnerable patient groups. The division provided reasonable adjustments for such groups, including those living with dementia, those with additional needs due to learning disabilities, and those with hearing problems or visual impairment.
- There was evidence of positive outcomes following divisional response to some patient concerns.

However:

- The division recorded longer than average length of stay durations for elective medical patients at FGH.
- Bed occupancy rates had seen a number of medical outliers encroach into other clinical wards. Medical outlier figures were consistent at FGH, and this coincided with a significant number of patient moves after 10pm.
- The full remit of ambulatory care services was not fully understood, therefore potentially leading to inefficiencies or inappropriate referral.
- Where vulnerable patients required 1:1 observation and this could not immediately be provided by existing ward staff or through the nurse bank, the division used staff from an external security firm.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- The division was engaged with the Better Care Together (BCT) strategy, bringing together a total of 11 local organisations, including neighbouring trusts, clinical commissioning groups (CCGs), GP Federations, local authorities and the ambulance service, to plan and deliver the BCT strategy.
- BCT was designed to provide integrated care closer to the community, through changes to clinical pathways aimed at reducing unnecessary interventions and, where clinically appropriate, introducing initiatives such as patient initiated follow-ups (PIFU), alongside innovative, locality based, out of hospital proposals to enhance locally provided health services and facilitate management of long term conditions closer to home, and to reduce the number of, predominately elderly, patients in acute hospital beds. There was a population health focus throughout the model, incorporating self-care and empowering the population, for example, in Millom, where a health and community partnership was helping to maintain services in a rural location.
- Since BCT was developed, thinking had evolved and work was ongoing to create an Accountable Care System to take responsibility for the whole health and care needs of the population. Clinical and operational partners were working with key partners across all the BCT workstreams to ensure that there was safe and sustainable planning across entire pathways of care, with whole system solutions to the challenges faced. BCT was the trust and divisional strategy.
- Divisional management staff attended meetings with local Clinical Commissioning Groups (CCGs) in order to feed into the local health network and identify service improvements to meet the needs of local people.
- In planning and delivering services, the wider BCT strategy was heavily influential and there were a number of priorities being considered to ensure that the needs of the local and regional population were being met.
- The division had appointed a number of specialist nurses and developed a number of specialist clinics.
- Patients at FGH had access to a nurse-led ambulatory care service, which provided care for those with certain clinical presentations meeting specific referral criteria, such as deep vein thrombosis, asthma, abdominal pain, pulmonary embolism, and urological problems. The unit was open seven days a week.
- The ward manager on the respiratory unit had worked with community colleagues, in particular the Home Care Respiratory Team in Barrow and the environs, to improve referral to and from the service.
- The division had appointed a specialist stroke nurse at FGH. The role had been developed to improve stroke services cross bay, and, in particular, to outreach into other clinical areas on site to capture patients requiring specialist stroke care. The specialist nurse at FGH had improved the patient pathway to accessing scanning services, and planned to develop stroke-specific care bundles as part of the EPR, which would inform SSNAP and get the patient on the right care pathway at the earliest opportunity. The specialist stroke nurse was heavily involved in the division cross bay stroke action plan to improve performance against key indicators in SSNAP. At FGH the specialist nurse had developed training packages for junior A&E medical staff to support early diagnosis, investigation and treatment. The unit had further developed guidelines for stroke care aligning to NICE and recognised best practice. The stroke team had drafted a business case to increase establishment of therapy services across the unit, which had resulted in a recent appointment in speech and language therapy (SALT).
- The division offered internal referral and external access into acute medicine clinics, also known as 'hot clinics', at FGH Croslands Centre, for example, to transient ischaemic attacks (TIA) clinics. This allowed patients to attend promptly, see consultants for same-day reviews, and avoid unnecessary admission. The services were used by GPs, community referrers, A&E and AMU. There had been over 300 new referrals between January and September 2016. The Crosland Centre also provided rehabilitation services and treatments for stroke, rheumatology, renal, multiple sclerosis and endocrinology. The Croslands Centre was also a hub for care of the elderly services, providing falls clinics, therapy services and access to support groups/ information. For those patients who resided nearer Kendal, a number of these services were provided at the Dunmail Treatment Centre, Westmorland General Hospital, which saw in excess of 600 patients and

provided almost 400 treatments during September 2016. On these units there was a strong emphasis on support and education, patient engagement, and multi-disciplinary team input.

- The division had installed clinical investigation units (CIUs) on all sites. At FGH, patients had access to echocardiography, pacing follow-up, ambulatory electrocardiography, stress testing within the rapid access clinics, and respiratory investigations. This had improved access to investigatory tests, and promoted prompter results and earlier treatment options for the treating physician and patient.
- The medical oncology and chemotherapy service provided a 24 hour helpline for patients and their families should they need advice or support Out of Hours.
- The stroke service accessed a telemedicine facility to allow face-to-face discussions with the on-call teamand specialist clinicians locally and further afield.

Access and flow

- The medicine division at FGH accounted for a third of the total admissions into the medicine service across the trust. The majority of these admissions (56%) were classified in the emergency category. The division provided care and treatment for patients in cardiology, gastroenterology, general medicine, oncology, respiratory, and stroke medicine across its 132 inpatient beds.
- Between October 2015 and September 2016, the trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance. The latest figures, for September 2016, showed 100% of this group of patients were treated within 18 weeks, versus the England average of 90%. The trust had been consistently better than the England average in the preceding 12 month period.
- There were no medical specialties below the England average for admitted RTT (percentage within 18 weeks).
- The latest figures, for July 2016, showed 100% of all medicine patients were treated within 18 weeks.
- Between April 2015 and March 2016 the average length of stay for medical elective patients at FGH was 5.2 days, which is worse than the England average of 3.9 days. For medical non-elective patients the average length of stay was 6.4 days, which is England average of 6.6 days.
- Between March 2015 and February 2016, patients at FGH had a lower than expected risk of readmission for non-elective admissions and a lower than expected risk of such for elective admissions. The elective specialty Clinical Haematology had the largest relative risk of readmission.
- Divisional managers confirmed bed occupancy had had a significant impact on flow through the service. The threshold occupancy levels for efficient transition within the service was 75% on AMU and 85% on the wards. Divisional managers confirmed bed occupancy had been running in excess of 100% in recent months, which had led to increasing numbers of medical outliers (medical patients being cared for on non-medical wards) and encroachment into surgical beds. This coincided with trust percentage occupancy, which rose between April and June 2016 to 99.1%. The divisional bed position had been further compounded by bed closures due to inadequate staffing levels.
- The trust provided data detailing numbers of medical outliers at FGH from July to September 2016. On average, the division had consistently seen approximately 147 outliers each month, with wards four and five (general surgery) and ward one (gynaecology) receiving the most. Medical outliers were cared for on 'buddy wards' to keep a particular specialism or cohort together in one location. This assisted non-medical ward based staff to work with one particular medical team, and assisted medical staff when reviewing outlying patients by keeping them together.
- Nursing staff we spoke with on the wards where patients were out-lying told us that they observed medical staff attending the ward every day to check on patients. Our review of medical records confirmed this.
- The directorate captured live bed occupancy rates, admissions by ward/consultant/site, outliers, bed vacancies, and patient length of stay on an electronic platform, which was accessed by matrons and senior managers. This assisted in anticipating access and flow issues, which senior staff responded to accordingly.
- All wards held daily board rounds, and staff worked with pharmacy colleagues to obtain patient medications to take home in a timely manner.
- The trust held local and cross-bay bed meeting teleconferences during the day to address access and flow issues. Division senior nursing staff, business managers, and discharge coordinators attended to record bed occupancy and availability, discharges, and

pending admissions. Here staff identified actual and potential bottlenecks to patient flow for that day, and prioritised actions to remove obstacles for patient admissions and discharges.

- The division had employed a number of discharge coordinators to support in the transition from hospital care into the community. Not all wards had a discharge coordinator in post, however, all staff commented on the positive impact this role had had on ward pressures, progressing care packages, and supporting patients and their families toward discharge.
- In AMU staff described how their discharge coordinator (who had a social work background) had been successful in progressing complex care packages very early in the care pathway, which had supported later discharge plans.
- Staff described patient flow being "snarled up" when awaiting community placements for ongoing patient care. Staff stated that this was due to a number of factors, such as resource issues in South Lakes, family resistance, and self-funding concerns, leading to delayed transfers and discharges.
- The reported reasons for delayed transfer of care (DTOC) between July 2015 and June 2016 were patients awaiting nursing home placement or availability (38.3%), and awaiting residential home placement or availability (23.1%).
- Divisional managers worked with multiple partners to look at improvements in DTOC. The priority of the group was to reduce unnecessary admissions in the first instance as it was found this patient cohort accounted for approximately 30% of inpatient bed occupancy. The project was six months old at the time of the inspection and work was ongoing. Divisional managers had also taken part in DTOC rapid improvement events with community care colleagues and 'Hospital Home Care Team' projects. Outputs from these pieces of work had seen the division support social workers to integrate into the discharge team, and care support workers appointed to the Hospital Home Care Team.
- Staff in AMU confirmed that they had seen a reduction in admissions to the unit (359 in September 2016 compared to 550 in September 2015) due to a combination of efficient streaming, ambulatory care pathways, rapid access clinics ("HOT clinics"), and direct admissions to specialist wards, such as the stroke unit. Of those patients admitted to the unit, staff confirmed that, due to consultant presence, they have been able reduce unnecessary admissions, and have seen an increase in discharges directly from the unit (reported as 42.9% in September 2016).
- The division had developed a nurse-led 7-day ambulatory care model at FGH. The service provided treatment to patients from a variety of specialisms and had standard operating procedures detailing referral criteria. These included patients requiring assessment and treatment for deep vein thrombosis, asthma, abdominal pain and urology problems. These pathways provided criteria to help staff identify patients who could be safely cared for in ambulatory care setting without hospitalisation. The unit tended to see in the region of 250 patients a month, however, staff on the unit commented that they did not feel as though the remit of the unit was fully understood.
- The division had also developed a number of acute medicine clinics or rapid access clinics (hot clinics), for example, to deal with suspected transient ischaemic attacks (TIAs). The hot clinic initiative avoided admission for many patients, ensured same-day consultant review, and was well regarded by local stakeholders. Between January and September 2016 new referrals into the clinics exceeded 320 patients.
- Between June 2015 and June 2016 FGH medical wards reported an average of 78% of patients did not have to move ward during their admission, 16% had to move on one occasion, 4% on two occasions, 1% on three occasions, and less than 1% on four or more occasions.
- From January to June 2016 there were several of patients moving wards at FGH after 10pm. The total number was reducing each month and, in June, was 129, with 48 (37%) of these recorded against the division. Ward managers confirmed that moves at night were not helpful to staff, and could lead to distress to patients. Staff confirmed that, when such moves weremade, this was generally due to changing patient need or late admissions from GPs or A&E.
- There had been no mixed sex breaches in the division in the preceding 12 months.

Meeting people's individual needs

- The divisional managers confirmed that, when planning services, the needs of all patients, irrespective of age, disability, gender, race, religion or belief, were taken into account.

Medical care (including older people's care)

- Staff confirmed that, where patients required additional support, for example, those with complex needs or who were vulnerable, the division took all reasonable steps to ensure the care they received was uncompromised.
- The division had appointed specialist nurses for vulnerable patient groups, such as those living with dementia and those with learning difficulties. The trust had a dementia strategy, which was embedded across the division.
- Staff ensured that patients living with dementia were appropriately screened, were treated for any underlying cause that may be contributory to a delirium, and were signposted for further assessment if needed. Where a patient was confirmed as living with dementia, the division had a designated care pathway, supported by specialist practitioners from the care of the elderly team, therapists and specialist nurses.
- Where patients living with dementia were admitted onto a ward, staff used the butterfly scheme to identify those patients as having particular needs. This was used in conjunction with a bed-side and e-whiteboard symbol, and a bed-side care summary identifying detailed personal preferences, likes/dislikes, anxiety triggers and interventions which would be helpful in supporting patients during difficult periods.
- Staff recognised that meal times could cause concern for many patients and their family members. The division had adapted visual menus which were suitable for those patients who preferred hot finger food options, and had snacks to improve calorific intake and the pleasure of eating. The division had also adopted 'John's campaign', a formal recognition of the importance of families and carers being involved in care and decision-making. The division offered open visiting and provided nominated persons with a lanyard and badge to identify them as being part of the scheme.
- We visited wards which had undergone some refurbishment to become 'dementia friendly', with appropriate signage to aid communication and perception, triggers for reminiscence, such as music and photographs, and decorations to encourage positive interactions and reduce environmental conflict.
- All patients coded with a diagnosis of dementia from an inpatient admission were identified by the Care of the Elderly (COTE) team. A carer survey questionnaire was sent to these patients, their families or their carers, to ask whether they had been adequately supported during the episode of care. Staff presented the feedback, along with dementia audit findings, to the ward managers in the quality committee report "I want great care", and published findings on ward information boards.
- The division was developing a frailty pathway to provide a comprehensive and holistic elderly care assessment, to ensure patients were receiving the appropriate level of care, delivered by the most appropriate team, on the correct care pathway.
- The division accessed the newly appointed learning disability (LD) nurse specialist for support where necessary. The LD nurse coordinated care for those patients with more complex needs. All LD alerts went directly to her and all reasonable measures were considered to assist the patient through their care pathway whilst hospitalised, and to support a smooth transition back into the community.
- Staff provided a 'passport' for patients with LD, which was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers, and interventions which would be helpful in supporting them uring difficult periods. The LD nurse specialist identified, in conjunction with carers and ward staff, which reasonable adjustments were required to support the patient whilst in hospital. This could be pre-visits to suites for procedures to support desensitisation, offering a side-room for privacy and to reduce anxiety, flexible visiting, carers staying with the patient overnight, and other individual preferences unique to that individual.
- Staff had built good working relationships with the community LD teams, and, where required, they would be invited to attend MDT meetings in order to encompass a wider, holistic assessment, and for involvement in any future ongoing care package.
- The division was in the process of making the transition onto the EPR. Consequently, the division was working to ensure that alert identifiers were included in the record, to assist staff and patients.
- Patients who had visual impairment or hearing difficulties had their particular needs fully assessed. Where appropriate, staff liaised with medical, nursing and specialist colleagues in Ophthalmology and ENT. To assist the MDT, staff used bedside and e-whiteboard identifiers to highlight particular patient needs associated with their visual or hearing deficit.

- The division was developing 'deaf champions' who were to undergo additional deafness awareness training to support patients. The division proposed to develop the role for those patients with visual deficits too.
- There were eye clinic liaison officers and audiologists based at FGH (and on all sites across the trust), who provided staff and patients with advice and guidance.
- Staff informed us that they had ease of access/referral into psychiatric services for those patients requiring this care, in particular, when needing MCA/DoLS guidance.
- We saw several information leaflets produced in an 'easy to read' format. The trust offered all patient information in a number of languages, in large print/braille, and in other formats.
- All wards displayed information for patients and carers on a variety of topics, such as trust information, quality standards, disease/condition specific information, ward/staff contact details, a who's who of staff on the ward, and general useful signposting on where to get further information, such as PALS, complaints and support groups.
- Staff explained that translation services were available by telephone or by attendance in person. Staff also accessed British Sign Language (BSL) services.
- The trust had Chaplains who provided access to major faiths within their communities. Staff accommodated faith preferences in accordance with patient wishes, and this was facilitated by the Chaplaincy service or at the bedside.
- Staff we spoke with explained that they could easily access bariatric equipment via equipment storage when this was required. This included access to special beds, wheelchairs and chairs.
- Staff at FGH used an external security firm to provide support with 1:1 observation for vulnerable or aggressive patients when they were unable to secure additional nursing staff. Staff recognised this was not an ideal scenario, however, this assisted in ensuring the safety and wellbeing of the vulnerable patient, whilst allowing staff to complete other duties on the ward.

Learning from complaints and concerns

- The division reported 120 complaints between October 2015 and October 2016, of which 34 (28.3%) were attributed to medical care at FGH. The division took an average of 25.16 days to investigate and close complaints. This is in line with its complaints policy, which states that complaints should be dealt with within 35 days of receipt, unless a different timescale has been agreed with the complainant.
- f the 34 recorded complaints, eight (21%) were logged against AMU.
- The main categories of complaint related to clinical treatment and staff attitude.
- The wards we visited displayed leaflets and posters outlining the complaints procedure. We saw that the trust had a complaints policy and staff were aware of it.
- Staff discussed feedback from complaints, and lessons learnt, at ward meetings and at safety huddles.
- Ward staff took action to address patient feedback. On CCCU staff received feedback from patients about uncomfortable fluctuations in the ward temperature. Staff immediately escalated this to the estates department to facilitate a more consistent and stable environmental temperature.
- Patients attending the Clinical Investigation Unit (CIU) felt a little disorientated and confused by the lack of reception on arrival. Here, staff improved signage and recruited administrative support to assist.

Are medical care services well-led?

Good

We found well-led to be 'good' because:

- The division had a clearly defined strategy and vision, which was aligned to organisational aims and wider healthcare economy goals. The division recognised that the delivery of the strategy could not be achieved in isolation, and therefore engaged with internal and external partners to drive objectives.
- Divisional leads had a real grasp and understanding of the pressures and risks the service faced. The service prioritised resources to address key considerations around quality and safety matters.
- The division embraced recent changes within the governance directorate, and, in a short space of time, appeared to have embedded the governance and assurance framework throughout the service from ward level into senior management structures. Governance arrangements enabled the effective identification and

monitoring of risks. Managers reviewed key divisional risks, action plans and progress in a timely manner. There was evidence that controls were in place to mitigate such risks.

- There were defined leadership structures in place supporting the division, which had recently changed following the merger of emergency medicine and acute medicine. Staff knew their individual roles and accountability, however, all considered themselves part of a wider cross-bay team with collective responsibilities.
- Staff confirmed the strength and culture within the divisional team had greatly improved over the preceding 12 months, and was underpinned by everyone being willing to "roll up their sleeves". Staff considered their clinical leaders to be peers and acknowledged a greater openness within the division.
- The division considered staff and public engagement to be fundamental to its future success. The organisation was involved in a number of known initiatives to gather feedback from persons using and working in the service.
- Staff at all levels were actively encouraged to get involved in projects to develop services, promote efficiencies, inform learning, and improve patient care. Senior staff member support for such projects was apparent, and there was evidence of some excellent project outcomes from the Learning into Action programme.

However:

- The divisional strategy stressed the importance of engaging with public and staff opinion to progress organisational priorities in the coming years. Whilst there was evidence of public and staff engagement, we did not see any new activity to suggest a shift in emphasis to reinforce this priority objective.
- The new governance framework had only been in place for a short time within the division and the effectiveness of the process needed to be fully reviewed.
- Divisional managers accepted there were current limitations within their leadership expertise. To reinforce their skills, knowledge and development in this area they had undertaken relevant courses and training to enhance their ability to manage and lead the service.
- Whilst staff accepted the difficulties for the division in recruiting to vacant posts, they felt as though there was a pressure and almost an expectation to work additional hours as a norm, and that this was not fully recognised by divisional leads. Senior clinical leads recognised the vulnerability of sustaining this in the medium- to long-term.

Vision and strategy for this service

- The vision and strategic goals for the division mirrored the aims and objectives of the trust, "to constantly provide the highest possible standards of compassionate care and the very best patient and staff experience by involving patients, staff and partners."
- Divisional managers expressed their overreaching vision to deliver a quality and safe service.
- The divisional strategy had short-, medium- and long-term projections. Managers were actively focussed on areas for improvement highlighted during previous inspection activity. The division also prioritised work to address current risks around workforce and patient safety. In the short- to medium-term, the division was keen to improve patient flow, through a number of options and by working with partner organisations. In the medium- to long-term, the division would work with the collaborative to develop and further the 'Better Care Together' agenda, aligned to the NHS Five Year Forward View.
- The division ambitions, service priorities, and principles of working in the coming year were incorporated into the trust priorities for 2016/2017, of strategy, engagement, quality and safety, partnership, and performance.
- The management team recognised the importance of 'the team' and encompassed opinion cross-bay. Managers considered quality clinical governance, an open and honest culture, and listening to patients, stakeholders and staff to be key to the success and development of the service. This was underlined by the considerable work undertaken by the trust in terms of governance review from ward to board during 2015/2016.
- The management team members told that us they were actively involved in the shaping of the trust agenda. The management team actively sought staff opinion on the strategy of the service and for future plans.
- Staff knew and understood the vision of the trust and the division.

Governance, risk management and quality measurement

Medical care (including older people's care)

- The division had clear governance channels into the wider organisational management structure. The medical division governance was clinician-driven with multi-specialism input.
- The governance and assurance framework permeated all levels within the division, and was well embedded throughout, despite the recent creation of the governance directorate.
- The two-way 'Board to ward' framework (known locally as 'WESEE') was well structured, and there were clear lines of responsibility and accountability from individual units, through DGAG, into the divisional management board and to divisional performance meetings, before moving into the workforce, finance and quality committees at Board.
- Ward staff described a new energy, and prioritisation of governance within the division, and considered the structure had considerably improved and strengthened in the preceding 12 months.
- We reviewed minutes of ward governance meetings under the 'WESEE' framework, covering the set agenda items of workforce, efficiency, safety, effectiveness, and experience. There was a clear and fluid process for sharing information (such as Board issues, divisional headlines, and ward matters) through this process up and down the organisational structure. The format allowed ward meetings to be consistent, structured, timely, and efficient.
- In conjunction with the division strategy, we were provided with sight of a very detailed and comprehensive risk register,which recorded concerns rated according to risk/priority, along with control measures and action plan progress.
- The management team's three main areas of concern were nursing and medical staffing, patient flow issues, and patient safety. These were recorded on the risk register, and we were told of progress made by the division to mitigate risk.
- There were consistency and alignment between what the division was concerned about and what appeared within the register. Senior management were open and honest about this and their plans to address perceived shortfalls in areas of concern.
- The division monitored risk register key performance indicators. Managers completed 90% of risk reviews on time, 79% of risks had ongoing or open actions, and 98% of open actions had progress recorded.
- The division was actively working to address areas previously highlighted for improvement and progress was monitored in the CQC action plan. The division also had a 'journey ahead' plan, which brought together the organisation objectives, divisional strategy, key priorities and the governance framework. The key themes highlighted and shown to be fundamental were recruitment, reducing patient harms, delivering RTTs, and engaging and motivating staff.
- The division was involved in the implementation and embedding of National Safety Standards for Invasive Procedures (NatSSIPs), revised in September 2015. In particular, staff were involved in local NatSSIP projects (LocSSIPs) aligned to national alerts and work streams, such as cardiological and endoscopic procedures. Projects were ongoing at the time of the inspection, however, we were able to review some of the safety changes implemented in the trust cardiac centre. Staff had revisited the cardiac centre safety standards, and had developed enhanced safetybriefing, checklist, handover and debrief standard documents for use in the service. Staff planned to audit the use of the new documentation as part of the division governance framework.
- The division was involved in the trust-wide QAAS (Quality Assurance Accreditation Scheme) to support the measurement of quality and effectiveness of care. QAAS aligned with division aims and national objectives. Division staff had developed QAAS tools to benchmark against standards, guidelines, staff-driven objective, and patient satisfaction. The tools included themes around safety, leadership, and the care environment. The designated matron implemented the process, with wards rated according to compliance (red – inadequate; yellow – requires improvement; and green – good). Lessons learnt and themes were highlighted to ward managers, discussed at quality committeeand division governance groups, and published in trust bulletins and newsletters.
- There was internal clinical audit activity and monitoring of performance and quality within the division. Senior staff recorded local and national measures and outcomes, which fed into divisional activityand drove the vision, strategy, and quality improvement projects.
- The service used clinical audit, monitored quality and performance dashboard measures, and took outcomes to identify areas of good practice, improvements projects and future initiatives. The DGAG led on sepsis

management across the division. Staff shared lessons learnt from all audit activity and performance measures using the governance framework, which also included wider input from the Patient Safety Unit and Learning Into Action (LiA) team.

Leadership of service

- The medicine division had a clear management structure, defining lines of responsibility and accountability. The division was led by a clinical director, a divisional general manager, and a chief nurse.
- The division and clinical directors had an open-door policy and invited regular contact with their unit heads.
- The division had recently brought together emergency medicine and acute medical services under one management structure cross-bay. A deputy chief nurse, deputy divisional general manager, six matrons, five service managers, and a designated divisional governance lead further supported the divisional management structure.
- Managers recognised the importance of having the right skills, knowledge and experience to carry out their duties. A number of the management team had completed higher education leadership courses at a local university to support their appointments.
- Ward staff described the divisional managers as part of the team and considered them to have the necessary attributes to manage and take the service forward.
- Divisional managers spoke with pride about the work and care their staff delivered on a daily basis despite the pressures faced.
- All staff we spoke with told us that their clinical managers were visible and approachable. Ward staff interacted with matrons and managers as peers. Staff commented that their matron and assistant chief nurse visited clinical areas regularly and often "rolled their sleeves up", which they found empowering, supportive, and demonstrative of a real understanding of the roles of ward-based staff.
- Divisional leadership recognised its cross-bay responsibilities and encouraged staff to engage with colleagues on other trust sites to build team networks. Some roles provided staff with the opportunity to work cross-bay and liaise with the wider divisional team. The division held regular videoconferencing meetings to get together to discuss issues, share learning, and cascade updates within their area.
- Staff were aware of the issues faced by the directorate, and considered their managers were doing everything in their power to improve the situation for them and their patients.

Culture within the service

- Staff at all levels spoke enthusiastically about their work, the quality of care they delivered, and the pride they felt working for the trust. Staff told us this feeling had really flourished in the preceding 12 months due to a real cultural change within the organisation.
- Staff felt the organisation and the divisional managers were on "the same page" as they were. They described how the organisational and divisional objectives aligned with their own aims and intentions to have the patient central to their purpose. Staff felt under pressure, and believed there to be an element of expectation for them to work additional hours to fill vacant shifts. In the NHS Staff Survey, however, the trust performed better than other organisations against the question 'staff working extra hours' (68% against the England average of 72%).
- At staff listening events and focus groups prior to the inspection, we heard staff describe a real 'team' culture. Staff stated that they were able to put forward ideas and express opinions, however, some felt this to be a redundant exercise in view of more pressing priorities within the division. This was supported by the NHS Staff Survey 2016 results, where the trust performed worse than other organisations in 'staff being able to contribute towards improvements at work' (66% versus the England average of 75%).
- All staff we spoke with told us their immediate line managers were professional, supportive, and helpful.
- Junior nursing and medical staff described their senior peers to be supportive, approachable, and willing to spend time with them when necessary.
- Junior doctors described the teamwork across all staff disciplines as "excellent".
- Staff agreed that there was a culture of openness and honesty throughout the division, underpinned by the trust 'Speak out Safely' campaign. Staff stated that they were comfortable with raising concerns with their line managers and knew of the trust 'Freedom to Speak Up Guardian' and its whistleblowing policy.
- In May 2016 the division managers published outcomes from their values- and culture-based project to gain further understanding of staff opinion on working for the organisation. There was some agreement amongst staff

that the culture within the division was caring, care was of a good standard, and there was a togetherness in working for patients. The project also identified some cultural entropy (an amount of time and energy consumed doing unproductive and unnecessary work associated with a degree of organisational dysfunction). This tended to focus around staff working long hours, a feeling of being taken for granted, and an element of bureaucratic control. The division managers acknowledged that the way in which they led required improvement. The trust supported a number of the division managers to attend internal and external management and leadership courses to address this.

- Overall, morale was good on the wards we visited. Staff commented on the strength of ward comradery and their resilience to difficulties. Matrons recognised that staff on wards were becoming stressed and tired from the constant pressures faced. Staff felt as though senior management could do more for staff wellbeing but acknowledged some of the issues faced across the division were outside their control.

Public engagement

- One of the organisational and divisional objectives was to canvas opinion on its services from the public.
- Patients and their families provided views and feedback on their experiences of using the service in the Family and Friends Test, through the 'taking two minutes of your time' capture, and via 'Tell us what you think' comment cards or website.
- Some wards provided designated appointment times for family members, at a time convenient to them, to discuss care and treatment plans for their loved one.
- Wards displayed information for patients and their families about ways in which they could provide commentary about their experiences in a more confidential setting, such as through accessing the Patient Advice and Liaison Service (PALS).
- The division invited members of the public to become members of the trust, allowing them to link into trust consultations and service development proposals, and vote for representation on the Council of Governors.
- The division supported the governance directorate mystery shopper project, whereby a member of the public would attend the division anonymously and provide feedback to the governance team about their experiences.
- The division had good links with numerous volunteer organisations, charities, and national support groups, such as Macmillan and Age UK.

Staff engagement

- One of the organisational and divisional objectives was to canvas opinion on its services from its staff.
- The division provided staff with information via WESEE, newsletters, intranet updates, and e-mail, on trust developments, clinical issues, patient themes, and staff recognition.
- The division was involved in a number of trust initiatives to engage with staff, such as the staff survey, invitations to listening events, involving staff with harm free care group projects, and LiA proposals. This provided staff with opportunities to input into areas of interest, influence change, and learn and develop.
- The division recognised staff achievements in a start of the month scheme and at annual events, such as the health hero award.
- The division encouraged staff to get involved in the '#flourishatwork' campaign to promote staff health and wellbeing. The flourish campaign focussed on physical health, mental health, and the importance of exercise and nutrition.
- The division implemented team-building away days for different staff banding groups. This allowed cohort groups of staff working cross-bay to come together to discuss topics of interest, attend learning events, and build team networks.
- Staff had developed good links with external professional colleagues, support organisations, and volunteer groups.
- Staff said they felt supported when personal or family issues affected their ability to work. Staff commented that their line managers and clinical support network showed understanding, empathy, and kindness during difficult times. Managers supported staff returning to work following a leave of absence.
- In the NHS Staff Survey 2016 the trust performed worse than other organisations in the question 'staff experiencing harassment, bullying or abuse from other staff in the last 12 months' (29% compared to the England average of 26%). Staff in the division at FGH reported no incidents of this nature to us during the course of our inspection.

Innovation, improvement and sustainability

Medical care (including older people's care)

- The division was proud to talk about the progress and improvements it had made over the preceding 12 months, in particular, responding to areas of concern previously highlighted, and a number of successful improvement projects.
- There were a number of cost improvement projects (CIPs) and quality improvement projects (QIPs) in the division, which were focussed on key areas of risk such as improving nursing and medical recruitment, reducing agency and locum spend, optimising patient flow, reducing length of stay, and procurement schemes.
- The division had used a number of innovative technological developments; two in particular are worthy of note. Divisional staff worked in alliance with GP colleagues in Millom to reduce patient admission into the service by providing a video consultation to primary care staff seeking a second opinion on a patient presentation. The stroke service was part of the North West Regional Stroke Network and used the 'telestroke' service, whereby patients could receive a consultant led thrombolysis assessment out-of-hours. This had strengthened network links across the region.
- The division was very active in the trust LiA improvement programme. These programmes, open to all staff, focussed on projects, proposals, suggestions, and research, to bring about change and improvements in working practice and patient outcomes.
- Staff in AMU wanted to improve outcomes for patients with AKI and devised a training package, new observation chart, and patient information. The project saw staff becoming more confident in dealing with this cohort of patients, fluid balance monitoring significantly improved, and average patient stay reduced.
- Staff in oncology wanted to develop and share guidelines with all staff involved in peripherally inserted central catheters line care (PICC) for chemotherapy administration. The project brought consistent practices across the division, the patient experience improved, lines of communication cross-bay were strengthened, and there were fewer blocked lines, thus reducing the numbers of removals and reinsertions and effecting cost savings.
- Division staff were involved in ongoing harm free care specific projects looking at reducing falls and pressure ulcers.
- As part of the LiA programme, the division was involved in a number of 'Big Ticket' schemes (larger, clinically-led projects). Following on from the AKI LiA, the division extended the reach of project to aim to reduce AKI mortality. The division employed two AKI practice nurses who provided specialist support to the trust, and a number of presentations were made to the collaboration. The dual approach to inform trust staff and engage with the collaboration led to a reduction in patient mortality from 25% to 18.6%. The divisional consultant leading on this project picked up an award from the network for the team's work.
- Staff made a number of changes to improve care for patients living with dementia. The project followed feedback from patients and families, staff concerns, and increasing use of security staff. The project brought a reduction in complaints, reduced spend on security staff, reduced staff sickness, and reduced harm to patients.
- At FGH staff on AMU wanted to improve patient flow and improve discharge planning as early as possible in the care pathway. Staff began recording estimated discharge dates and clinical criteria for discharge for each patient. Staff saw an increase in recording of this information on AMU, which has assisted ward staff later in the care pathway when coordinating discharge.
- Respiratory staff across the division sought to redesign the care pathway to improve patient access to diagnosis and treatment. This project saw division staff working with community colleagues to improve access to investigations and develop a one-stop clinic, and a specific sleep apnoea pathway progressed within the CIU. Respiratory RTTs have been reduced and patient flow improved.
- Division staff were involved in the 'Think SEPSIS: Save Lives' project to reduce patient harm. This project was heavily focussed on education and training to improve early recognition and treatment of sepsis. Staff improved screening compliance, increased intravenous antibiotic administration within one hour, and standardised training in line with national guidance.
- In stroke services, the team wanted to maximise performance, deliver better patient outcomes, and improve patient care. The team developed a rapid access service for brain scans, introduced stroke champions in A&E, extended the scope of the advanced nurse practitioner to request CT scans, developed specialist e-learning training packages, and developed an expert patient programme.
- On the stroke unit, staff developed a care package simulation area where patients and their family

members could 'live' the agreed real-time community care package in the safety of the hospital environment. Ward staff engaged with the patient and the family in accordance with the proposed care package to be provided at home, for example, care input three times a day. This gave the patient and the family a real experience and time to get used to the transition. The trial was followed up by an MDT case conference to confirm arrangements or make any necessary changes to the proposed package.

- Ward nine staff at FGH secured Gold Standards Framework accreditation for their work in optimising care for all patients and their families approaching end of life.

Surgery

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

Information about the service

Furness General Hospital provides a range of elective and non-elective surgical inpatient services. There is also a sub-regional service for upper gastro-intestinal surgery. There are six surgical wards, a day case unit and a theatre suite comprising of seven theatres. There are 109 inpatient and 22 day case beds. The surgical services are managed divisionally across all three acute hospitals.

Hospital episode statistics data for 2015/2016 showed that 11,870 patients were admitted for surgery at this hospital. As part of our inspection we visited the main theatres, the pre-operative assessment unit, the surgical admission unit, the day case unit, ward 2 (trauma & orthopaedics), ward 4 and 5 (this was the female general surgical ward). This ward also accommodated urology, ENT, colorectal and ophthalmology patients. We visited the elective orthopaedic unit (EOU) and discussed the patient progression unit. The patient progression unit was a four bedded surgical unit that accepted all surgical discharges from intensive care, all major post-operative cases that do not require intensive care, direct surgical admissions from A&E, and any surgical ward patients who require closer monitoring, observation and treatment. There were 131 beds located within 6 wards

We spoke with 11 patients. We observed care and treatment and looked at 10 care records. We also spoke with 22 staff at different grades including nurses, doctors, consultants, ward managers, general managers, theatre managers, and clinical leads.

We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Surgery

Summary of findings

The overall surgery rating from the 2015 inspection was requires improvement. Actions the trust were told they must take were:

- Ensure there were systems in place to identify themes from incidents and near miss events.
- Ensure all theatres were monitoring compliance with the 5 steps to safer surgery.
- Ensure all staff understood the process for raising safeguarding referrals (in the absence of the safeguarding lead).
- Reduce and improve readmission rates.
- Ensure they were clear risk assessments in place for situations where practice deviates from the guidance.
- Must continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

During the 2016 inspection we found that these actions had been taken. There were systems in place to identify themes from incidents and near miss events. We saw improved audits for the 5 steps to safer surgery and had discussions with staff about the process and procedure for raising safeguarding referrals. There were risk assessments and escalations plans in place for situations where practice deviated from guidance. Readmission rates were worse that than the England average in 2015. In 2016 we found that Between March 2015 and February 2016, patients at Royal Lancaster Infirmary had a similar expected risk of readmission for non-elective admissions and a higher expected risk for elective admissions compared to the England average. We found that although the culture of the surgical division was much improved, work was ongoing with further improvement required.

We rated surgical services as good because:

- Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned. All wards used an early warning scoring system and risk assessments for the management of deteriorating patients. Infection prevention and control was managed effectively on most wards. We saw staff treating patients with compassion, dignity, and respect throughout our inspection.
- Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of staff induction. All the staff we spoke with had received training and knew about safeguarding policies and procedures. The division had a dementia champion and could access an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Wards and theatre skill mix was variable during shifts, but measures were in place to ensure the safety of patients until staffing numbers improve. Qualified nursing staff to patient ratio was one to eight. We reviewed the nurse staffing levels on all wards and theatres and found that levels of skill mix were appropriate at the time of inspection.
- The hospital had an escalation policy and procedure to deal with busy times and senior staff attended bed meetings to monitor bed availability on a daily basis. Staff treated patients in line with national guidance and used enhanced recovery (fast track) pathways.
- Local policies were written in line with national guidelines. Staff told us appraisals were undertaken annually and records for Furness General Hospital showed that 82% of staff across surgical wards, and theatres had received an appraisal.
- Allied Health Professionals worked closely with ward staff to ensure a multi-disciplinary team approach to patient care and rehabilitation. We saw that orthogeriatricians had input into the care pathway of elderly patients.
- Evidence based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures. The Patient Outcomes Reporting Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance. Ward managers and matrons were visible and available on the wards so that relatives and patients could speak with them.

Surgery

- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks versus the England average of 75%.
- Complaints were dealt with informally at ward level and escalated as necessary to ward managers and matrons in line with trust policy. Complaints were discussed at monthly staff meetings where training needs and learning was identified.
- Staff said speciality managers were available, visible, and approachable; leadership of the service was good, staff morale had improved a great deal and they felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

However:

- Theatre staffing comprised of 60:40 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.

Are surgery services safe?

Good

We rated safe as 'good' because:

- Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system and feedback was given from a senior level. Patients at risk of falls, pressure ulcers, and urinary tract infections had robust electronic care management plans.
- Records we checked showed risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. We observed theatre staff practice the 'Five Steps to Safer Surgery' and complete the World Health Organisation (WHO) checklist appropriately.
- Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.
- All the staff we spoke with were aware of the safeguarding policies and procedures and had received training. Mental capacity assessments were undertaken and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the mandatory training programme.
- Planned nurse staffing levels for wards worked on a one to eight qualified nurse to patient ratio. In times of greater patient need, ward staff levels were increased or ward beds were closed. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were variable due to both nursing and medical staff shortage, but the trust were actively recruiting to these posts.
- The hospital had an escalation policy and procedure to deal with busy times and bed management meetings were held to monitor bed availability on a daily basis. Surgical consultants from all specialities led ward rounds and were involved in handovers.

However:

- Theatre staffing comprised of 72:28 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The

average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.

- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation.

Incidents

- Definition of Never event has changed. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a Never EventThe trust were aware they must ensure systems were in place to identify themes from incidents and near miss events following the 2015 inspection.
- Between September 2015 and August 2016, Furness General Hospital reported one incident which were classified as never events for surgery. The incident involved a right plate placed in a left wrist.
- In accordance with the Serious Incident Framework 2015, the surgery directorate reported five serious incidents (SIs) which met the reporting criteria set by NHS England during September 2015 and August 2016 Of these, the most common type of incident reported was 'Slips/trips/falls.
- Staff told us how they reported incidents through the electronic system and most said learning was shared through meetings, ward communication, team briefings, handovers, and notice boards.
- Matrons had an overview of every incident, complaint, and concern and operated a system of response and feedback to patients and staff.
- The trust introduced a weekly patient safety summit to review any harm (or near miss) incidents with senior doctors, nurses and AHPs within a week of that harm occurring. The detail relating to the incident was discussed along with any actions taken and confirmation of individual learning. An example provided was a case of testicular torsion that was missed. This went to the patient safety summit and shared with CCG's. Training was provided by urology clinical lead, at the time. Duty of candour was shared with the patient. The senior team leading the patient safety summit considers and promotes wider learning that can be applied across the organisation, and monitors adherence to the duty of candour. This evidence was obtained the Divisional Governance & Assurance Group.
- Duty of candour is a process of open and honest practice when something goes wrong. We saw that legal requirements were explicitly stated within trust policies, intranet guidance, and training.
- The trust held regular mortality and morbidity case review meetings within all specialities, and these were well attended by the multi-disciplinary team (MDT). Staff presented and discussed case descriptions, outcomes and key lessons learned. The lessons learned were used to inform service development through audit safety huddles, ward meetings and on a one to one basis as necessary.

Safety thermometer

- The national safety thermometer approach was used to record the prevalence of patient harms , and to provide immediate information and analysis for teams to monitor their performance in delivering harm free care. Measurement was intended to focus attention on patient harms and their reduction.
- Data from the Patient Safety Thermometer showed that the trust reported a prevalence rate for Surgery of 22 pressure ulcers, 13 falls with harm and 12 catheter urinary tract infections between September 2015 and September 2016. The prevalence rate of pressure ulcers and falls has fallen over time.
- An audit sample of 116 surgical patients completed in April 2016 showed 110 patients had venous thromboembolism (VTE) and bleeding risk recorded within 24 hour of admission (95%), 34 patients had VTE risk and bleeding risk reassessed 24 hour after admission (29%) . As a result of poor audit results, the trust established as VTE Lead, VTE Policy now rewritten to comply with NICE guidance, a steering group established, standalone bridging guidelines developed, VTE training package now available on the training management system and there was a new VTE algorithm in the clerking documentation.

Surgery

Cleanliness, infection control and hygiene

- The trust had policies in place, for all aspects of infection prevention and control. We observed examples for aseptic technique, hand hygiene, management of outbreaks, norovirus and Methicillin Resistant Staphylococcus Aureus (MRSA). These were available on the trust intranet.
- The trust reported no incidences of MRSA between September 2015 and May 2016. Eight cases of clostridium difficile were reported in the same period.
- Hand hygiene audits showed that all wards were achieving a higher compliance against the threshold target of 85% between February 2016 and July 2016. However, the ophthalmology, patient progression unit, pre-op assessment, orthoptics, and the day care unit had achieved 100% staff compliance with hand hygiene in the same time period.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistent and we observed clear signage for isolation of patients in single rooms.
- Each ward had daily, weekly, and monthly cleaning schedules for domestic staff, housekeepers and nursing staff. Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas.
- Environmental hygiene audits showed that ward 4 did not achieve the 95% target in July 2015 (81.6%), September 2015 (92.5%), October 2015 (93.8%), and November 2015 (92.8%). Similarly, ward 5 did not meet hygiene targets October 2015 (87.3%), November 2015 (87.5%), January 2016 (91.2%), and March 2016 (93.4%) and ward 2 did not meet targets in November 2015 (91.4%) and March 2016 (93.6%). The elective orthopaedic unit consistently met the target. Action plans were in place to improve the environmental hygiene to within trust targets.
- Information from the 'Public Health England, surgical site infection (SSI) surveillance report' (December 2015) showed a rate of 2.8% for knee replacement and 4.3% for hip replacements in the previous four reporting periods across the division. The trust had reviewed these data and taken action to reduce incidences through analysis of cases, increased awareness and training.
- Sepsis screening for emergency admission patients was 75% with a target of 70% showing improvement.
- We observed staff washing their hands and all patients we spoke with told us that this was done, hand gel was available throughout the hospitals, at the point of care, and staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules. Wards had appropriately equipped treatment rooms, used for aseptic technique and dressing changes.
- Clinical and domestic waste disposal and signage was good, staff observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.

Equipment

- All wards and surgical areas were uncluttered and in a good state of repair. Wards had a spacious design, large floor plan and storeroom capacity was available on all wards.
- We inspected resuscitation trolleys and suction equipment on wards and found all appropriately tested, clean, stocked, and checked weekly as determined by policy.
- All managers were responsible for ensuring risk assessments were completed to reduce the risk of slips, trips, and falls. Risk assessments included types of hazard and likelihood of occurrence, quality, and condition of flooring, maintenance and cleaning procedures.
- The arrangements for managing domestic and clinical waste was good.. All staff were aware of the clinical and domestic waste disposal procedures, the use of specific bags and ties to seal clinical waste.

Medicines

- Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained in accordance with trust policy, including regular balance checks.

- Staff we spoke with knew how to report incidents involving medicines. There was an open culture to incident reporting and staff received support from ward managers to learn from incidents.
- We found that medicines reconciliation was not always completed in a timely way. Medicines reconciliation had not been carried out by a member of the pharmacy team within 72 hours of the patient being admitted to hospital in the three records we reviewed. A pharmacy technician attended the ward daily to undertake medication reconciliation.
- Medicines requiring refrigeration were stored securely, and maximum and minimum temperatures had been recorded in accordance with trust policy and met the Medicines and Health Regulatory Agency (MHRA) national guidelines on 'Control and monitoring of storage and transportation temperatures of medicinal products'. However, temperatures had been recorded outside the recommended range for storing medicines on ward 5 on 13 occasions in October and 19 occasions in September 2016. Staff had not taken or recorded any action and the ward manager was not aware temperatures had been outside of the recommended range.
- We checked medicines and equipment for emergency use and found they were readily available and stored appropriately. Staff carried out regular checks to ensure these were in place and fit for use.

Records

- We looked at 10 sets of medical records across Furness General Hospital surgical wards. We saw they were appropriately completed, legible and organised consistently. All documentation checked was signed and dated, clearly stating named nurse and clinician. However, audit has showed varied performance in 5 case note reviews and the GMC/NMC number is not done well.
- Daily entries of care and treatment plans were clearly documented and care plans and charts we reviewed had a completed patient assessment, observation charts and evaluations, food and fluid balance sheets, consent forms with mental capacity assessments where necessary, diabetes and wound care charts as applicable.
- Records included pain scores and allergy documentation.
- We reviewed handover sheets used by ward staff and the situation, background, assessment and recommendation (SBAR) escalation documentation which was effective in guiding staff in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in patient's notes.

Safeguarding

- The trust set a mandatory target of 95% for completion of safeguarding adults and children level two training and at July 2016 the completion rate at Furness General Hospital was 82% for adults and 98% for children. The trust aim to achieve this by the end of the year.
- The trust had a clear safeguarding strategy and safeguarding board meetings. Minutes and action plans were clear and these meetings were well attended by senior staff from across the trust. Learning from serious case reviews was monitored and showed good of staff at safeguarding training.
- Safeguarding training plans and schedules were displayed in ward offices and held centrally by the training department.
- Following the 2015 inspection the trust were asked to ensure all staff understood the process for raising safeguarding referrals. We found that staff on the surgical wards understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust.
- Information was available at ward level with guides, advice, and details of contact leads to support staff in safeguarding decision making.
- A safeguarding thematic review took place in 2015. The action plan from this thematic review was discussed monthly at the safeguarding operational performance group and also quarterly at the Clinical Commissioning Groups (CCG) and Local Safeguarding Committee Board.

Mandatory training

- The trust set a mandatory target of 95% for completion of mandatory training.
- The trust had adopted the ten key subjects as defined in NHS Core Skills Training Framework, as its reference

point for mandatory training. Equality and diversity, health safety and welfare, infection prevention and control and information governance met or exceeded the target.

- Records showed 100% of staff at Furness General Hospital attended the trust induction, 99% completed equality and diversity training, and 100% of staff had completed health and safety training, with 98% having completed governance information training. Additionally, 95% of staff had attended adult basic life support, 96% infection, prevention, and control training level one and two.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning and key trainer delivered sessions. Staff said they were supported with professional development through education
- Display boards in each ward manager's office had a mandatory training plan information and staff training data. An action plan was in place to achieve trust targets.
- Most staff we spoke with confirmed they were up to date with mandatory training. However, some felt they were behind with training due to staff shortages.
- Senior managers told us that training rates were increasing due to easier access to eLearning.
- Staff said they had a robust induction, and mentorship and preceptorship programme.

Assessing and responding to patient risk

- The trust had recently introduced the National Early Warning Score (NEWS) risk assessment system for recognition and treatment of the deteriorating patient. Prior to this, the trust used their own version of an early warning system for 15 years. The strategy and processes for recognition and treatment of the deteriorating patient in surgery had been updated in August 2016 to align with national guidance and change from a previous early warning score and 'track and trigger' system.
- Staff recorded observations, with trigger levels to generate alerts, which identified acutely unwell patients. NEWS audits in 2015 showed that a target of 91% was not met between October (81%), November (88%) and December 2015 (86%), and April (83%), May (83%) and June 2016 (84%). EOU did not meet the 91% target in April 2016 (80%). The three remaining surgical departments consistently met the target.
- We saw full completion of national early warning score (NEWS) risk assessments and sepsis screening tools in the records we checked. Staff we spoke with told us that they were aware of escalation procedures.
- Patient safety was monitored through the completion of moving and handling assessments; falls risk assessments, the national early warning score (NEWS) and malnutrition universal screening tool (MUST) assessments and by following infection, prevention and control measures.
- Comprehensive risk assessments were in place in surgical records and included the completion of cognitive assessment tools, falls risks, pressure ulcer risks, and bed rails assessments.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- Hospital data (April / May / June 2016) showed 97% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives', 2010) for note completion, sign in, time out and sign out.
- Time out was taken for all patients with all members of the team listening and stopping and 99% responding as required at Furness General Hospital. Debrief was recorded at 92% attendance rate. The audit recommended further work on encouraging the team debriefs and the dissemination of learning.
- We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in patient's notes.

Nursing staffing

- As at July 2016, the trust reported a vacancy rate of 4.1 % in registered nurses. The trust reported that national and international campaigns were in place to address the recruitment gap.
- As at July 2016, the trust reported a turnover rate of 8% The trust reported that turnover is reducing in key areas and hot spots are being acted on at a divisional level.
- Between April 2015 and March 2016, the trust reported a sickness rate of 6% the Surgical division.
- As at July 2016, the trust reported a trust wide attendance rate of 95.5% for all staff groups; this is 0.2% below their target of 95.7%. The trust reported that workforce teams are identifying hot spot areas, provide intervention and support, plan programmes of support, and conduct audits including return to work. Long term

absence cases are reviewed on a monthly basis by the divisional workforce teams, supported by occupational health & wellbeing to consider reasonable adjustments to facilitate a return to work.
- The trust had introduced a 'red rules' and 'safer staffing system' to identify when lower than optimal staff numbers may affect patient care and to provide support and initiate mitigation of risk to patient safety. Escalation processes were in place through a process of contacting the matron, service manager and chief matron.
- The patient progression unit had a higher level of staff ratio compared to the wards, and more in line with that of high dependency care (level 2) in critical care environments. Staff ratio was 1:2 patients for 4 beds.
- Monitoring of patient acuity, dependency and actual against planned staffing levels took place on a shift-by-shift basis on all wards. Site management cover was provided out of hours and 24 hours per day, seven days per week by a team of senior nurses.
- Trust information (September 2016) showed actual staffing levels were less than planned staffing levels on some shifts, but safe in relation to surgical activity and the assessed patient acuity.
- The planned qualified nursing staff levels across all wards was 133.9 whole time equivalent (WTE) between April 2016 and July 2016. The actual qualified staffing levels across the same period was 125.5 WTE.
- Figures provided showed non-qualified staff levels across all wards was 55.9 5 WTE between April 2016 and July 2016. The actual qualified staffing levels across the same period was 74.4 WTE.
- Figures show that unqualified staff was increased to support the shortfall of qualified staff.
- Theatre staffing comprised of 60:40 ratio of qualified nurses to support staff. The lowest monthly level of agency usage was 12.8% in April 2015 and the highest monthly agency usage of 20.9% August 2016. The average level of agency use in theatres was 16.5% across the 12 month period from April 2015 to March 2016. Although the agency figures were high, staff we spoke to felt that practice remained safe.
- The trust had established a staff 'bank', which provided cover for short notice requests to reduce agency staff usage.
- Numbers of staff on duty was displayed clearly at ward entrances.
- Although, most staff acknowledged the trust had tried to increase the effectiveness of recruitment and retention, they told us individuals had been working under extreme pressures for some time to cover shifts. During individual and group interviews staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages
- We reviewed staff rotas for the month before inspection and saw numerous shifts not staffed to establishment at Furness General Hospital. There were processes in place to move staff from other wards and departments when possible to ensure safe staffing levels.

Surgical staffing

- As at July 2016, the trust reported a vacancy rate of 4.6% in consultant medical staff. The trust reported that a major recruitment programme was underway to address the gaps in consultant medical staffing.
- Between April 2015 and March 2016, the trust reported a turnover rate of 8% in the Surgical division.
- The proportion of consultants and junior (foundation year 1 and 2) doctors reported to be working at the trust were higher than the England average. Junior doctors we spoke with said they required additional doctors at foundation level one and two due to the demands of the service. They were aware of on-going recruitment drives, felt supported by managers and told us that they felt that practice was good regardless of the shortages.
- Consultants followed an 18 week rota. However, this will change in January 2017 to a 10 week rota to increase consultant visibility, continuity and to extend theatre lists.
- There was consultant, specialist and associate specialist (SAS), and specialist trainee (ST3) doctors onsite and out of hours on-call providing cover from 8am to 6pm Monday to Friday for general surgery, trauma and orthopaedics, urology, ENT, ophthalmology, breast and maxillofacial.
- ENT and urology (each service) had an on-call Monday to Thursday with one consultant & one SAS. Friday to Sunday, 24 hour cover was provided from one site, by either a consultant or SAS. Maxillofacial and ophthalmology (each service) received 24 hours per day consultant on-call cover across the trust.

Major incident awareness and training

- Surgical staff participated in training, to test the business continuity plans and escalation processes.

Surgery

- The trust major incident response plan was in place and available to staff on the trust intranet.
- There were business continuity plans for surgery and senior staff explained these during a group interview. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

We rated effective as 'good' because:

- Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery.
- Evidence based care and treatment national audits identified mixed outcomes for all audits. The National Bowel Cancer Audit Report (2015) showed better than the England average for four measures.
- The National Oesophago-Gastric Cancer Audit (2015) showed patients diagnosed after an emergency admission was 0.0% placing the trust within the lowest 25% of all trusts for this measure.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Furness General Hospital achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit.
- The Patient Outcomes Reporting Measures (PROMS) for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance.
- Pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively, which improved patient comfort.
- Thematic reviews were undertaken as part of everyday practice and included patient falls, number of injuries and low harm incidents, ophthalmology capacity issues, urology incidents, waiting list office incidents, safeguarding referrals, and pressure ulcers.
- The enhanced recovery pathway was used for patients requiring hip and knee replacement, with multidisciplinary input from the pre-assessment team, nurses, physiotherapists, occupational therapists, consultants, orthogeriatricians, and anaesthetists.

However:

- In the 2016 Hip Fracture Audit for the Furness General Hospital, the risk-adjusted 30-day mortality rate was 3.5%, which falls within expectations. The 2015 figure was 4.4%. The proportion of patients having surgery on the day of or day after admission was 85%, which does meet the national standard of 85%. The 2015 figure was 76.9%. The perioperative medical assessment rate was 75.7%, which does not meet the national standard of 100%. The 2015 figure was 41.3%. The proportion of patients not developing pressure ulcers was 94.1%, which falls in the middle 50% of trusts. The 2015 figure was 88.5%. The length of stay was 28.2 days, which falls in the worst 25% of trusts. The 2015 figure was 26.1 days.
- In the 2015 Oesophago-Gastric Cancer National Audit , the trust reported the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0.0%. This placed the trust within the lowest 25% of all trusts for this measure.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetists, and The Royal College of Surgeons.
- We saw that patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice.
- The trust did not participate in the 2015 National Vascular Registry (NVR) audit.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary

achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to orthogeriatricians input for patients over 70 years old.
- Results from the Patient Outcomes Reporting Measures (PROMS) from April 2015 to March 2016 for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance with EQ VAS being better than the England average, EQ 5D index and the Oxford score were slightly worse.
- According to the National Joint Registry Report covering period January 2016 to October 2016 data, the trust had performed 129 hip and 132 knee replacements.
- Thematic Reviews were undertaken as part of everyday practice and included patient falls, number of injuries and low harm incidents, ophthalmology capacity issues, urology incidents, waiting list office incidents, safeguarding referrals, and pressure ulcers.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients.
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- An audit of pain management in the recovery room recommended the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief. Staff asked patients regularly if they had any pain, so they could administer analgesia promptly or request an anaesthetic review.
- A dedicated pain team was accessible to educate on new equipment and medications. The pain team visited patients with PCAs the day after surgery. The pain team were available Monday to Friday 8am to 5pm. Anaesthetists provided support with pain relief out of hours.
- Patients admitted with a fractured neck of femur had their pain assessed immediately upon presentation at hospital and within 30 minutes of administering initial analgesia, hourly until settled on the ward and regularly as part of routine nursing observations throughout admission.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Staff identified patients at risk of malnutrition by working with patients and their families to complete a malnutrition universal screening tool (MUST) score.
- Snack rounds were carried out on all surgical wards to supplement scheduled meals and ensure that patients had high calorie options throughout the day.
- Ward audits included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales. We observed appropriately completed fluid balance charts and dietary intake charts. .
- The nutritional risk assessment identified the levels at which dietitian referral was recommended. The dietetics service received electronic inpatient referrals and provided input to all wards as required.
- Arrangements were in place for when enteral feeding was required out of hours as part of a protocol to ensure that patients did not have to wait for a dietitian to be on duty.
- We saw a range of food choice, meals and snacks. Patients who required nutritional support were identified.
- Surgical pre-operative assessments performed by nursing staff, offered tailored nutrition and hydration guidance to patients and provided all elective patients with fasting instructions to follow on the day of their surgery.
- Information and lessons learnt information was shared at the clinical leaders, clinical managers and nutrition link nurses forums, nutrition steering group, and with catering managers.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.
- We reviewed 18 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department.

- Meal charts were completed comprehensively and reviewed.

Patient outcomes

- Patients at Furness General Hospital had a lower expected risk of readmission for non-elective admissions and a lower expected risk for elective admissions. Elective Trauma and Orthopaedics has the largest relative risk of readmission.
- In the 2016 Hip Fracture Audit for the Furness General Hospital, the risk-adjusted 30-day mortality rate was 3.5%, which falls within expectations. The 2015 figure was 4.4%. The proportion of patients having surgery on the day of or day after admission was 85%, which does meet the national standard of 85%. The 2015 figure was 76.9%. The perioperative medical assessment rate was 75.7%, which does not meet the national standard of 100%. The 2015 figure was 41.3%. The proportion of patients not developing pressure ulcers was 94.1%, which falls in the middle 50% of trusts. The 2015 figure was 88.5%. The length of stay was 28.2 days, which falls in the worst 25% of trusts. The 2015 figure was 26.1 days.
- There were 107 cases in the audit and the case ascertainment rate was 78.1% which lower than the national aggregate of 90.7%.
- In the 2015 Bowel Cancer audit (trust wide results), 75% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was better than the national aggregate. The 2014 figure was 52%. The Risk-adjusted 90-day post-operative mortality rate was 3.8% which was within the expected range. The 2014 figure was 3.4%. The Risk-adjusted 2-year post-operative mortality rate was 24.7% which falls within the expected range. The 2014 figure was 26.7%. The Risk-adjusted 90-day unplanned readmission rate was 16.8% which falls within the expected range. The 2014 figure was 14.3%.
- The Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 56% which falls within the expected range. The 2014 figure was 59%.
- The trust did not participate in the 2015 National Vascular Registry (NVR) audit.
- In the 2015 Oesophago-Gastric Cancer National audit (OGCNA), the trust reported the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0.0%. This placed the trust within the lowest 25% of all trusts for this measure. The 2014 proportion was not reported. The 90-day post-operative mortality rate was not applicable and they were not eligible for this metric.
- The proportion of patients treated with curative intent in the Strategic Clinical Network was 41.6%, significantly higher than thenational aggregate. This metric was defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.
- The National Emergency Laparotomy Audit (NELA) report (2015) showed Royal Lancaster Infirmary achieved a rating over 70% for five measures and had a good rating for nine out of 10 elements of the audit. The element which was worse than required related to orthogeriatricians input for patients over 70 years old.
- Results from the Patient Outcomes Reporting Measures (PROMS) from April 2015 to March 2016 for groin hernia metrics and knee replacement metrics were about the same as the England average whilst hip replacement metrics had mixed performance with EQ VAS being better than the England average, EQ 5D index and the Oxford score were slightly worse.
- Furness General Hospital theatre usage in June 2016 was highest in Theatre 6 at 89.7% and lowest in the Women's Unit Theatre 2 (Obstetrics) at 80.7%. The operating time is calculated as time between anaesthetic being induced and operating ending.

Competent staff

- At July 2016, the trust reported that 71% of leadership appraisals had been completed against a target of 100%. Eighty-two percent all other staff had received an appraisal compared to a trust target of 95% for other. The trust has implemented a new e-appraisal system for leadership appraisals and that some appraisals in the 'other' category have had to be deferred due to acute service pressures. We saw evidence to confirm appraisal rate data. Staff told us the appraisal target would be met within the allocated timescales.
- The trust has implemented a new e-appraisal system for leadership appraisals and that some appraisals in the 'other' category have had to be deferred due to acute service pressures. We saw evidence to confirm appraisal rate data.

- Staff we spoke with felt able to discuss their training needs with their line manager. Many discussed opportunities to further their career and stated they were encouraged to undertake modules appropriate to their training needs.
- Support was provided for nursing revalidation by identifying expectations and continued education required.

Multidisciplinary working

- Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- A Pharmacy Transformation Project was underway to enable focusing the pharmacy workforce towards clinical activities; working more closely with patients and working alongside doctors and nursing staff in clinical roles to optimise medicines and secure better outcomes for patients. It included review of all non-clinical pharmacy services to identify those that might be stopped or delivered differently in future. The trust has developed a partnership with a provider of pharmaceutical services; external pharmacy to provide on-site retail outlets and undertake dispensing for outpatients. Good progress has been achieved with seven day opening hours.
- Staff explained to us the wards worked with local authority services as part of discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Protocols had been developed for the effective handover of patients to Royal Lancaster Infirmary when needed. These involved the identification of bed availability, NEWS assessment and both verbal, electronic and written transfer of information.
- We observed staff, including those in different teams and services, becomes involved in assessing, planning and delivering people's care and treatment.
- There were established multi-disciplinary team (MDT) meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with the patient, their family, allied health professionals and the local authority when planning discharge of complex patients to ensure the relevant care was in place and that discharge timings were appropriate.

Seven-day services

- The elective orthopaedic theatre and surgical team had plans to deliver a seven day service from January 2017. Weekend morning capacity was currently utilised in theatres.
- Out of hours ward and on-call cover for general surgery and trauma & orthopaedic service had a non-resident overnight consultant, SAS or ST3.
- We were told that medical support was provided by foundation year 1 doctors and a senior review on Saturday and Sunday. Weekend ward cover was provided as part of general on-call with junior doctors providing 24 hours per day ward cover. Theatres had 24 hour shift cover plus a non-resident on call.
- All surgical wards were looking at undertaking Keogh ward rounds to improve seven day working. Keogh ward rounds are consultant-delivered ward rounds providing a structured and consistent opportunity for the multidisciplinary team to review patients' progress, share information, and communicate with the patient.
- There were dedicated physiotherapist and occupational therapists for each ward available Monday to Friday. There was limited access to physiotherapists and occupational therapist at the weekend and patients were prioritised by level of need and orthopaedic plan of care and treatment. Prior to visiting patients the physiotherapist and occupational therapist receive a handover from the weekday dedicated team.
- There was no speech and language support service at the weekends.
- There was a pharmacist onsite Monday to Sunday, 9am to 5pm.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.

Surgery

- We saw surgical wards utilise a new electronic records system to record patient care plans and risk bundles. This allowed for immediate access by any other clinician or professional providing care for that patient. The system was not fully embedded but actively used on all surgical wards.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures, and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the nurse or consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The completion rated for MCA and DoLS training was 88% and was completed as part of the Safeguarding adults level 2 training.
- We found policy and procedures in place, ensured that capacity assessments and consent was obtained by middle grade level medical staff or above. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications. However, most patients consented on the day of procedure.
- An action plan created to improve consent practice included the creation of patient information leaflets, procuring color printers for clinical areas-consent to be taken in the clinics with documentation of contact details, developing electronic consent forms, and the standardizing of the consent process with clear documentation.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.
- Mental health liaison support was available at Furness General Hospital.

Are surgery services caring?

Good

We rated caring as 'good' because:

- The Friends and Family Test response rate for surgery at the trust was 31%, which was better than the England average of 29%, between October 2015 and September 2016. FGH had a response rate of 36% had a higher, and therefore better, response rate than the England average. The monthly percentage recommended fluctuated between 82% and 100%.
- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating. In that survey 81% of patients stated they were involved in decision making, 89% said they were given the name of their specialist nurse, 93% said they were treated with dignity and respect, and 92% stated they received contact information.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary. We saw patient information leaflets available for patients that explained their procedure and after care arrangements.
- Patients and relatives said they felt involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained procedures and treatment. Patients felt they were well educated, supported, and prepared for their surgical procedures.
- Patients we spoke to said, "excellent throughout", "happy with treatment", "very good service", "food had been good" and "staff were very caring", and "the anaesthetist was marvellous".
- Multi-faith spirituality groups were accessible.

Compassionate care

- The Friends and Family Test response rate for Surgery at the trust was 31% which was better than the England average of 29% between October 2015 and September

2016. Furness General Hospital had a response rate of 36% had a higher and therefore better response rate that the England average. The monthly percentage recommended fluctuated between 82% and 100%.

- The National Cancer Experience Survey 2015 (published 2016) published a score of 8.8 out of 10 average rating. 81% of patients stated they were involved in decision making, 89% given the name of their specialist nurse, 93% treated with dignity and respect and 92% stated they received contact information.
- The trust took part in the Patient Led Assessment of the Care Environment (PLACE, 2015). The results showed the surgical division scored 85.3% for providing privacy and dignity for patients and 86% for dementia care.
- 'You said, we did' was used to identify patient views. Some comments related to the improved food with involvement of the hospital chef and meals being plated up on the ward.
- Patients we spoke to said, "excellent throughout", "happy with treatment "very good service", food had been good" and "staff were very caring", and "the anaesthetist was marvellous".
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- During inspection we observed patients being spoken to in an appropriate manner, information being shared in a method that they understood and saw staff take time to reassure and comfort patients.

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the Consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients reassured.
- As part of the elective surgery pre-operative assessment process, patients had the opportunity to bring relatives or friends along to the consultation should they so wish.
- Patients felt they were well informed , supported, and prepared for their surgical procedures.
- Patients said staff took time to explain procedures, risks and possible outcomes of surgery.
- Complex information was repeated more than once by different levels of staff so that they understood their care, treatment and condition. Patients and relatives felt involved in their care and regular ward rounds gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan.
- Senior nursing staff were visible on the day of inspection and staff reported the Ward Manager and Matron were available for patients and their relatives. It was made clear to patients and visitors to the ward who was on duty as this was displayed at the ward entrance.
- The trust follows the Butterfly Scheme which provided an option of joining for people who go into hospital with dementia, acute or longstanding memory problems and confusion. It allows all staff to know that the person may need extra care and attention safe. The butterfly is displayed on their electronic record for any future needs.
- The trust offers a forget me not passport of care for every inpatient admission. This is completed by the families and carers, telling the staff how to care for the person in their unique way, offering individual detail to give that personalised approach.
- Easier to access 'translation and Interpretation' services were available.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- We were given information about support groups for patients. These included stoma care support groups, pain management groups and open access to clinical nurse specialist helplines for surgical patients.
- An extensive multi-faith chaplaincy service was available within the hospital. We observed chaplains during their support to patients and relatives. Patients and relatives said this was an extremely positive experience and individualised support.
- Clinical psychology support services commissioned by the trust supported patients as necessary. For example support was routinely provided for burns patients, amputees and those requiring stomas.

- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially.

Are surgery services responsive?

Good

We rated responsive as 'requires improvement' because:

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements. This included changes in discharge procedures such as the implementation of the 'Hospital Home Care Team' and the discharge support team to enable more efficient and timely discharge with on-going rehabilitation.
- The trust's referral to treatment time (RTT) for admitted pathways for Surgery has been worse than the England overall performance between October 2015 and August 2016. However, the latest figures for September 2016 showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks versus the England average of 75%.
- The divisional management team had taken action to address the low referral to treatment targets. This included a local amnesty with CCGs allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and through provision of additional capacity (sub-contracting to the independent sector, additional activity sessions and operating department efficiencies).
- For the period Q1 of 2015/2016 to present the trust cancelled 561 operations on the day of surgey. Of the 561 cancellations, all were rescheduled and treated within 28 days. This was better than the England average. The trust's cancelled operations as a percentage of its elective admissions was worse than the England average.
- The hospital had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.
- The service was responsive to the needs of patients living with dementia and learning disabilities. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.
- Complaints had reduced from the previous year, were handled in line with the trust policy, and discussed at all monthly staff meetings. This highlighted that training needs and learning was identified as appropriate.

Service planning and delivery to meet the needs of local people

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements. This included changes discharge procedures such as the implementation of the Hospital Home Care Team and the Discharge Support Team to enable more efficient and timely discharge with on-going rehabilitation.
- The trust advised that delivery plans with three main objectives were in place to implement the NHS Five Year Forward View; to restore & maintain financial balance; and to deliver core access and quality standards for patients.
- Additionally, the trust aim to ensure clinical services were structured to deliver Better Care Together (local population health needs) by recruiting & retaining motivated and valued leaders and teams, consistent delivery of patient care every day and by implementing a single electronic patient record to aid the sharing of information and efficiency of practice.

Access and flow

- Between April 2015 and March 2016 the average length of stay for surgical elective patients at Furness General Hospital was 2.8 days, compared to 3.3 days for the England average. For surgical non-elective patients, the average length of stay was 6.1 days, compared to 5.1 for the England average.
- The trust's referral to treatment time (RTT) for admitted pathways for Surgery had been worse than the England overall performance between October 2015 and August

2016. However, the latest figures, for September 2016, showed an improvement in the trust's performance, with 75% of this group of patients treated within 18 weeks, versus the England average of 75%.
- The divisional management team had taken action to address the low referral to treatment targets. This included a local amnesty with CCGs allowing the treatment of patients in order, treating the longest waiters on the RTT pathway, changes to the RTT standard, and through provision of additional capacity (sub-contracting to the independent sector, additional activity sessions and operating department efficiencies).
- All specialties except trauma and orthapedics, and opthalmology were above the England average for admitted RTT (percentage clock stops within 18 weeks), in September 2016.
- The National Cancer 2 Week Wait Targets confirmed performance was 95.2%, 98.2%, 96.3%, 96.6%, and 95.3% between April 2016 and August 2016, across the trust.
- For the period Q1 of 2015/2016 to the date of inspection the trust cancelled 561 operations on the day of surgery. Of the 561 cancellations, all were rescheduled and treated within 28 days. This was better than the England average. The trust's cancelled operations as a percentage of its elective admissions was worse than the England average.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.
- There were no 28 day breaches encountered for the year to June 2016.
- Pre-operative assessment of elective patients was organised to take place as early as possible in the elective pathway once patients were added to the waiting list.
- The orthopaedic service operated electively up to six days of the week. Elective admissions were planned based on consultant availability and complexity of the procedures. We found the trust had plans in place to increase the service with a daily extra theatre list and by extending hours at the weekend.
- The elective ward had daily consultant led ward rounds, Monday to Friday. Work was on going to review the options available to the department to enhance the care provided to patients and to increase flexibility with theatre lists.
- The trust followed a transfer policy regarding the movement of patients between hospital sites for rehabilitation. This policy was in place to minimise the risk to patients post-surgery and to prevent transfer of patients with complex medical needs.
- The current length of stay for trauma, orthopaedic and general surgery patients was above the national average. Ward managers said this was due to complexity of cases and shortage of local authority services.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Surgical wards worked with the discharge co-ordinators to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs.
- At an operational level, flow was maximised by employing discharge co-ordinators. The role of the co-ordinator enabled improved communication between patient, ward staff, clinicians, Adult Social Care and all allied health professionals involved in the care. We were told that having dedicated co-ordinators increased efficiency on the ward when planning and arranging appropriate discharges.

Meeting people's individual needs

- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- Leaflets were available for patients regarding their surgical procedure, pain relief, and anaesthetic. Alternative languages and formats were available on request.
- Ward managers were clear about zero tolerance for discrimination.
- There was good access to the wards. There were lifts available in each area and ample space for wheelchairs or walking aids.
- The surgical division applied the 'This is me' personal patient passport / health record to support patients with

learning needs and dementia. Symbols on electronic white boards identified special requirements such as dementia, falls risk, and dietary needs. There were forget-me-not personal information booklets.

- The care of the elderly team screened everyone for confusion, delirium, and undiagnosed dementia as part of the National Commissioning for Quality and Innovation(CQUIN), which also identified diagnosis of dementia using specific admission documentation. If confusion or forgetfulness was evident but there was no confirmed diagnosis of dementia a cognitive assessment was carried out by nurses on the surgical ward and appropriate referral is made for diagnosis.
- There was a matron for professional standards in dementia in post that formed part of the safeguarding team. She managed the care of the elderly teams to ensure the appropriate care was put in place on assessment, and carer/family involvement was included. The surgical division had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Furness General Hospital offers a dementia menu for those who need it. Support needs were identified through the Butterfly Scheme; it encouraged family and carers to be involved in choosing from the menu and helping at mealtimes.
- Specific equipment had been purchased and was available for use patients with bariatric needs. This promoted safe practice for both staff and patients. Staff were able to make requests if additional equipment was required.
- The trust utilises the NHS shared business contract and regularly accesses services from two translation providers. The translation and interpretation service is available 24 hours per day and is booked by the ward or department by calling the hospital switchboard. The switchboard holds the corporate booking PIN and passcodes. For planned activity the translation service can been booked in advance., Pre booking has the option of requesting a preferred translator to ensure continuity.
- We saw that 'Twiddlemuffs' were available from the wards, which were nitted woollen muffs with items such as ribbons, large buttons, or textured fabrics attached that patients with dementia can twiddle in their hands. Patients with dementia often have restless hands and like something to keep them occupied. The 'Twiddlemuffs' provide a source of visual, tactile and sensory stimulation at the same time as keeping hands snug and warm. We did not see patients offered these.
- There was one mixed sex accommodation breach on the patient progression unit in July 2016. This was due to a delay in discharge to a ward due to no ward beds being available.

Learning from complaints and concerns

- Between 27 October 2015 and 27 October 2016, there were 126 complaints about Surgical Care. The trust took an average of 27.71 days to investigate and close complaints. This is in line with its complaints policy, which states that complaints should be dealt with within 35 days of receipt, unless a different timescale has been agreed with the complainant. There were 25 complaints relating to FGH, 6 (24%) of which referred to theatres.
- Complaints were discussed in ward meetings as a standing agenda item. A full report was provided monthly, quarterly and annually.
- All wards and departments had posters situated at the entrance clearly explaining what to do if anyone was unhappy with the care, services, or facilities we provide. Contact details for the Patient Advice Liaison Service (PALS) was clearly listed. Wherever possible the PALS would look to resolve complaints at a local level.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were discussed with staff who were encouraged to share learning to prevent recurrence.
- Mandatory training complaints workshops were organised by the practice educators and presented by the head of patient relations were provided (approx. 80 workshops per annum).
- Ward staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.

Are surgery services well-led?

Good

We rated well-led as 'good' because:

- Senior managers had a clear vision and five year plan for the surgical service division. Staff were able to repeat and discuss its meaning. Joint clinical governance and directorate meetings were held each month.
- The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Staff said managers were available, visible, and approachable. They also said leadership of the service and staff morale was good with staff supported at ward level.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Improvements compared with results from the 2014 survey were seen in other areas, such as staff who felt they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, improved percentage of staff reporting most recent experience of harassment, bullying, or abuse.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrates the views of people with safety, quality, activity, and financial information.

However:

- Staff told us they had been working in difficult circumstances during the last eighteen months to cover staff and skill shortages. Staff said this had led to some staff working under extreme pressures for an extended period to cover shifts.
- The trust supported the Nursing Times 'Speak Out Safely' campaign encouraging staff members who had a genuine patient safety concern to raise this within the organisation at the earliest opportunity. Staff we spoke to told us they felt confident about speaking out. However, some staff continued to have concerns about speaking out and felt that there were on-going difficulties around speaking out due to a previous blame culture and alleged bullying.

Vision and strategy for this service

- The trust launched the Better Care Together clinical strategy in February 2014. We met with senior trust and divisional managers who were clear about the vision and strategy for the division and identified actions for addressing issues within the division. The trust vision and strategy was displayed in wards and staff demonstrated the values of the trust during the inspection and were clear about the trust vision and understood their role in contributing to achieving the trust wide and directorate goals.
- The trusts Better Care Together was one of 50 'vanguards' helping to deliver the Five Year Forward View, the vision for the future of the NHS. Vanguards were leading on developing new care models that will act as blueprints for the future of the health and care system across the country.
- The Sustainability Programme Board met monthly. This group led the development and the delivery of the trust sustainability plan ensuring, on behalf of the trust, that all key milestones were met. This board fed into the trust Board through the finance committee.
- The programme management office reported into the Sustainability Programme Board and offered support to the divisional teams, with hands-on assistance to help identify and deliver efficiency.

Governance, risk management and quality measurement

- Staff told us that the governance framework had greatly improved. They said process was effective and efficient at to supporting the delivery of the strategy and good quality care. Registered nurses we spoke to felt that the greatest area of improvement was in relation to lessons learned from complaints and incidents.
- We were told that wards received a monthly 'WESEE' report, which provided lessons learned feedback for matrons who disseminated information with ward staff at ward meetings and safety huddles.
- A clear responsibility and accountability framework had been established and was referred to as 'Board to ward'. Staff at different levels were clear about their roles and understood their level of accountability and responsibility. It was highlighted that staff felt that openness and transparency had also improve and that staff at all levels were eager to learn and improve their practice.
- The trust had a detailed risk register for the surgical division, which was robust for identifying, recording, and

managing risks, issues, and mitigating actions. There was alignment between the recorded risks and what people said was 'on their worry list'. The main concerns were linked to staff shortages at nursing and junior doctor levels.

- The risk register for the Surgical Division was updated frequently, with high risks reviewed with input from medical staff, ward staff, and senior management. Monthly meetings were held to review incidents, which had occurred, and any wider risks identified.
- Statistics showed that the number of risk reviews completed on time was at 94.1%. The risk register showed that there were 86.3% risks with open actions and 88.9% open actions showing progression.
- All senior staff in the service were responsible for the monitoring of performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance. The matrons conducted weekly audits of the ward areas with ward managers to measure quality.
- Clinical audit and effectiveness steering groups took place on a monthly basis to provide a holistic understanding of performance, which integrated the views of people with safety, quality, activity, and financial information.
- The Medical Staffing Committee met every three months and now in core time (agreed by trust), which enabled a higher attendance rate. Meetings were said to be productive and accountable, with dissemination of progress and opportunity to share ideas. Clinical commitments were re-scheduled to help attendance and management were said to attend every meeting. It was felt that the management team had 'done a good job' changing culture, communicating, making improvements, and managing engagement with medical staff.

Leadership of service

- The clinical director, divisional general manager, and assistant chief nurse led the surgical division. The surgical division comprised five matrons, five service managers, and eight clinical leads.
- Staff felt that leaders had the skills, knowledge, experience and integrity that they needed, both when they were appointed and on an on-going basis. This included the capacity, capability, and experience to lead effectively.
- Staff said that leaders understood the challenges of achieving and maintaining good quality care and had identified the actions needed to maintain and improve services.
- Senior team members were said to be visible and approachable. It was acknowledged that matrons, service managers and assistant chief nurse were very "hands on" in supporting the staff on the wards.
- Staff were able to clearly identify the emergency surgery medical/nursing lead and their roles and responsibilities.
- The staff in the surgical division were clear about their roles, responsibilities, and accountability. Reinforcement of this was through annual appraisal, one to one sessions, preceptorship, mentorship, clinical supervision, and annual mandatory training.
- The matrons met regularly with all of the divisional matrons and the deputy director of nursing. Information from these meeting was shared with ward managers, clinical leads, and ward staff as necessary.
- The trust offer a range of management and leadership development programmes through on-going work with local universities.
- A new quality ambassador scheme has been developed to help improve quality of care at Furness General Hospital. The scheme gave staff the opportunity to explore and promote good practice by understanding the way care was delivered in different settings, and sharing good practice with colleagues across the two organisations.
- We found that ward managers were clear around transfer protocols and the level of patient acuity accepted at WGH. The ward manager and RMO felt able to challenge inappropriate transfers to and from the hospital. Staff stated that patients who did not meet the criteria would not be accepted as an inpatient. There were procedures and protocols in place which were accessible to all staff on the intranet.

Culture within the service

- During interviews with staff, they told us the division had strong leadership and most of senior managers were

highly visible and 'hands on'. This reflected the vision and values of the division and the trust. We interviewed staff on an individual and group basis throughout surgical wards, theatres, and units.

- Staff spoke positively about the service they provided for patients and high quality compassionate care was a priority. We saw examples of good team working on the wards between staff of different disciplines and grades. Staff were enthusiastic about their work, the service they provided and generally the organisation they worked for, however they told us that staff morale was variable but had increased greatly on wards and in theatres.
- This trust supports the Nursing Times 'Speak Out Safely' campaign encouraging staff who had any patient safety concern to raise this within the organisation at the earliest opportunity. The majroty of staff we spoke to told us they felt confident about speaking out. However, we spoke with individual staff who continued to have concerns about speaking out and felt that there were on-going issues around this issue.
- The trust developed and implemented a Behavioural Standards Framework to improve patient experience and satisfaction, staff well-being and experience, partnership working, performance, culture and Progress continuous improvement. The Behaviour Standards Framework was mandatory and incorporated into induction and appraisal.

Public engagement

- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the Friends and Family Test (FFT), and Patient Advice Liaison Service (PALS) and 'Tell us what you think?' questionnaires were available on all wards and reception areas. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients the opportunity to express their views and opinions.
- Discussions with patients and families regarding decision making was recorded in patient notes.
- The Friends and Family Test (FFT) survey was used to elicit patient feedback on how likely patients were likely to recommend the hospital to family and friends, respect and dignity, involvement in care and treatment, cleanliness, kindness and compassion received. Test performance (percentage response rate) was 31%, which was better than the England average of 29%. The monthly percentage recommended fluctuated between 82% and 100%.

Staff engagement

- Staff survey results published February 2016 showed more staff felt motivated at work and would recommend University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) as a place to work or receive treatment. The score for staff feeling motivated at work rose to 3.95 out of 5, compared with 3.81 in 2014, and the score for staff recommending the organisation as a place to work or receive treatment rose to 3.72 out of 5, compared to 3.47 in 2014. Improvements compared with results from the 2014 survey were seen in other areas, such as staff who felt they received support from their immediate line manager, staff feeling the trust made effective use of patient and service user feedback, improved percentage of staff reporting most recent experience of harassment, bullying, or abuse.
- Results also showed staff felt the trust had improved in satisfaction with pay, managers taking an interest in health and wellbeing, incident reporting, acting on concerns, and prioritising the care of patients.
- We saw senior managers communicate to staff through the trust intranet, e-bulletins, team briefs, and safety huddles. Each ward held monthly staff meetings, which discussed key issues for continuous service development.
- All staff were invited to speak with the matron and were able to voice their opinions, receive feedback, and discuss any concerns.
- Staff we spoke to said they felt appreciated and listened to when they raised concerns.
- Staff said they were well supported when dealing with personal or family illness and advised that the trust as employers showed compassion, kindness, and support.

Innovation, improvement and sustainability

- The Bay Dementia Hub was a service created to help people worried about their memory, or diagnosed with dementia. This new initiative sought to build on the existing work of dementia-specialist.

Surgery

- Surgical wards worked with the discharge co-ordinators to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs.
- At an operational level, flow was maximised by employing discharge co-ordinators. The role of the co-ordinator enabled improved communication between patient, ward staff, clinicians, Adult Social Care and all Allied Health Professionals. We were told that having dedicated co-ordinators increased efficiency on the ward when planning and arranging appropriate discharges.
- The surgical wards had implemented safety huddles to improve communication and safety.
- The electronic patient record enabled staff to document patient information in real time and the information was accessible by all appropriate nursing, medical and surgical staff immediately.
- The surgical division used a new quality ambassador scheme to help improve quality of care.
- The dementia care volunteer ward programme was launched to support dementia patients, prevent isolation, encourage engagement, and to provide support and stimulation.
- Each ward had electronic smart boards, which displayed minimal patient information with coding known to nursing and medical personnel, which enabled them to received 'live' patient information at a glance. The use of symbols meant patient information was anonymous, such as a butterfly for dementia, care and a maple leaf for end of life care.
- Further initiatives such as completion of the Intensive Support Team (IST) model, identification of theatre productivity improvement through The Productive Operating Theatre model (TPOT) and identification of outpatient efficiency improvement were developed.

Critical care

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

Information about the service

The University Hospital of Morecambe Bay (UHMB) provides critical care services in the Furness General Hospital (FGH) and Royal Lancaster Hospital. The surgical and anaesthetic directorate manages the service. The unit is part of, and works closely with, the Lancashire and South Cumbria Critical Care Network (LSCCCN).

At the time of this inspection the trust had a total of 14 adult critical care beds and the Intensive Care National Audit and Research Centre (ICNARC) data indicated that there were around 850 admissions a year, with 350 at the FGH site. Across two sites there were nine 'intensive care' (ITU) beds, for complex level 3 patients who require advanced respiratory support or at least support for two organ systems, and five 'high dependency' (HDU) beds, for level 2 patients who required very close observation, pre-operative optimisation, extended post-operative care, or single organ support, and this included care for those 'stepping down' from level 3 care.

The focus of this report was the critical care unit at FGH. ITU could flexibly admit three level 3 and three level 2 patients; two bed spaces of the six in total were single rooms. The service provided intensive and high dependency care for patients who had had complex surgery. It also provided care for emergency admissions.

During inspection our team spoke with nine members of staff. We spoke with three patients and two relatives. We observed care, reviewed policy and documentation, and checked equipment. We were able to review a range of performance data during the inspection.

Summary of findings

Following our previous inspection, in July 2015, we found that overall the critical care service provided at FGH required improvement. During this inspection we rated this service as 'good' overall with 'good' ratings in safe, effective, caring, responsive and well-led because:

- During our inspection we found that nurse staffing was good, with sufficient staffing levels for provision of critical care. Recruitment was underway to provide a supernumerary coordinator and practice educator in line with Guidelines for the Provision of Intensive Care Services (GPICS) (2015). Supernumerary induction for new nursing staff was good, with an organised approach to nurse appraisal and to nursing achievement of competence in critical care skills. This was an improvement upon findings in 2015, when we found that, although nurse staffing levels had improved from the 2014 inspection, there was no supernumerary coordinator nor any funded practice educators in post.
- Medical staff we spoke with discussed the historical shortfalls in anaesthetic staffing levels for out of hours cover, and this was being addressed by increasing numbers of consultant staff. We had noted in 2015 that the intensive care services, obstetrics, anaesthetics, and emergency surgical services across the trust did not have enough anaesthetic staff to meet the required national recommendations and standards. However, this was well understood by the

executive team and clinical staff. We can now report that an additional five consultants at FGH have been funded to ensure safe staffing levels and mitigate risks. A recruitment strategy was in place.

- We observed good medical handover, and staff we spoke with told us that the systems in place for responding to acutely unwell patients outside of ITU was good.
- We had reported in 2015 that medicines were not stored securely in the unit, however, this had improved, and we did not observe any breaches in pharmacy storage standards, nor poor compliance in regular safe storage of medicines audits. Similarly, improvement in general storage in the unit was observed with well organised locked access storage rooms available on the entrance corridor to the secure main unit. The main unit was tidy and stores were well organised.
- The emergency resuscitation equipment and patient transfer bags were checked daily, with a good system in place as per trust policy. There was good provision of equipment in critical care, with robust systems for medical device training. The risks associated with loss of service should equipment be broken and require replacement were on the risk register.
- The unit was visibly clean and appeared light and spacious for the four patients in the main bay. Staff we spoke with told us that there had been capacity to flexibly increase to five bed spaces in the main area, but there had been recent agreement to close that area to create more floor space. The strategy included future planning for a larger combined critical care unit.
- Standards of infection prevention and control were in line with trust policy. Staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported assurance that patients with infections received best practice, and the small proportion of patients that may need specialist ventilated isolation facilities would be transferred if required. Patients with infections were isolated as per policy, however, the two isolation rooms were not designed in line with Health Building Note (HBN 04-02) and did not have ensuite shower rooms or ventilated lobby areas.
- There was ongoing progress towards a harm free culture. Incident reporting was good, with low incidence of harm and infection. There was a proactive approach to the assessment and management of patient-centred risks, and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. The programme for care of patients with tracheostomy across wards was comprehensive, and there was further work ongoing to identify specific admission wards at FGH, in line with work at the RLI site.
- In 2015 we reported that there was no Critical Care Outreach Team (CCOR) across both units at UHMB. At this inspection , the trust did not have a dedicated CCOR team and this continued to be on the risk register. However, we noted good provision of principles in line with GPICS (2015) and NICE CG50, and against the seven core elements of Comprehensive Critical Care Outreach,(C3O 2011) 'PREPARE'; (1. Patients track and trigger, 2.Rapid response, 3.Education and Training, 4.Patient safety and governance, 5. Audit and evaluation [monitoring patient outcome], 6.Rehabilitation after critical illness and 7. Enhancing service delivery.) Staff we spoke with told us that there was an 'educational model' of outreach embedded across the trust. We observed one occasion of a rapid response to an acute emergency by the team during the inspection.
- Patients were at the centre of decisions about care and treatment. The weight of positive comments that we found gave evidence of a caring and compassionate team. Staff were positive, motivated and, without exception, delivered care that was kind, promoted dignity, and focused on the individual needs of people.
- The team in critical care services was well-led. A genuine culture of listening, learning, and improvement was evident amongst all staff we spoke with. Staff we spoke with across the team were passionate about their roles and proud of the trust. The investment in leadership programmes was good, and it was clear the learning was shared and staff had a shared purpose and made an impact in practice. Governance arrangements were embedded in the directorate.

Critical care

- We found that ICNARC data showed that patient outcomes were comparable or better than expected when compared with other units nationally, this included unit mortality.
- Follow up clinics were in place at the FGH for critical care patients who had experienced a stay in critical care of longer than 4 days, as recommended by NICE CG83 and GPICS (2015). Emotional support was given as part of the follow-up appointmentand post critical care admission, and additional psychological support was assessed on an individual basis. The use of patient diaries had been embedded in practice since our previous inspection.
- Patients received timely access to critical care treatment, and consultant-led care was delivered 24/7. A low number of critical care elective admissions were cancelled, and there was a low number of readmissions to the unit. Patients were not transferred out of the unit for non-clinical reasons. Staff worked hard to not discharge patients to wards during the night, resulting in a low number of out of hours discharges, comparable with other similar units.
- Fewer than half of all discharges to ward areas were delayed beyond 4 hours due to the pressures on hospital beds, with 25% to 40% reported in ICNARC in 2015/2016. This did not prevent patients from receiving the care and treatment they needed, and staff paid attention to patient dignity when Department of Health (DoH) single sex accommodation breaches occurred. ICNARC data did indicate that the unit position was comparable nationally with other units against the 8 hour reported target in the CMP.
- Staff we spoke with in critical care and theatres did not express concern about the patients when 'outlier' admissions took place, and staff had not reported any incidents of harm as a consequence. The FGH unit had reported an increase in annual admissions, of around 40 in 2015/2016. Staff we spoke with attributed the outliers to bed pressures across the trust. Critical care training had been increased for staff in theatres as part of a 'Listening in Action' (LiA) project. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as had been previously reported, and all admissions were short stay and rarely level 3.

However:

- There was no provision for dedicated critical care pharmacy cover at the FGH site as recommended by GPICS (2015).
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.
- We observed that physiotherapy cover in the unit did not provide enough opportunity to be involved in unit activity, did not deliver care to six patients that was in line with GPICS (2015), and reduced opportunity to develop standards of patient rehabilitation in critical care. Critical care should provide a physiotherapy and rehabilitation service that meets the GPICS (2015) standards.

Critical care

Are critical care services safe?

Good

We found improvement in safety during this inspection and rated safe as 'good' because:

- Reporting and learning from incidents was embedded across the critical care team. There was an open and transparent reporting culture and low incidence of patient harm in the unit.
- At the time of inspection there were good numbers of skilled nursing staff. Staffing levels and acuity of patients was monitored.
- Recruitment was underway to provide a full time clinical nurse educator across both critical care units, who would work 2 days per week at FGH, and a supernumerary coordinator in line with the Guidelines for the Provision of Intensive Care Services (GPICS) (2015). This was an improvement from inspection findings in 2015.
- Medical staffing offered continuity for patient care and we observed good handovers and consultant led ward rounds. Consultants were all experienced in critical care and communicated well as a small team in critical care at FGH. There had been agreement to fund additional posts to ensure future medical staffing would provide additional cover at weekends and overnight. A recruitment strategy was in place. The plans would support meeting the requirements of GPICS (2015). There was a designated clinical lead.
- The unit was visibly clean and appeared light and spacious for the four patients in the main bay; although staff we spoke with told us that there had been provision for five bed spaces, with recent agreement to close one to ensure sufficient floor space. There was improved provision of storage, and it was well organised, in contrast to findings on previous inspections. We observed staff adhering to infection prevention and control policy without exception.
- Mandatory and essential clinical training provision was organised and staff attendance was good overall with a plan to achieve the trust target of 95% attendance in all areas across 2016/17. This included safeguarding training and blood transfusion training, which had been a safety concern during our previous inspection. There had been zero incidents reported as related to blood transfusion in 2015/16.
- Progress was being made with the new electronic patient record systems in critical care. We observed paper and electronic approaches during inspection. Risk assessments for patients were individualised and complete in all three records we reviewed.
- There was a proactive approach to the assessment and management of risks to patients and staff took responsibility for driving improvement to reduce risk of patient harm or acute deterioration. We saw good practice around; the implementation of the National Early Warning Score (NEWS) and escalation systems, care of patients with tracheostomy in wards, with oversight from critical care staff and significant reduction in avoidable in-hospital cardiac arrests, with low readmissions to critical care.
- We observed safe storage of medicines and good management of stock control with support from Lloyds pharmacy. There was pharmacy technician support for top up and reconciliation of medicines. Fridge storage was in line with trust policy and we observed good daily checks for minimum and maximum temperature recording, however there was no dedicated critical care pharmacy provision at FGH. There was telephone support from main pharmacy department and RLI lead pharmacist when needed.

However:

- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.

Incidents

- There was a consistent understanding by staff of the incident reporting system and trust policy. Learning from incidents was shared across the team in meetings and daily communications. There was good understanding of duty of candour amongst nursing staff we spoke with, however zero incidents that had

triggered the duty in 2015/16. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong.

- We reviewed the National Reporting and Learning System (NRLS) incidents between September 2015 to August 2016. There were 407 incidents attributed to critical care across both hospital sites. All incidents were reported in low, no harm or moderate harm categories. There were five moderate harm incidents with no themes or trends. Of the remaining reported incidents half were reported as delays in discharges or admissions. There was a good level of detail in the reporting and it was clear that staff were able to report safety concerns and near misses accurately.
- There was an open and transparent safety culture and approach in the unit. We saw display of information in staff areas promoting learning and sharing of safety, lessons learnt and patient 'no harm' information. We reviewed minutes of meetings were actions and learning had been discussed.
- Mortality and morbidity review took place as part of the surgical and anaesthetic division. Staff we spoke with told us that meetings took place regularly (weekly) for review of all deaths and alternate monthly themes were discussed in the directorate audit meeting. Where there are lessons to be learnt details are discussed in monthly medical meetings. Grading of cases adhered to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidance. The meeting was open to the MDT. We reviewed minutes of meetings for the directorate, and themes were discussed with and open and transparent reporting approach to learning
- Staff we spoke with told us that a recent 'no harm' incident involving failure to isolate a patient with infection had warranted the duty of candour process to be followed, although the incident itself was not categorised as a serious incident. A plan was in place to cascade the learning to staff.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harm-free care. This focuses on four avoidable harms: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and blood clots or venous thromboembolism (VTE).
- Avoidable patient harm incidents were reported as zero or low in FGH critical care across all four reportable areas.
- The unit displayed information at the entrance to the unit on a 'how are we doing board'. The display included two of the measures of harm, including pressure ulcers and falls for the previous month, both had been recorded as zero. We found in 2015 that information was previously not displayed and noted the improvement in approach at FGH.
- We observed good practice in critical care for completion of VTE risk assessments on admission and prescription of prophylaxis. There were zero reported incidents for 2015/16 in critical care. The surgical and anaesthetic directorate were working to improve variable compliance with the standard, in order to reduce preventable incidence. We noted consistent audit, teaching and monitoring of progress. The issue had been reported in the directorate risk register with improvement being made against an action plan.
- There had been a commitment to reducing pressure ulcer incidence in ITU by senior staff. Staff reported three grade 2 pressure ulcers in critical care in 2015/16.
- The team had regular updates on trust and unit safety thermometer incidents and a monthly 'learning to improve bulletins' highlighted areas to target for improvement.

Cleanliness, infection control and hygiene

- According to the data published by the intensive care national audit and research centre (ICNARC) the unit performed better than similar units for unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.
- The clinical environment was visibly clean in all areas.
- There was good domestic staff provision and cleaning schedules were complete. The domestic cleaning cupboard was well organised and clean with provision of information around cleaning duties and responsibilities, including running water programmes. Used mop heads were bagged for collection and disposal as per waste policy.
- There was a green label system in place to indicate that clinical equipment was clean. We checked 26 pieces of equipment and found all to be clean with appropriate labelling and safety checks.
- Staff had access to trust infection prevention and control policies. During the 2015 inspection we had

concerns about staff hand decontamination. This was not the case during this visit as we observed good compliance with hand hygiene by all staff and visitors entering the unit, using hand gel dispensers at the entrance and hand wash sinks in the unit. We observed staff using alcohol hand gels whilst providing care to patients. Uniform and 'bare below the elbows' policy was observed to be good and staff use of personal protective equipment whilst caring for patients was also good.

- The two isolation rooms were not designed in line with Health Building Note (HBN 04-01, HBN 00-09) and did not have ensuite shower rooms and ventilated lobby areas. However staff we spoke with told us that isolation of patients was risk assessed and documented. Liaison with the infection control team supported that patients with infections received best practice and would be transferred out of unit if required; this was relevant for a small proportion of patients who would require specialist ventilated isolation facilities. We observed patients with infections were isolated as per policy.
- As part of the Quality Assurance Accreditation Scheme (QUAAS) a range of audits were performed and monitored by the unit matron on a monthly basis to monitor standards of infection prevention and control practice. Hand hygiene, environmental cleanliness, disposal of sharps and aseptic technique audit data showed consistently good standards in critical care. When standards fell below expected quality targets we saw evidence of action plans that had been implemented with good effect.
- The consultant microbiologist attended the unit daily and reviewed patients as part of the Consultant led ward round.
- Care bundles for infection prevention and control of Central Venous Catheter (CVC) and Ventilator Associated Pneumonia (VAP) were completed by staff with improved compliance. There was zero incidence of both infections reported in 2015/16.The VAP bundle had been the focus of a trust ambassador LiA project with ongoing audit and action to improve and sustain compliance and understanding amongst staff.

Environment and equipment

- The unit was accessed from a corridor with good signage for handwashing and display of information for patients and staff. There was access to a visitors room, kitchen, offices, equipment storage and large staff room, with outdoor space from the corridor without the need to pass through the clinical unit.
- The clinical area had six bed spaces including two single rooms. A central nurses station allowed staff good visibility to all patients in the unit. Patient bed spaces were noted to be more than half the recommended 25.5 m2 (Department of Health HBN 04-02, 2013) for a new build intensive care unit. The bed space size we observed, gave reasonable clear floor space to allow room for visitors, staff and equipment brought to the bedside.
- Storage of equipment was well organised, in contrast to previous inspection findings.
- Staff and visitor access to hand washing facilities was good. In the main unit two sinks serviced four beds, both single rooms had dedicated handwashing sinks.
- The emergency resuscitation equipment for adults and children and patient transfer bags were checked daily with a good system in place as per trust policy. The equipment was central and easy to access.
- There was good provision of equipment required for level 3 and level 2 critical care. We observed a thorough record and robust system of medical device training for all staff. Staff we spoke with told us that the links with the medical engineering team were good.
- Staff had access to a large staff room and secure outdoor garden area. Storage of food items in the staff fridge were labelled, dated and for staff use only.
- The main relatives room was small but adequately equipped, although there was limited space to talk privately with relatives away from that room when the unit was busy. Staff we spoke with told us of plans to expand the units facilities to improve provision for family and friends of patients into a ground floor area adjacent to the relatives room.

Medicines

- The unit had good medicines storage with locked cabinets, this had been improved since our last inspection findings, where we reported concerns around storage and security. The space for safe and secure drug storage was good at the time of inspection. We found all cupboards to be locked, Controlled drug checks were carried out by staff and assurance audit performed by the main pharmacy department.

Critical care

- The unit did not have a dedicated critical care pharmacist to provide medicines management and critical care support as per GPICS (2015). The guidelines state that there should be at least 0.1 whole time equivalent (WTE) Band 8a specialist clinical pharmacist for each level 3 bed and for every two level 2 beds. There were plans to provide senior technician support in the FGH unit, however it was not clear what strategy was in place for band 8a pharmacist provision.
- Subsequently, there was no pharmacist involvement in the daily consultant led ward round, however staff we spoke with told us that medical staff provided the daily review of prescribing, antimicrobial stewardship and provided teaching to junior medical staff and nurses.
- Nursing staff managed most aspects of ordering, stock control and reconciliation of patients own medications, with support from FGH pharmacy and a technician. Intravenous fluids stock control was also managed by the nursing team and main pharmacy team. The team did not report any problems with the ordering system, with good supply of medicines.
- Monthly pharmacy audits were performed. A safe storage and security audit, controlled drug management and antibiotic usage audit in critical care were performed by the main pharmacy department. There was good performance against audit in all areas and 100% compliance with 72 hr review of antibiotic prescriptions.
- We spoke with the senior nursing and medical staff about sharing learning from any medicines incidents. There was a low number (three) of drug related incidents in the unit in 2016 and the process for reporting and investigation was good. We noted that an open and transparent approach was taken to sharing lessons learnt with the team by the clinical nursing lead and consultant staff.
- We observed three prescription charts and allergies were clearly documented in all cases. There was a paper system with good documentation of antibiotic prescriptions with stop or review dates.
- We observed a consistent minimum and maximum fridge temperature recording system. The main drug fridge had integral electronic temperature recording and a paper record was signed by staff with a good system for checking.

Records

- We observed three care records, care charts and three drug prescription charts. We observed the electronic and paper systems. Staff were using both systems whilst learning to use the electronic system in practice. All entries in the records were complete and in line GPICS (2015) and professional General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards.
- Notes were stored securely at the bedside and the electric versions were accessed in computers on trolleys with appropriate password protection as per trust policy. There had been no incidence of confidentiality breach in the unit. Staff however did report some occasions when poor internet access led to staff being unable to access the electronic record.
- We observed consultant and junior doctors accessing and completing paper and electronic notes during ward rounds and at the patient bedside. All member of the multidisciplinary team completed their care plans and evaluations in the main record.
- Eighty six percent of staff attended information governance training as part of mandatory training.

Safeguarding

- The trust safeguarding policy was available to staff and the unit had an organised approach to provision and staff attendance of safeguarding training to protect vulnerable adults and children, with good planning by senior staff to ensure staff were up to date. ITU at FGH had staff attendance compliance of 95% for level one safeguarding training for adults and children, which was above the trust target and 90% for level two, with remaining staff booked into sessions.
- The unit at FGH took a small number of children admissions who required stabilisation prior to retrieval and transfer to specialised children's hospitals in the region. This required staff to be updated with children's safeguarding training and policy, and we found good compliance during inspections.
- Staff we spoke with told us that they understood the processes and could identify staff to contact to escalate concerns for vulnerable adults and children. Staff could access minutes from safeguarding board meetings and case reviews and matrons and clinical leads would share any learning in team meetings.
- Safeguarding resources and information was available in the unit and on the intranet.

Mandatory training

- The trust had a mandatory training compliance target of 95% for staff attendance and senior nursing staff we spoke with had developed an organised approach to achieving the targets for unit staff across the year since our last inspection.
- Senior clinical leads we spoke with reported overall 91.3% achievement at the end of August 2016 and had plans in place to achieve greater than 95% by December 2016.
- The trust provided core elements in mandatory training to include, fire, conflict resolution, BLS, ILS, equality diversity and inclusion, infection prevention and control, information governance, health and safety, safeguarding adults and children, and manual handling. However, fire training attendance was poor across the directorate with 67% of critical care staff attending at FGH to the time of inspection. The clinical lead had a knowledgeable and organised approach to ensuring staff attended essential training.
- Staff could access mandatory training in a number of ways, online eLearning modules and face to face sessions delivered by key trainers.

Assessing and responding to patient risk

- Patients had a range of risk assessments completed on admission to critical care. We observed good compliance with completion for Malnutrition Universal Screening Tool (MUST) assessment, moving and handling, tissue viability, VTE, delirium, infection control and falls risk. If a patient was identified as having an elevated risk the action required to reduce it was evident in the care plan and practice.
- There was not a designated Critical Care Outreach Team (CCOR) at the trust however there was an effective educational model of CCOR and this included patient follow up after discharge to wards within 36 hours, provided by nurses in the unit. Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator.
- There was good discussion between the ITU team and the staff from the surgical and medical high observation areas, (CCCU and PPU), in order to assess patients at risk of deteriorating and plan admissions and discharges. We had previously reported in 2014 a lack of management and understanding of the levels of care and governance of 'critical care' patients outside of the unit. The arrangements were clear and in line with GPICS (2015) during this inspection with good escalation of care when required. Level 3 and 2 patients were not cared for in the high observation units.
- There were additional posts across the trust and directorate that supported the key elements of the outreach role for example, an Acute Kidney Injury (AKI) nurse and Sepsis specialist nurse. The resuscitation team and acute care matron were responsible for delivering training in recognition and treatment of the acutely ill patient. Practice Educators (PED's) were in each directorate, and the Hospital at Night (HAN) team was well established.
- There had been significant (37%) reduction of all and avoidable cardiac arrests reported from April 2014 to September 2016. All cardiac arrests were discussed in patient safety summits and initially reported as moderate or major incidents. There was an ongoing commitment to continuous improvement as part of Commissioning for Quality and Innovation (CQUIN) targets.
- The trust had introduced the National Early Warning Score in 2016. The trust had used an Early Warning Score System (EWS) as part of recording patient physiological observations, for over 15 years. The previous advanced nurse practitioner in critical care had supported implementation and ongoing management of the former EWS and POTTS (patients observation track and trigger system). Training for staff was in place and the Acute Life-Threatening Events: Recognition and Treatment (ALERT) course was well attended by staff across the trust and critical care.
- NEWS audit for critical care was comparably good across both sites with 91% to 100% compliance.
- Directorate PED's delivered once a month training sessions as part of a 'listening into action' (LiA) project. These included Basic Life Support (BLS), Acute Kidney Injury (AKI), National Early Warning Score, (NEWS), sepsis and fluid balance sessions and could be booked in the Training Management System (TMS) by staff across the trust. The delivery of and attendance by staff to these key sessions were part of the approach to assessing and responding to patient risk.

- The trust had implemented a Situation, Background, Assessment and Recommendation (SBAR) approach to handover communication when escalation of acutely ill patients was required at ward level. There are escalation policies in place and staff we spoke with were aware of good practice.
- The staff we spoke with told us that they were involved in ongoing improvement work against a national CQUIN target and sepsis care pathway. There was significant improvement against screening, antibiotic given to patients within an hour and antibiotic review after three days across the trust. These key targets were reported as 22% compliant in the first quarter of 2015, with an improvement to 76% in the following quarter. There had been an improvement to 70% compliance with antibiotics given within an hour to patients screened as at risk of sepsis.
- Staff had been commended for their care for patients with tracheostomy was across the hospital. A care plan had been developed for patients and this had been shared across the network. This had reduced the need for patients to require level two care in the unit. Bedside emergency boxes had been standardised for wards. Critical care had recruited a patient representative to the teaching team who helped to deliver sessions to staff four times a year.
- Staff we spoke with told us that transfer of patients was well managed. A trust and critical care network policy was in place. There was zero incidents to report as part of critical care transfers. Nursing staff told us that cross site transfer of patients was well organised. The network STaR (Safe Transfer and Retrieval) training programme uptake and delivery was led by the clinical leads in ITU.

Nursing staffing

- Nurse staffing in the unit at the time of inspection was good. We did not see any evidence of reducing qualified nurse to patient ratios below critical care staffing guidance (GPICS, 2015) of 1:1 for Level 3 patient care and 1:2 for Level 2 patient care during day or night shift. There were three vacant nursing posts at the time of inspection and planned recruitment was making progress, with good use of established bank nurses covering any shortfalls in the rota.
- There was a positive approach to managing team rotas and the clinical leads and senior nursing staff were knowledgeable about the challenges and shortfalls, addressing risks as required on a daily basis and proactively as part of an efficient approach to managing the unit. Clinical leads attended trust bed management meetings, and performed a daily telephone call to the high observation units.
- We observed rotas during our inspection and gained assurance that the actual staffing numbers were as planned. The eRoster system ran alongside the trust dashboard system and senior teams had access to the acuity of patients across the wards and departments. There was a 100% compliance with updating the acuity dashboard, which had been based on the 'Safer Nursing Care' Shelford Group tool. Site managers were visible and attended the unit to request staffing support from critical care to ward areas.
- The unit had been given funding to support a supernumerary unit coordinator across a seven day week and 12 hour day shift in line with GPICS (2015) standards. In addition to achieving this standard, recruitment for a supernumerary clinical educator across site was in progress.
- Staff sickness was below the trust target of 4.3% at 3.28% between June 2015 and May 2016. The new policy and approach for managing staff sickness was understood by the clinical leads. The clinical leads we spoke with demonstrated a "health and wellbeing" approach to the short and long term sickness experienced by the nursing team, and reported good support from human resources.
- The trust had developed a system to send secure text messages to staff to offer additional shifts when cover was required at short notice and this was reported as working well. The use of agency staff was minimal.
- Nurse handovers were well organised and effective with a five point communication system approach. All nursing staff we spoke with told us about the 5 point system and its use in practice.
- There were plans for advanced critical care nurse practitioners and nursing staff were completing non medical prescribing qualifications.
- Nursing staff we spoke with were positive and morale appeared to be good. All staff reported that they felt supported and 'felt proud of working in the critical care unit'.

Medical staffing

- Care was led by a consultant in intensive care medicine and we found 24 hour period cover and rotas to be similar than during our last inspection. This

arrangement was good and staff were clear about roles and responsibilities, communicating well between one another. Consultant staff to patient ratios were in line with GPICS (2015). There were consultant led unit ward rounds and patient review twice daily. Attendance by the Multidisciplinary Team (MDT) was encouraged by the consultant team, but restricted by staffing resources in all disciplines. Microbiology staff would attend as required.

- We found improvement in medical handovers in critical care and consistent routines for handover. There was a formal morning consultant led ward rounds and an informal afternoon review. Any changes in treatment plans were documented.
- There had been nil incidence in 2015/16 of delayed treatment as a consequence of medical staffing levels. There was a consultant on call out of hours. The historical anaesthetic staffing levels (24/7) for intensive care services, obstetrics, anaesthetics and emergency surgical services across the trust had previously not met the required national recommendations and standards. This was well understood by the executive and senior team and clinical staff. We reviewed finance meeting minutes from September 2016 where it was outlined that current staffing posed a risk to the delivery of safe and quality anaesthetic services at RLI and FGH. The trust, as part of their Better Care Together strategy, had committed to recruiting three consultants at FGH and five consultants at RLI to ensure safe staffing levels and mitigate risks. We reviewed documents to confirm that recruitment was well underway.
- We spoke with a junior doctor who gave us positive feedback about training and support in critical care. The unit did not have anaesthetic trainees, and FY2 medical staff had a 4 month rotation which allowed for attendance of the foundation training. They also participated in the surgical on call rota and worked Monday to Friday 8am until 4pm. There was good opportunity to participate in ward rounds and attend the FY2 teaching programme.

Major incident awareness and training

- Major incident and business continuity plans were in place as policy was clear and available to staff on the intranet and in paper copy in senior staff offices. Staff had attended training to test the plans and escalation processes in critical care as part of the surgical and anaesthetic directorate.
- Staff we spoke with told us that there had been no incidence to test the policy in practice, but they were aware of a range of scenarios that had been included in the training that could disrupt business continuity.

Are critical care services effective?

Good

We rated effective as 'good' because:

- During this inspection and our 2015 inspection we found patient care was planned and delivered by staff who were knowledgeable and aware of implementing current evidence based guidance and standards.
- Patient outcomes were comparable or better than national and local critical care unit performance. Unit mortality had improved since our last inspection and was low in comparison to other units as reported to ICNARC. The patient readmission rate within 48 hours of discharge from the unit was also low and better than the national average.
- Commitment to education and training was improved since 2015, with supernumerary induction for new nursing staff, and a sustained performance in ensuring 50% or more nursing staff had a post registration award in critical care or were working towards achievement at local universities. Continued commitment to nurse appraisal was evident and agreement to fund and recruit a supernumerary practice educator across sites, improving the overall compliance with standards in line with GPICS (2015). Staff were knowledgeable and committed to critical care education.
- Patient's pain was well managed. Individual patient nutrition and hydration needs were met, and we observed a person centred approach to assessment and planning of care. We observed support from specialist pain nursing staff.
- There was a good culture of discussion, documentation of decisions and challenge from nursing staff around MCA and DoLS. Consultants were knowledgeable and engaged with the process, and discussed a MDT approach to decision making.

However:

- Critical care should provide dedicated critical care pharmacy support in line with GPICS (2015) guidance. There is currently no provision of dedicated pharmacist at the Furness General Hospital critical care unit.
- Physiotherapy staff should provide a full service against GPICS (2015) standards for multidisciplinary working and rehabilitation of patients during and after critical illness. , Due to staffing constraints staff we spoke with told us this shortfalls in staffing had been escalated to managers in the therapies directorate.

Evidence-based care and treatment

- We reviewed policies and guidelines in the unit, on the intranet and in paper copies and found all to have review dates. The unit used a combination of national guidelines and policy to determine the care and treatment they provided. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society, the Faculty of Intensive Care Medicine and the LSCCCN.
- We reported in 2015 that we were not clear if adherence with NICE CG83 pathway for rehabilitation after critical care was supported fully and had a lead for rehabilitation. During this inspection we saw evidence of a partially met standard. Collection of data to measure if assessment and rehabilitation prescriptions were documented within the first 24 hours of admission and pre-discharge showed good performance for patient admission, but pre discharge plans were documented in as low as 60% of cases from April to July 2016 across both units. It was not clear who was leading against the rehabilitation standard.
- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 quality statement and pathway. Audit and monitoring was carried out to ensure compliance targets were maintained in critical care and across the directorate improvement work was a current priority.
- We spoke with nursing and medical staff and observed that a range of local and national audit had continued since our last inspection. Results were shared with the team and network. Staff told us that work was ongoing to contribute to reducing sepsis as part of the trust targets. There was good involvement with the LSCCCN in terms of benchmarking, and annual peer review.
- The nationally recognised care bundle to reduce the risk of ventilator – acquired pneumonia (VAP) is implemented and audit work was ongoing to improve compliance. VAP bundle compliance had been adopted as part of the trust quality ambassador programme to reduce incidence of infection and improve implementation of the care bundle.

Pain relief

- We reviewed three care records and bedside care charts and three prescription charts and observed that pain was assessed and pain scores recorded in the unit. All patients we spoke with told us that staff paid attention to their pain and comfort needs.
- We observed assessment of patients pain being discussed in the ward round by the medical and nursing staff, including a specialist pain nurse. Conversations were led by the consultant.
- Staff administered prescribed analgesia regularly and as required. We observed nursing and medical staff reviewing the daily plan of care and patients would be given pain relief as part of planning to support their comfort when they are mobilised out of bed.
- Patients received visits from the specialist nurse pain team when they had epidural and intravenous pain relief in progress post operatively. Unit staff were able to make referrals to the pain team for advice. We spoke with a member of the pain team during the inspection, who provided a cross bay service and electronic referral system.
- Delirium and sleep study information was displayed as part of an ongoing project in critical care**.** We observed consistent recording pain scores and Confusion Assessment Method for Intensive Care Units (CAM-ICU) in the three care records we reviewed.

Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese were identified using this tool. In all three care records scores were documented.
- A dietitian was dedicated to the unit and had expertise in critical care in order to support patients effectively. Patients were commenced on feeding regimes as soon as possible. Nursing staff were knowledgeable and skilled in the critical care nutrition needs of patients and had protocols that supported commencing nasogastric and total parenteral nutrition.

- We saw excellent fluid management and hourly documentation of fluid balance. There was good training provision for fluid balance management for staff in the unit. We saw evidence of fluid balance audits being performed.
- We observed nursing staff taking time to assist patients with choosing meals for that day from menus. Patients whose condition had improved were offered drinks by staff and assisted as needed. Nutritional intake was also documented.

Patient outcomes

- The unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated staff were in post to support ICNARC data collection and reporting.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM). We also saw a 'partially met and unmet' 2015 benchmarking activity against National D16 commissioning service specifications for critical care services, which is underpinned by GPICS (2015) within the Lancashire and South Cumbria Critical Care Network (LSCCCN).
- Since our 2015 inspection risk adjusted hospital mortality ratio had improved and was comparable with national reporting at 1.0 – 1.1 across both units at UHMB. Risk adjusted mortality ratio for patients with a predicted risk of death of less than 20% was 1.1 at FGH. Mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. It was reported that mortality was comparable or lower than expected range within the ICNARC CMP.
- Unplanned patient readmission to ITU within 48 hours after discharge was comparable with all units in the reporting period April to August 2016 at 1.3%, and comparable to units in ICNARC 2015-2016. Over the year July 2015-2016, we noted that FGH reported zero readmission in with the exception of a 2% incidence in June 16. The readmission rates were comparable with other units in ICNARC 2015-2016.
- We also noted that against regional units the 'post unit in hospital survivorship' was better than the LSCCCN average.

Competent staff

- Staff we spoke with told us that they received trust induction and we noted that 100% had attended. Appraisals had been carried out for 82% of staff at the time of inspection, and we observed a plan was in place with staff booked in for appraisal to achieve 100% in 2016.
- GPICS (2015) outlines that critical care units should have a supernumerary educational coordinator. The funding had been agreed and the process of recruiting an educator to work across the two hospital sites had begun. In the absence of the coordinator senior staff provided support for training junior and new members of the team and mentorship programmes were organised.
- New nursing staff to the unit were given a local induction and a eight weeks supernumerary period whilst they achieved critical care competencies essential for safe practice. Junior staff are supported by working alongside senior skilled nurse mentors in the unit.
- Fifty percent of staff should hold a post registration award in critical care nursing, in line with GPICS. At the time of reporting 60% of nursing staff on ITU had achieved this target There was good access locally to the course and staff were supported to attend.
- There was also a commitment to the Critical Care Steps programme for staff with good levels of achievement, 84% of staff had achieved level 1.
- We observed examples of staff teaching junior members of the team at the bedside and during handovers and ward rounds.
- Nurses we spoke with told us clinical supervision was available and the trust had a supportive strategy in place for revalidation. We saw nursing staff sharing the processes for revalidation in the unit.

Multidisciplinary working

- We observed good working relationships and commitment to critical care between members of the Multidisciplinary Team (MDT).
- Physiotherapists were an essential part of the critical care team and the unit had a plan for twice daily cover from a team of qualified physiotherapists Monday to Friday, however staff we spoke with told us that cover could be reduced to 9am to 10.30am for eight patients. We spoke with physiotherapists and the current

establishment of 1.0 WTE did not provide opportunity to be involved in the consultant led ward round and MDT handovers, and reduced the opportunity to work in a coordinated way with the ITU team to plan care for complex and long stay patients. Staffing provision was found to be, 0.5 WTE at band 7; 0.5 WTE at band 6.

- Physiotherapy lead staff were supporting other services outside of critical care due to staff vacancies across the team. The team however were essential in supporting respiratory assessment, review and rehabilitation from critical care and provided treatment for patients requiring passive movements to prevent muscle contracture during periods of restricted mobility. GPICS (2015) supported a minimum rehabilitation standard of 45 minute sessions, admission and discharge prescriptions and staff were not able to consistently deliver this during weekdays or weekends. These issues were documented on the directorate risk register.
- We spoke with the dietitian during the inspection. The dietitian had a daily visit to the unit and took referrals on unit attendance or by telephone. They did not attend ward rounds, unless requested.
- The units had dedicated administrative ICNARC support to ensure consistent data collection and reporting. We spoke with staff across site who were well supported and valued and provided an essential service in critical care. The level of understanding of ICNARC data was very good and presented at the critical care delivery group. There was evidence of developing further audit to supplement the ICNARC data for local use and improvement, for example the collection of utilisation of theatre recovery space for patient admission.
- The pharmacy trust team were in the middle of a workforce reconfiguration. The line management for the RLI unit staff was clear in the proposed new structure, however the FGH unit did not have any current or planned dedicated pharmacy cover. This is not in line with GPICS (2015) guidance.

Seven-day services

- Consultant anaesthetists were available 24/7 through an on call system to support the junior team. Daily consultant ward rounds were embedded with documented daily reviews. The critical care unit provided services 24/7.
- There was an on call physiotherapy and pharmacy service out of hours and at weekends.
- Critical care did not have access to services that supported 7 day working. Staffing was significantly reduced across the MDT at weekends. Access to some specialist diagnostic testing, for example endoscopy and echocardiography was not routinely available at weekends. Admissions to critical care of emergency and unplanned patients can be at any time of day or night, in the case of critical emergencies consultants directed diagnostic tests and reporting of results.

Access to information

- Information could be accessed in electronic and paper systems. Since our inspection in 2015 the trust had implemented an EPR. We observed staff using the new electronic care record system and this was making good progress, although access was reported as inconsistent in the unit based on issues with internet connection and training support had been reduced.
- Staff involved in the critically ill patients care pathway at every stage could access the information that they needed in a timely manner. We saw good evidence of access to transfer and discharge summaries in paper and electronic versions. It was noted that staff had a degree of duplication which was ongoing until the full electronic patient record system was implemented.
- We observed safe transfer and handover processes and had assurances for staff we spoke with that practice was consistent.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- We observed good decision making by two consultants in critical care and staff we spoke with would seek independent mental capacity advocate advice (IMCA) when required. There was a good culture of discussion, documentation of decisions and challenge from nursing staff around MCA and DoLS.
- There was varied levels of understanding of the MCA and DoLS in critical care by the junior nurses we spoke with. Staff had attended training with an 92% attendance rate against the trust target, and could explain experiences of application in practice in the critical care environment. Senior staff and medical staff were knowledgeable, however all staff we spoke with knew how to seek advice, could access guidance easily in paper and intranet resources.
- We observed good assessment of consciousness, delirium and confusion with use of Glasgow Coma Scale

(GCS) and Richmond Agitation Sedation Scale (RASS) and the, CAM-ICU, all recorded on the daily observation chart and care plan. These validated measures supported assessment of patient confusion, delirium and subsequent level of mental capacity in the unit.

Are critical care services caring?

Good

We rated caring as 'good' because:

- From our observations, evaluation of data and conversations we had with families, patients and staff we judged the critical care unit at the FGH to have a strong visible person centred culture. Staff were positive and motivated and without exception delivered care that was kind and promoted peoples dignity.
- The critical care team had developed a comprehensive approach to care for patients with tracheostomy who were cared for in wards. As part of the project a patient who had a laryngectomy was recruited to support delivery of staff training up to four times a year.
- Patients were invited and encouraged to be involved in decision making about services and staff listened to patients and focused improvements in practice with their suggestions.
- We saw good use of individual patient diaries to support care planning, rehabilitation and recovery in ITU.
- Family and Friend Test (FFT) survey responses from service users were consistently positive and the team and individual staff frequently received 'special mentions'.
- Liaison with the bereavement team was good and staff we spoke with gave examples of using the service to support families of patients who died in the critical care unit.
- The unit had been involved in arranging a regional 'afternoon tea' event with support from the LSCCCN, for patients who had experienced a critical care admission. Further events were planned.

Compassionate care

- We observed staff to be caring and compassionate with patients and their relatives without exception during the inspection. We observed episodes of care that promoted patient dignity and respect. Staff promoted privacy, with good use of bed space curtains and privacy glass in single rooms.
- We observed letters and cards of thanks from patients and relatives on display and filed in the staff room.
- The NHS Family and Friends Test (FFT) data is collected in critical care and there is a commitment to continuous improvement to response rates. Display is consistent with the trust approach in a format that is easy to understand by staff and visitors. We saw positive results and comments.
- In September 2016 the unit rated 2nd out of 28 departments at the FGH site with a 4.95 out of 5.0 result overall. The dignity/respect, cleanliness, and staff elements consistently scored 5.0 with a slight reduction in scores for involvement and information as a trend. One hundred percent of the seven respondents (which represented a 58.3% response rate to surveys in September) stated they would recommend the service.
- A 'special mentions' section of the 'how are we doing' board displayed thanks to those staff who had received patient compliments. Examples we observed had names of individuals from the MDT. During the inspection a visitor to the unit from stores/estates department told inspectors that the individual who had received the special mention from a patient was a new recruit from a non-clinical department in FGH and that the compliment around caring for patients individual needs was "well deserved."
- The following quote represented the themes in many of the comments and compliments we observed; "It was excellent, just what my husband needed. Professional people", "My care was first class", "Always plenty of staff/ doctors on duty to manage number of patients and patients care needs", "The care given to my husband was excellent. The staff were very helpful and willing to explain procedures".
- We spoke with three patients and two relatives who all had positive feedback about the nursing, medical and MDT staff in ITU. They told us that when they experienced pain and discomfort staff responded appropriately with different approaches, for example repositioning, pain control and medication and caring reassurance. We observed a specialist pain nurse visit a

patient receiving an epidural and another patient had an individual care plan for a chronic pain condition in addition to their acute episode needs being responded to.

Understanding and involvement of patients and those close to them

- We saw evidence of use of patient diaries in critical care. A relative of a patient had given positive feedback in the FFT survey, "The whole team was great with all the family. The care that was given to my husband was excellent. The diary idea is great."
- We spoke with a patient with learning disabilities who told us that his mum had been resident in the relatives room during admission. They had been supported with open visiting and spoke highly of the care in ITU. However we did not see any written information about the patients individual needs in the care and treatment plans, despite the trust approach to using a passport method of documenting individual needs, like and abilities.
- We saw good examples of documented discussions between medical staff and patients and families in the records.
- The critical care team had developed a comprehensive approach to care for patients with tracheostomy who were cared for in wards. As part of the project a patient who had a laryngectomy was recruited to support delivery of staff training up to four times a year.
- The unit had been involved in arranging a regional 'afternoon tea' event with support from the LSCCCN, for patients who had experienced a critical care admission. Further events were planned.

Emotional support

- The spiritual needs of patients takes a priority in critical care and the trust had good access and provision of spiritual, religious and pastoral support. Individual needs of patients were recorded as part of their assessments.
- Emotional support was given as part of the post discharge home follow up appointment, post critical care admission. Additional psychological support was assessed on an individual basis. General Practitioner (G.P) referrals to a psychologist could made when required as recommended by the senior nurse in the clinic.
- Liaison with the bereavement team was good and staff we spoke with gave examples of using the service to support families of patients who died in the critical care unit.
- The unit operated a flexible approach to visiting times for family and friends to promote the emotional support of patients. We observed nursing, medical, support workers, and members of the MDT talking to relatives and patients and it was evident that they had established positive, supportive relationships.

Are critical care services responsive?

Good

We rated responsive as 'requires improvement' in 2015. During this inspection we found improvement and rated responsive as 'good' because:

- The critical care team was skilled in managing patients with complex needs, and we saw evidence of individual care planning and treatment. We saw good individual care and management of patients isolated with infection, those requiring one-to-one support, patients with critical level 3 needs, and those who were level 1 because of a delayed discharge to wards. It was clear that under busy circumstances staff did not lose sight of the individual needs of their patients.
- The team worked to ensure it met needs of local people and individuals when trying to make improvements or develop services. The opinion of patients and relatives was valued by staff.
- Follow up clinics, in line with GPICS (2015) were in place at the FGH for critical care patients who had experienced a stay in critical care of longer than 4 days. This gave the patient opportunity to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support required. We observed good use of patient diaries.
- There were no formal complaints in critical care and when people did complain at a unit level action staff knew how to respond. The policy and processes for managing complaints was good and understood by all staff we spoke with.
- Patients received timely access to critical care treatment, a low number of critical care elective

admissions were cancelled and this exceeded national targets. Patients were not transferred out of the unit for the non-clinical reasons and readmission rates were low.

- Bed occupancy in critical care was around 87% overall. The team recognised the need for the plan to refurbish and extend critical care services at the FGH and this was included in future service planning.
- Delayed discharges at the FGH were measured as delays greater than 4 hours from the decision to discharge. These delays had been reported in 2015/16, from approx. 25% to 40% of all discharges delayed greater than 4 hours. However, ICNARC data for 2015/16 reported greater than 8 hour delays and the unit in FGH had better performance against other units nationally. We did not see evidence of delays preventing the patient from receiving the care and treatment they needed and staff paid attention to patient dignity when DoH single sex accommodation breaches occurred.
- We have previously reported concerns with the admission of critical care patients (also known as outliers) to theatre recovery in 2014/15. During this inspection we found arrangements to be much improved, despite admission figures at FGH having increased. We found that critical care patients in theatre recovery each month in 2015/16, with 40 admissions for the year at FGH, all short stay, mostly level 2 and nil overnight stay admissions, however there was around a 50% increase in admissions from previous reports.
- Patients were admitted to theatre recovery as per policy with activity and acuity closely monitored by senior staff. There was a focus on preventing any 'gaps in care' as part of an LiA project and priority for the patient to be in a 'place of safety' existed amongst staff we spoke with. Critical care training had been increased for staff in theatres. Nursing skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as previously reported. We did not see any incidents associated with demand for critical care beds and staff did not report any concerns with the current arrangement.

However,

- FGH critical care discharges out of hours were 6.7% which is worse than the national average of 2.3% as reported by ICNARC for 2015/16. Discharges out of hours, between 22.00hrs and 07.00hrs have been proven to have a negative effect on patient outcome and recovery.

Service planning and delivery to meet the needs of local people

- Critical care service planning and delivery was managed as part of the Surgical and Anaesthetic Directorate in the trust. There was evidence of consistent and collaborative working during our inspection and in the review of minutes of senior meetings.
- There was involvement in the LSCCCN and good practice and learning was shared across the region.
- Follow up clinics, in line with GPICS (2015) were in place at the FGH for critical care patients who had experienced a stay in critical care of longer than 4 days. This gave the patient opportunity to gain further explanation of events, access screening for critical care complications, including psychological, physiotherapy or pharmacological support required.
- The one visitors room was small but adequately equipped, however there was limited space to talk privately with relatives away from that room when the unit was busy. Staff we spoke with told us of plans to extend the visitors facilities into the outside ground floor space adjacent to the room, and that this had been discussed with the executive team. We did not review any complaints or comments about the limited facilities.

Meeting people's individual needs

- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning and treatment. We saw excellent individual care and management of patients isolated with infection, those requiring one to one support, patients with critical level 3 needs, and those that were level 1 because of a delayed discharge to wards. It was clear that under busy circumstances staff did not lose sight of the individual needs of their patients.
- Patient diaries were introduced as part of a LiA project. The project had been implemented in early 2016 and all level 3 and 2 patients had opportunity to complete with support from staff, as part of promoting rehabilitation after critical care admission.
- A range of information leaflets and specific guides were on display in the unit for visitors and an orientation folder for patients was available in the visitors area.

Critical care

- Staff we spoke with were clear about the range of services available at the trust to support patients individual needs, including seeking specialist nursing advice for pain relief and dementia care. The trust advocated the 'butterfly system' as part of a broader approach of good practice for patients with dementia.
- The trust had a robust system for access to translation services through switchboard as either an on-call or pre-booked service.

Access and flow

- The unit had written operational policy for admission and discharge.
- GPICS (2015) states admission to critical care should be timely and within four hours from the decision to admit for emergency patients, to improve their outcomes. The unit was reported as having 'partially met' this standard as a number of patients were admitted to theatre recovery whilst a critical care bed was made available. Consultant reviews were performed within 12 hours of admission in line with GPCS (2015)
- There were zero transfers to other units for non-clinical reasons in 2015/16.
- The proportion of elective surgical critical care bed bookings cancelled due to lack of availability of a post-operative critical care bed were general low across both FGH and RLI sites. FGH had minimal cancellation from July 2015 – May 2016.
- There was a recorded 40 critical care patients admitted to theatre recovery in 2015/16, with 40 admissions for the year at FGH, all short stay and not overnight. Staff in theatre recovery reported that a LiA project supported a 'no gaps in care' approach and each incident was recorded in the electronic system with data collected by the ICNARC data administration team**.** Staff we spoke with in critical care and theatres did not express concern about risk to patients when admissions took place and staff had not reported any incidents of harm as a consequence. This was an increase of around 50% since our last inspection. Critical care training had been increased for staff in theatres. Nurse skill mix in the critical care unit was not compromised to cover the theatre recovery activity, as previously reported.
- Discharges out of hours, between 22.00hrs and 07.00hrs have been proven to have a negative effect on patient outcome and recovery. FGH critical care discharges out of hours were 6.7% which is worse than the national average of 2.3% as reported by ICNARC for 2015/16.
- FGH bed occupancy over a 12 month period to May 2016 ranged from 70% to 87%. There was a consistent average occupancy of around 87% from October 2015.
- Activity was monitored closely and 'mixed sex accommodation' breaches were included on the risk register. Patients who were ready for transfer to wards but whose discharge was delayed were declared as a 'mixed sex accommodation breach' after the decision to discharge had been made. The unit did not have capacity to provide the privacy of single rooms. Staff managed to support patient dignity when breaches occurred with good use of privacy curtains around the bed space and documented assessment of patient needs.

Learning from complaints and concerns

- The UHMB had a Patient Advice and Liaison Service (PALS) and we observed patient information leaflets in the relative room areas.
- The surgical and anaesthetic directorate had good processes for the management of complaints. Staff we spoke with were aware of the complaints policy and process.
- We did not see any evidence of complaints in critical care for 2015/16. We spoke with senior managers who told us that concerns were resolved locally and not escalated to formal complaint in critical care.

Are critical care services well-led?

Good

We rated well-led as 'good' because:

- The governance framework in critical care at the FGH was clear and the service was managed by an knowledgeable and motivated team. They understood and provided solutions for the challenges of providing high quality care in critical care
- Improvement was achieved by working closely together at all levels. Staff felt valued and it was evident from conversations we had with staff that patient centred, quality of care was the priority. Staff we spoke with across the team were passionate about their roles and proud of their trust.
- The investment in leadership programmes was good and it was clear the learning was shared, staff had a shared purpose and made an impact in practice.

Leadership development was a key strategy and priority in the UHMB trust for all levels of staff. Staff we spoke with reinforced that the strategy was applied to practice and clinical leaders were supported to attend NHS Leadership Academy programmes and other external courses.

- We found a positive, open culture with confident, knowledgeable staff at all levels. Staff were encouraged to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in critical care. The team communicated very well with one another and with partners across the trust and network. Staff were supported with ideas and innovation and opportunity to make improvements.

Vision and strategy for this service

- All senior staff we spoke with in critical care were knowledgeable about the trust vision, values and strategy and junior staff told us that patient safety and quality of care was a priority. During the inspection we observed a commitment by critical care staff to the five trust values of patients, performance, progress, partnerships and people.
- It was clear that progress against the strategy and vision for the service was a priority for all staff we spoke with. Critical care priorities were given proportionate and appropriate attention as part of the larger surgical and anaesthetic directorate. The findings on this inspection, particularly around the environment in ITU and plans for consultant anaesthetic cover were clear in strategic plans, with realistic timescales and actions for improvements to deliver good quality care to patients.
- There was evidence of innovation and staff we spoke with were enthusiastic and positive about the challenges in critical care and felt involved.

Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service.
- Guidelines and policy were consistent across both sites and units.
- Dedicated data administrators produced the critical care ICNARC submission, by working closely with the consultants and clinical team. There was consistent submission of information to the ICNARC CMP.
- The service measured itself against the GPICS (2015) standards, which underpins the D16 service specification used by LSCCCN to provide a benchmarked peer review.
- The risk register for critical care was detailed with progress and ownership being documented as part of the surgical and critical care directorate's overall risk register. We saw reviews and action plans associated to risk, and felt that the items on the register reflected what we observed and discussed with staff as their concerns.
- There was an embedded approach to sharing performance information with staff in way that could be understood and interpreted as part of improving quality, safety, experience and activity. This included 'WESEE' reports and bulletins. Matrons and senior staff shared information in a variety of ways to reinforce the quality agenda with good effect.
- The matrons performed weekly audits and monthly (QUAAS) ward rounds for quality assurance. This approach was consistent and the feedback communication to the team in ward meetings was evident.

Leadership of service

- The senior team structure was established and understood by staff we spoke with and consistent across critical care sites. There was good leadership support and clear line management, with an emphasis on 'cross bay working' and support.
- The senior team were identified in photographs on the unit display boards visible to the junior team and patients. Staff visiting the unit as part of their duties, approached inspectors to give positive feedback about senior staff across both sites.
- We interviewed the senior individuals responsible for critical care units at both sites and they consistently reported that they felt supported by the executive team. There was a Clinical Director in intensive care, and experienced senior nurses. The appointment of a supernumerary clinical coordinator was planned to further support the team, although visible senior staff had been in place and had been supportive of staff in ITU prior to this appointment.
- Leadership development was a key strategy and priority in the UHMB trust for all levels of staff. Staff we spoke with reinforced that the strategy was applied to practice and clinical leaders were supported to attend NHS

Leadership Academy programmes, e.g. the Nye Bevan and Mary Seacole leadership programmes, and post graduate certificates (PgC) in healthcare leadership. There was an ongoing commitment to staff attendance and critical care clinical leads had attended the Lancaster University, Centre of Excellence for Training and Development (CETAD) PgC Professional Practice (Clinical Leadership) course, which was delivered by the trust.

- Examples of application of improvement in practice were numerous with a culture of sharing learning from programmes, implementing change and commitment to 'Listening into Action' (LiA) projects and Ambassador and Champion programmes for improving quality of care.
- The clinical leads we spoke with demonstrated a "health and wellbeing" approach to managing the short and long term sickness experienced by the nursing team, and reported good support from human resources.
- During interviews with staff, they told us the division had strong leadership and senior managers were visible on a daily basis or available for one to one discussions. Senior managers told us that the executive team were equally supportive. This reflected the vision and values of the division and the trust. We interviewed number of staff on an individual basis and held group discussions throughout surgical wards, theatres and units.

Culture within the service

- Morale was good amongst the nine staff we spoke with.
- There was an open and transparent culture. Staff were encouraged to share concerns or comments they had about patient care, colleagues or the service. We did not hear of any complaints or conflict amongst staff in critical care.
- Collaboration was good within the surgical and anaesthetic directorate, the wider trust team and across the region in the critical care network (LSCCCN).
- Staff we spoke with, without exception told us that they were proud to work for the trust, and in particular they were proud of the improvements and vision that had taken priority over more recent years. Staff used positive statements to describe the culture in critical care.

Public engagement

- We observed how experiences of patients influenced staff to improve care and develop new services. We saw examples of this from the follow up clinic and involving people who use the service in teaching clinical staff. Staff were engaged with seeking patient feedback and acting on results.
- The involvement with the LSCCCN allowed access to public events and consultations related to critical care services regionally

Staff engagement

- The trust recognised that ongoing work was required to continue improvement in employee engagement and employee recognition, however we saw good progress in critical care units.
- As part of a first wave LiA the trust developed a Behavioural Standards Framework (BSF) to underpin its vision and values. The BSF was embedded and staff we spoke with in critical care had a good awareness of how it had been incorporated into values-based recruitment, induction, appraisal and leadership strategy and training.
- Ten percent of trust employees responded to a 2016 pilot of the Barrett Cultural Values Assessment Tool. The 10 top personal values selected by employees presented "a strong and positive picture of caring, empathetic employees, with a can-do attitude, dedicated and committed to fairness." As reported in the trusts September 2016 Organisational Development Strategy Update meeting. These values were evident during the inspection amongst the critical care team.
- There was investment in staff in critical care. We spoke with members of the team who felt valued and had opportunity to develop professionally.
- We spoke with the lead consultant about plans to develop advanced critical care practitioner (ACCP) posts, in line with other units where the strategy had been proven to work well to support the care and treatment of critical care patients. This strategy would be an opportunity for skilled and knowledgeable nursing staff to develop their roles and initial team feedback about the approach was positive. The first cohort was planned for 2017 February and recruitment to the programme had commenced.

Innovation, improvement and sustainability

Critical care

- The comprehensive approach to caring for patients with tracheostomy had been adopted and shared by Lancashire and South Cumbria Critical Care Network (LSCCCN) Staff had received a trust 'Health for Heroes' award for the work achieved in 2016.
- A 'Sleep Well' project had been undertaken to decrease the noise and light disturbance to patients on the unit by introducing ear plugs and blindfolds. Although this was reported to us by staff we did not have opportunity to observe this during inspection.
- Critical care had introduced patient diaries to allow patients to process the impact of critical illness, improve memory recall and support staff to respond more holistically to patient's needs.
- The intensive care outliers LiA project to ensure there are 'no gaps in care' when a patient is cared for in theatre recovery on a temporary basis was an improvement to support sustaining safety and quality of the critical care admission experience.
- The unit continued to be an active member of the LSCCCN. Membership of the network enabled the unit to work collaboratively with commissioners, providers and users of critical care to focus on making improvements.

Maternity and gynaecology

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

Information about the service

Furness General Hospital (FGH) offered midwife-led and obstetric consultant-led care for high risk and low risk women and a range of gynaecology services.

Within the Labour Suite at FGH there were four delivery rooms and two active birth rooms

There were 24 maternity beds for antenatal and postnatal care, and a day assessment unit. The gynaecology ward had 8 inpatient and 2 day case beds.

Between April 2015 and March 2016 there were 1,054 births at FGH. Across the trust the percentage of births to mothers aged 20-34 and percentage of births to mothers aged 20 and under was slightly higher than the England average.

During our inspection we visited the antenatal clinic, antenatal and postnatal ward, labour ward, and gynaecology ward. We spoke with seven women and 35 staff, including midwives, ward sisters, matrons, doctors, consultants, senior managers, and support staff. We observed care and treatment and looked at five care records. We also reviewed the trust's performance data.

Summary of findings

At our previous inspection, in July 2015, we rated maternity and gynaecology services as 'requiring improvement' for being safe and well-led, particularly in relation to checking of equipment, medicine management, assessing and responding to risk, embedding governance and risk processes, joint working, and culture. During this inspection, we found good progress had been made in these areas and rated FGH maternity and gynaecology services as 'good' because:

- Staff understood their responsibilities to raise concerns and record patient safety incidents. There were processes to ensure reviews or investigations were carried out and action taken.
- Staff were aware of the procedures for safeguarding vulnerable adults and children, the infant abduction policy had been tested.
- There were processes for checking equipment and arrangements for managing medicines.
- Medical, nursing and midwifery staffing levels were similar or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.

Maternity and gynaecology

- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had identified action.
- Women were positive about their treatment by clinical staff and the standard of care they had received. They were treated with dignity and respect.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- The leadership team understood the challenges to the service and actions needed to address these. Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.
- There were many examples of how people's views and experience was used and acted on to develop and delivery maternity care.

However:

- Not all care records were fully completed, dated and signed. This included inconsistent recording on cardiotocographs (CTG) which was not in line with the trust fetal monitoring policy. These areas were audited and recommendations made.
- Although there was a plan, which set out the principles, and governance arrangements for a strategic partnership with Central Manchester and Lancashire further work was required to effectively capture and monitor outcomes.

Are maternity and gynaecology services safe?

Good

We rated safe as 'good' because:

- Serious incidents were reported in line with national frameworks. The number of reported serious incidents compared to the last inspection had improved. Processes were in place to review serious cases by using a multi-disciplinary approach and external peer review. There were changes made to the delivery of care because of leaning from incidents.
- There were processes for checking equipment and medicines. Standards of cleanliness and hygiene were maintained.
- The service assessed staffing numbers and skill mix using an acuity tool. Medical, nursing and midwifery staffing levels were similar or better than the national recommendations for the number of babies delivered on the unit each year.
- Systems were in place for assessing and responding to risk. Staff received training that enabled them to identify and act in the instance of a critically ill woman. There was improvement in the use and completion of the surgical safety checklist compared to the last inspection.
- Staff were aware of the procedures for safeguarding vulnerable adults and children. The service had carried out practical tests of the child and infant abduction policy.

However:

- There were some entries in clinical records where the signature and identifiable name of staff was illegible.
- There was inconsistent recording on cardiotocographs (CTG); this included entries with missing signatures at the beginning and end of the trace, no classification of the traces, no reason for commencing or discontinuing the trace and recording of the maternal pulse during first stage of labour. This was not in line with the trust fetal monitoring policy.
- There were some gaps in recording of medicine fridge temperatures to ensure appropriate temperatures were maintained for the storage of medicines.

Maternity and gynaecology

Incidents

- In accordance with the Serious Incident Framework 2015, the maternity services at Furness General Hospital reported two serious incidents (SIs) which met the reporting criteria set by NHS England between November 2015 and October 2016. Both incidents related to obstetrics, one referred to the mother only and one to the baby only. This was an improvement from the last inspection, which reported six serious incidents.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Between September 2015 and August 2016, the trust reported no incidents, which were classified as Never Events for maternity services.
- Trust policies for reporting incidents, near misses and adverse events were effective in maternity services. All staff we spoke with said they were encouraged to report incidents, and were aware of the process to do so. Staff said they received feedback about incidents they had reported with details of the outcomes of any investigations.
- There were 1,384 incidents reported for maternity and gynaecology across all hospital sites between September 2015 and September 2016. The majority of incidents were reported as low or no harm, 25 (2%) were moderate, one severe and one death. The service completed Root Cause Analysis (RCA) reports including external peer review. We found evidence of discussion and learning shared with staff.
- There were quarterly joint perinatal mortality and morbidity meetings across the three hospital sites. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group which included obstetricians, paediatricians, midwifes, medical students and risk management leads. Minutes for September 2015 to June 2016 showed that recommendations to improve practice had included changes to practice and guidelines. The March 2016 minutes showed that there was a plan for Consultants from Burnley and Preston to attend perinatal mortality meetings to maintain links with tertiary centres. The June 2016 minutes show that a consultant obstetrician from Preston attended.
- We looked at two RCA reports following incidents, which showed that duty of candour regulations, were followed. There was evidence to show women and families were involved in the investigation process, and informed of the outcomes.

Safety thermometer

- The maternity services used the national maternity safety thermometer. This allowed the maternity team to check on harm and record the care.
- A snapshot of the maternity safety thermometer for August 2016 showed that 94% of women did not experience any of the four physical harms at the trust (infection, perineal trauma, PPH>1000mls, Apgar<7 (term only) or transfer (term only)). 100% of women did not express concern over their perception of safety and 94% of women did not experience any of the combined harms at this trust.
- The safety thermometer information was not displayed in clinical areas but was available on the maternity website.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2016/17.
- Observations during the inspection confirmed that all staff wore appropriate, personal protective equipment when required, and they adhered to 'bare below the elbow' guidance in line with national good hygiene practice. All clinical areas were clean.
- Hand hygiene audits showed between 98% and 100% compliance for maternity wards and the gynaecology clinic.
- Environmental audits were carried out as part of the trust Quality Assurance Accreditation Scheme (QAAS). The QAAS showed that standards were met and where areas for improvement were identified, action was taken.
- Training records showed that 100% of maternity and gynaecology staff had completed Infection Prevention and Control (Core Skills) Level 2 training.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.

Environment and equipment

- At the CQC inspection in July 2015, processes for checking expiry dates of stock items were not consistent. During this inspection, we found stock was in date and weekly checklists were completed.
- Adult and neonate resuscitation equipment was checked, stocked and maintained. Records showed that checks were carried out daily.
- There was adequate equipment on the wards to ensure safe care, specifically cardiotocograph (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet women's needs.
- All community midwives had emergency equipment bags. These were standardised across areas with checklists so that staff could access the correct equipment for home births.
- One midwife said that the maintenance processes for returning repaired equipment was sometimes slow; for example, the ward was using one blood pressure monitor for some time because two monitors had gone for repair.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. Specialist equipment for women with a high body mass index (BMI) was available when required.
- The neonatal unit was close to the delivery suite. Staff said that paediatric staff could attend emergencies quickly.
- There was a newly refurbished birthing pool. There was appropriate evacuation equipment, which was tested.
- The milk fridge did not have a lock. There was a simple thermometer inside the fridge, which recorded current temperature but no minimum and maximum recording. This was referred to the ward manager for action.

Medicines

- We looked at four prescription charts three was competed correctly. The other had no allergies documented, and paracetamol PRN was timed and dated but not signed for. This was not recorded in the records therefore we were unable to evidence if this drug was given or not.
- Drugs and IV fluids were stored appropriately on both the labour and post-natal ward. The medicines trolley on the post-natal ward was locked and secured. All emergency drugs were stored in tamper proof boxes.
- Controlled drugs were checked in line with trust policy.
- The majority of records showed medicine fridges were monitored in line with trust policy to ensure appropriate temperatures were maintained for the safe storage of medicines. However, there were eight gaps in recording between 1 September and 5 October 2016.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute. We reviewed four records, which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of their labour.
- There were a few entries where staff signatures were illegible or the staff designation was not recorded.
- Standard operating procedures and care pathways were included in records for care of women with diabetes, epilepsy, hypertension or a high body mass index (BMI) in pregnancy.
- Records showed that the management of pregnancy-induced hypertension followed trust guidelines appropriately.
- A venous- embolism risk assessment form was completed at booking with obstetric referral as indicated.
- A cross-bay record keeping audit was completed between April and July 2016. The audit sample of 30 records showed that some areas required improvement. Action plans were completed and showed areas of good practice. Staff attended mandatory study days for record keeping and a new e-learning package was developed for completion of Maternity Early Obstetric Warning charts.
- We looked at nine CTG's; only one was recorded according to the trust fetal monitoring policy. There were entries with missing signatures at the beginning and end of the trace, no classification of the traces, no reason for commencing or discontinuing the trace and no maternal pulse was recorded on the partogram during first stage of labour. An audit of CTG recording between February and May 2015 showed similar findings. Recommendations included to share the audit with staff through the WESEE meetings, ward managers effectiveness meeting, senior leadership meeting, monthly audit update report for clinical staff, and to feed audit results to the education team to add results to the CTG teaching session.

- Trust data showed 100% of staff had completed information governance training.

Safeguarding

- There was a named midwife for safeguarding and a full time safeguarding specialist midwife. Both worked across all sites. There was good liaison with other specialist midwives such a teenage pregnancy, mental health, domestic violence and substance misuse.
- The safeguarding midwife carried out a snap shot audit of safeguarding records. The latest audit showed 80% compliance against a target of 95%. There was a trigger sheet to prompt staff to ask questions about social and family circumstances. There was an alerting system for vulnerable women and babies attending maternity, children's services or the emergency department.
- Safeguarding supervisors had protected time. A formalised system was being developed which included an additional safeguarding training day incorporating an hour of supervision. Data showed 76% of midwives had received safeguarding supervision and 75% of community midwives.
- The service had employed a social worker experienced in child sexual exploitation (CSE). Staff received information about CSE through case study, conferences and newsletters. There was close working with the CSE nurse in Blackpool.
- There was a safeguarding trigger tool used for women attending termination of pregnancy. Children aged 13 to 16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team.
- Women were asked about abuse at booking and when they were alone. Midwives tried to see women alone at least twice in their pregnancy. The safeguarding and domestic violence midwives were reviewing recording of domestic abuse conversations with women and providing further training for staff.
- Staff had access to an independent domestic and sexual violence advisor.
- There was a process for reporting cases of female genital mutilation (FGM) in response to the Department of Health's multi-agency guidance. There were two midwife FGM champions.
- The trust had carried out practical tests of the child and infant abduction policy in July 2016. There were no issues identified.
- Training figures showed 95% of staff had received training at level 1 for safeguarding vulnerable adults and children; 100% of staff had completed training for safeguarding children level 2; and 83% level 3. Schedules showed remaining staff were booked to attend before the end of the year.

Mandatory training

- Mandatory training was provided using either e-learning or study days. Staff accessed e-learning through a trust-wide training system which sent email prompts when learning was due.
- There was a dedicated practice development midwife who monitored attendance and organised training sessions. A monthly attendance repot was sent to the divisional monthly assurance committee.
- Mandatory training included moving and handling, infection prevention, equality and diversity, information governance, conflict resolution and basic life support. The trust's target compliance rate was 95%. Data provided by the trust for Furness General hospital showed training compliance rates were mostly in line with the trust target apart from adult basic life support (76%).
- At the time of our inspection, there were three mandatory midwifery study days. These would increase to four in the following months.

Assessing and responding to patient risk

- The service used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support. The records we looked at showed that a set of observations were recorded on admission to the unit and an early warning score was calculated in line with trust guidelines, recording of observations were increased when MEOWS increased.
- The service was not commissioned to provide anything above level 1 care for women in maternity services and therefore there was a low threshold for transfer to HDU/ITU. However, staff did undertake training that enabled them to identify and act in the instance of a critically ill woman. Trust data showed that 100% of community midwives and 90% of staff on the maternity ward had completed Acute Life Threatening Events Recognition and Treatment (ALERT) training. The care of critically ill

obstetric cases were also picked up through 'PROMPT' (Practical Obstetric Multi-Professional Training); a evidence based training package for obstetric emergencies.
- At the last inspection, we found that the 'five steps to safer surgery' procedures (World Health Organisation safety checklist (WHO)) were not completed consistently. During this inspection, we found improvements in this area. A range of audits from January to July 2016 showed that compliance was 100%.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings. However, we saw that documentation of CTG recordings were not consistent with trust policy for fetal monitoring.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' with a ratio of 1 midwife to 27 births, which was better than the RCOG recommendation of 1 midwife to 28 births.
- The service assessed staffing number and skill mix using the acuity tool Birth-rate Plus Intrapartum Score card. This reviewed intrapartum, postnatal and antenatal activity three times a day in the unit. If required staff were asked to provide care in a different area to which they were allocated if further, midwifery cover was required due to activity. This was in line with the trust escalation policy.
- There was a band 7 senior midwife on duty at all times on the labour ward. The planed and actual staffing levels were displayed on notice boards on each ward. On the days, we inspected there were no shortfalls in planned staffing levels.
- Over the last 12 months, midwives in post had increased by 9.6 WTE (whole time equivalent) and by head count; this had increased by 15 midwives. The residual midwifery vacancy rate was 6.2%.
- Internal staff were offered unfilled shifts six weeks in advance. Bank shifts were paid at the top the grade as an incentive for internal staff to fill.
- There were three vacancies in community midwifery. Staff said this was not affecting safety but sometimes affected continuity of care because of increased on-call with less staff to cover the rota. However, there was cross-bay working to help with the rota and a plan that community midwives would only need to be on-call when home births were planned. Caseloads were around 60-70 women per midwife.
- A multidisciplinary handover took place on the labour ward. All women were discussed, including women under midwifery led care who may require obstetric input. There was good communication observed between midwives and medical staff. There was a further bedside handover between midwives.
- At September 2016, there was three agency staff at Furness General Hospital, which had worked over six months. There was an action plan to reduce agency spend trust-wide this included interviews planned for November 2016 to recruit to one Labour ward Co-ordinator post and there are 5 applicants for Band 6 Midwives and two for Band 5. All suitable applicants would be appointed and all applicants are external.
- Nurse staffing in gynaecology was assessed twice a day using a safe staffing acuity tool. Nurse to patient ratio was 1:8.

Medical staffing

- The service provided 52 hours of consultant presence on the labour ward each week. This was because of the appointment of new consultants having resident night shifts on the delivery suite as part of their job plan. This was in line with the recommended RCOG safer staffing standards for a services delivery less than 3,000 births per year.
- The proportion of consultants and junior doctors was better than the England average. There were six consultants at Furness General Hospital**,** four of which were on the non-resident on call rota and two provided resident on-call.
- There was no dedicated anaesthetic cover for non-elective care. In regular working hours (9am to 5pm) first on-call senior anaesthetist or intensive care consultant provided cover for maternity. Between 5pm and 9.15am, a resident senior anaesthetist covered maternity, intensive care unit and general emergencies. In addition, a third on-call anaesthetic tier was available if required. The clinical lead for obstetrics said they had never had a problem in getting an anaesthetist within 30

minutes for caesarean section or experienced delays in getting epidurals. They felt that cover was sufficient for the intensity of workload. A business case for the recruitment of three additional consultant anaesthetists was submitted to the trust Finance Committee on 26 September 2016.
- There was a cross-hospital handover each say using a video conferencing facility.
- There were no consultant vacancies in obstetrics. Locum use for gynaecology was 13%. Three new consultants were recently appointed.

Major incident awareness and training

- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Medical staff and midwives undertook training in obstetric and neonatal emergencies at least annually.
- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.

Are maternity and gynaecology services effective?

Good

We rated effective as 'good' because:

- Women's care and treatment was planned and delivered in line with current evidence-based practice, which was audited to ensure consistency of care and treatment pathways.
- Care outcomes were meeting expectations in most areas, and where improvements were required the service had taken action.
- The service participated in local and national audits and external reviews to improve care.
- Staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development was maintained through supervision.
- Women had their pain effectively managed. There were processes to support women to feed their babies.
- There was improvement to ensure teams worked together across all hospital sites. Communication between medical, midwifery and nursing staff was described as good in the unit. There were good working relationships with other services including neonatology and paediatrics.
- Consent practices were monitored and reviewed and women were involved in making decisions about their care and treatment.

Evidence-based care and treatment

- From our observations, records and through discussion with staff we found that care was in line with the National Institute for Health and Care Excellence (NICE) and Royal College Recommendations.
- Records showed women received care in line with NICE Quality Standard 22, covering antenatal care of pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital based care.
- For women who planned for or needed a caesarean section, this was managed using NICE Quality Standard 32.
- Care of women was in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (including 'safe childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- A baseline assessment of Intrapartum Care: Care of healthy women and their babies during childbirth (CG190) showed 100% of recommendations were met.
- The service used assessments of how it compared with NICE statements through a range of quality standards. Completed assessments included: maternal and child nutrition (QS98), diabetes in pregnancy (QS109), and antenatal and postnatal mental health (QS115). Action plans (July 2016) showed these were partially compliant.
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. We looked at six guidelines, found these were in date, and in line with evidence based practice.
- A clinical audit lead and dedicated audit lead midwife covered all three sites. The service participated in local

and national audits and external peer reviews to improve care. There was a three-year audit programme, additional audits were completed following any learning from incidents, and case reviews.
- Audits showed action was taken when risks were identified. For example, the maternity dashboard showed a significant increase in the number of post-partum haemorrhage (1500mls) in January 2016. A thematic review was carried out which showed all cases with the exception of one case followed PPH guidance and managed appropriately. The one case was escalated to a root cause analysis investigation due to delay in recognition and treatment.
- The service used evidence based birth centile charts from the Perinatal Institute, which identified which babies required enhanced observations.
- The Screening Quality Assurance Visit Report NHS Cervical Screening Programme (Public Health England June 2016) showed there were no immediate concerns for improvement. Four high level issues were identified relating to guidance and data; NHS England Screening & Immunisation Team Lancashire and Cumbria would monitor progress against the action plan for these areas.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them. Most women we spoke with said they had received sufficient pain relief.
- The maternity dashboard showed that between February and July 2016, the average of epidural deliveries was 14% against a trust target of 20%.
- An audit of the 'Epidural in Labour Guideline' May 2016 showed that anaesthetist response times within 30 minutes for epidural analgesia was good.
- There was access to various types of pain relief for birthing women, which included drug-free methods such as hypnobirthing. There was access to a new birthing pool. Data showed there was a 3% water birth rate.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the trust for February 2016 to July 2016 varied between 56% and 64% against a trust target of 61%.
- At the time of inspection, the trust had not registered intent to undertake the United Nations Children's Fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme. However, there was an infant feeding guideline and the service was involved in a 'Listening in Action' (LIA) project to develop an infant feeding strategy.
- Breastfeeding support was included in mandatory study days and preceptorship training for newly qualified midwives.
- Formula milk was available. There were day rooms where women could go to feed their babies and availability of breast pumps. Breastfeeding peer supporters attended the ward to support women.
- Snacks were offered to women 24 hours a day as required, and staff were able to order extra food and snacks for pregnant women as required.
- Women told us they had a choice of meals and these took account of their individual preferences including religious and cultural requirements. Women we spoke with said the quality of food was good.

Patient outcomes

- There were no risks identified in: maternal readmissions; emergency caesarean section rates; elective caesarean sections; neonatal readmissions or puerperal sepsis and other puerperal infections. (Hospital Episode Statistics April 2012 to May 2015).
- Between April 2015 and March 2016, the number of caesarean sections was similar to expected. The standardised caesarean section rates for elective sections were similar to expected. The rates for emergency caesarean sections were similar to expected.
- The normal vaginal delivery rate was 56%, which was worse than the national average of 60%.
- Between 1 April and 30 September 2016, there were 49 admissions to the special care baby unit. The common primary diagnosis for admission for babies born at term was due to respiratory distress (3 cases) and infection (3 cases). For the same period, there were two at term admissions, which were transferred outside of the trust.
- Between 1 April and 20 September 2016, there were four maternal admissions with a level 2 HDU or Level 3 ITU critical care period.
- Between October 2015 and September 2016, there were no stillbirths at Furness General Hospital.
- Between October 2015 and September 2016 the average number of women, sustaining serious perineal trauma during birth was one per month, which was lower (better) than the trust target of nine per month.

- Between October 2015 and September 2016 the average number of women, sustaining a post-partum haemorrhage >1500ml was two per month, which was the same as the trust target.
- The 'National Neonatal Audit Programme 2015' (NNAP) showed Furness General Hospital met or was above the NNAP standard for one of the five indicators. This indicator was 'do all babies of less than 29 weeks gestation have their temperature taken within an hour after birth'. The remaining four indicators were worse than the NNAP standards. There was an action plan with timescales in response to the findings.
- The NHS screening programme sets key performance indicators (KPI) for antenatal and new-born screening programmes. The trust was meeting acceptable levels within six of the eight KPIs for which data was submitted for April to July 2016. The trust provided a copy of their action plan and we saw that steps had been taken to improve performance, for example, a change of equipment and continued staff education to reduce the number of avoidable repeat new-born blood spot tests.

Competent staff

- Newly qualified midwives completed a comprehensive two-year preceptorship programme. This included protected study days, one morning per month. Preceptorship packages were individualised and provided a framework to develop staff from a band 5 to a band 6 in maternity care. This included rotation across all sites.
- Staff told us they received a yearly appraisal. Trust data showed that 84% of medical staff, 88% of band 1-7 and 93% of Band 8a midwifery and gynaecology staff had received a yearly appraisal.
- The 'North of England Local Supervising Authority's (LSA) annual report to the Nursing and Midwifery Council September 2016' showed the trust had met all LSA standards. Recommendations from the audit included a review of SoM caseloads, which were not evenly distributed, and SoMs seeking assurance from the trust that recommendations made following investigations had been actioned.
- The caseloads held by supervisors of midwives were in line with the recommended ratio of 15 midwives for each supervisor. All midwives had 24-hours access to supervisors. The LSA report confirmed that for the practice year 2015/2016 100% of annual reviews had been completed. This provided assurance that midwives had met the NMC requirements for practice.
- There was a full time dedicated SoM. Three midwives have completed the Preparation of Supervisor of Midwives (PoSoM) programme at Manchester City University with appointments from the LSA to take place in October 2016.
- All student midwives had access to supervision; a full time supervisor of midwives facilitated this.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audit. They told us they had good support from seniors and could approach them for advice at any time. There was a weekly trainee forum where doctors could raise any training issues.
- The results of the General Medical Council National Training Scheme Survey 2016 showed that the trust was 'within expectations' for clinical supervision and adequate experience and 'above expectations' for a supportive environment.

Multidisciplinary working

- Communication between medical, midwifery and nursing staff was described as good in the unit. We observed good working relationships with other specialties including neonatology and paediatrics.
- Specialist midwives worked closely with their colleagues across all hospital sites and had regular meetings to discuss practice issues.
- Staff confirmed there were systems to request support from other specialities such as pharmacy, allied healthcare professionals and physicians.
- Newcastle was a referral centre for high-risk women requiring an antenatal review. There were systems to receive advice and staff said this was supportive.
- Some community midwives had regular meetings with GPs to discuss cases. A quarterly meeting was held with community midwifery and health visitor leads for the area. There were good relationships with the hospital and good referral pathways for antenatal visits. Community midwives had an office in the maternity unit at Furness General Hospital.
- The gynaecology multi-disciplinary (MDT) meetings were cross-bay; the colposcopy MDT was held once a month.

- There was a new birth screening operational group, chaired by the Director of Midwifery who met quarterly. The group included staff from the laboratory's, child health, sonographers and paediatricians. There were positive outcomes for example previously there had been inconsistent coding of abnormalities by sonographers across the trust, this was now standardised and had improved coding.
- Records showed communications with GPs summarising antenatal, intrapartum and postnatal care.
- The post-natal ward had no formal transitional care facility for babies requiring additional support; however, staff said they worked closely with the neonatal unit to care for babies who required additional clinical interventions.
- There were joint education meetings with the neonatal unit and multidisciplinary obstetric skills and drills training days.
- Safe active birth specialist midwives worked closely with women's health physiotherapists to plan and deliver the active birth sessions available to women. Physiotherapists delivered sessions to band five midwives as part of the preceptorship programme.

Seven-day services

- 'Out-of-hours' services were available in emergencies. All women could report to the hospital in an emergency through either A&E or maternity reception.
- There was seven-day medical cover provided with the minimum of a resident middle grade doctor, and at times a resident consultant.
- A supervisor of midwives (SoM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided support to midwives at all time and was available to women.
- There were no sonographers available at weekends. The head of ultrasound had completed a capacity and demand exercise for staffing in antenatal clinics. Actions were agreed at the Antenatal and New-born Operational Group in May 2016 which was to pursue a 'Listening into Action' approach, and the work with Lancashire Teaching Hospitals to introduce midwife led obstetric sonography.

Access to information

- All local and national policies were available on the trust intranet for staff to access. Senior staff informed us they were responsible for updating pathways when new policies were approved. We reviewed five guidelines relating to maternity care; all were in date and followed evidence based practice.
- All community midwives had mobile phones and could access guidelines by ringing the unit or use PCs in GP surgeries.
- The GP and health visitor received a copy of the delivery summary to inform them of the outcome of the birth episode.
- There was a system in place to ensure women's medical notes were transferred to their chosen maternity unit at 36 weeks of pregnancy. Service leads told us they made arrangements to transfer medical notes by courier in the event women were diverted to a different maternity unit.
- Staff told us there were processes to ensure medical and hand held records travelled with women in the event of a transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at a sample of consent forms during our inspection and found these records met legal requirements.
- Staff had an awareness of Deprivation of Liberty Safeguards. The safeguarding midwife gave two examples where women required mental capacity assessments. This was carried out in line with the Mental Capacity Act (MCA) and involved multidisciplinary input including support from the learning disability nurse.
- The MCA and Deprivation of Liberty Safeguards were included in mandatory study days.

Are maternity and gynaecology services caring?

Maternity and gynaecology

Good

We rated caring as 'good' because:

- Maternity and gynaecology services were caring. The NHS Maternity Friends and Family Test for August 2016 showed the number of women who would recommend the maternity service was similar or better than the national average.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- There were effective and confidential processes for women attending the gynaecology ward. Women received emotional support where required; appropriate specialist bereavement and midwifery support was provided which met the individual circumstances of women.

Compassionate care

- Between August 2015 and August 2016 the trust's Maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to than/ to the England average. In latest month, September 2016 the trust's performance for antenatal was 96% compared to a national average of 96%.
- The trust's Maternity Friends and Family Test (birth) performance (% recommended) was generally similar to than / to the England average. In latest month September 2016 the trusts performance for birth was 95% compared to a national average of 96%.
- The trust's Maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally better than the England average. In latest month September 2016 the trusts performance for postnatal ward was 100% compared to a national average of 94%.
- The trust's Maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In latest month September 2016 the trusts performance for postnatal community was 97% compared to a national average of 98%.
- Internal patient survey results for the hysteroscopy and colposcopy clinic at September 2016 showed 100% of patients would recommend the service. Average scores were 'five stars' (highest score) for dignity and respect, involvement, information, cleanliness and staff.
- The trust scored 'about the same' as other similar size trusts in all 17 indicators in the CQC Survey of Women's Experience in Maternity Care 2015.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way.
- Six months of the safety thermometer/open and honest data showed that for four months 100% of women said that 'they were not left alone by midwives or doctors at a time when it worried them during labour or birth'. Two months of the data showed that 10% to 16.7% of women stated that they were left alone. The reasons from this was not specified but may include preparation of analgesia or equipment, making appropriate referrals to obstetricians, allowing privacy or seeking advice from senior colleagues. There were no incidents or complaints reported regarding failure to provide 1:1 care in labour during this period.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in clinical areas.
- We observed that the midwife call systems were within reach and women said that staff responded to the call bells quickly.

Understanding and involvement of patients and those close to them

Maternity and gynaecology

- Women were involved in their choice of birth at booking and throughout the antenatal period. Women said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Patients attending the hysteroscopy unit said staff explained the procedure before, during and after treatment.
- Supervisors of midwives and the consultant team were involved in agreeing plans of care for women making choices outside of trust guidance for example requesting homebirth with either a current or previous high-risk pregnancy.
- Results from the CQC Maternity Service Survey 2015 showed the trust scored about the same as other trusts for 'women being involved enough in decisions about their care during labour' and for 'the partner being involved as much as they wanted'.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; two specialist midwives supported families from their initial loss, throughout their time in hospital and when they returned home.
- There were effective and confidential processes for women attending the gynaecology ward. Staff supported women to make informed choices about their termination of pregnancy options.
- Specialist midwives for substance misuse, mental health, safeguarding and domestic violence provided support to women in clinics and at home.
- There was ongoing assessment of women's mental health during the antenatal and postnatal period. Referral could be made to the crisis team and adult mental health team.
- The service has a 'Listen to Mother' birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.

Are maternity and gynaecology services responsive?

Good

We rated responsive as 'good' because:

- The service was working in partnership with other organisations to implement an integrated maternity care pathway and worked closely with the Maternity Services Liaison Committee to design services to meet the needs of women and their families.
- Access and flow such as clinic waiting times were managed appropriately. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway.
- Services were planned, delivered and co-ordinated to take account of women with complex needs, there was access to specialist support and expertise.
- There were processes in place for women to make a complaint. There was learning and improvements were made to the quality of care because of complaints and concerns.

However:

- Due to capacity issues, patients from other specialties were cared for on the gynaecology ward. If the ward was full this meant the gynaecology assessment unit closed and delayed admissions of elective and emergency patients from A&E. This was identified at our last inspection and remained an issue on the divisional risk register. The matron and ward managers were reviewing the gynaecology admission pathway and adaptations to the ward following the new maternity unit build.

Service planning and delivery to meet the needs of local people

- The service worked closely with commissioners and other stakeholders to build stronger relationships through the trust strategy 'Better Care Together' projects. This included implementation of an integrated maternity care pathway, equitable provision of midwife led services, options for birth and provision of neonatal transitional care in acute and community settings.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community.
- Through the Maternity Services Liaison Committee (MSLC), the service was working with North West ambulance service to increase awareness amongst ambulance crews of women's specific maternity needs.
- The service was working in partnership with Healthwatch and MSLC colleagues in developing the Healthwatch Maternity Matters Survey for the RCOG Implementation Review.

Maternity and gynaecology

Access and flow

- During 2015/2016 maternity bed occupancy rates were lower than the England average of 61%, except quarter one 2016/2017 where occupancy levels were approximately 1% (62%) higher than the national average.
- Between January 2015 and June 2016, there were no closures of the maternity unit at Furness General Hospital. There were contingency plans for the delivery suite in the event of the unit becoming full.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments, ultrasound scans and routine blood tests. Midwives were available on call 24 hours a day for advice. Community midwives were integrated into the service. Women with high-risk pregnancies attended consultant-led clinics.
- There were no problems with access and flow in the antenatal clinic. We observed a clinic and saw that women did not have to wait long before being seen.
- Between October 2015 and September 2016 the percentage of women booking for antenatal care before 20 weeks was between 95.3% and 99%, which was better than the trust target of 90%.
- There was good support from sonographers. There were no delays reported for scans.
- There were colposcopy co-ordinators at the hospital sites that covered clinics and worked well as a team to ensure women received appointments quickly. The service had introduced two additional colposcopy appointments.
- Between April and June 2016, 18-week referral to treatment times for gynaecology was 97%, which was better than the national target of 92%.
- Staff told us that due to capacity issues, patients from other specialties were cared for on the gynaecology ward. If the ward was full, there were only two registered nurses on duty, which meant the gynaecology assessment unit closed and delayed admissions of elective and emergency patients from A&E. This was identified at our last inspection and remained an issue on the divisional risk register. The matron and ward managers were reviewing the gynaecology admission pathway and adaptations to the ward following the maternity unit new build.
- The antenatal day assessment unit (ADAU) was open 8am to 6pm. A midwife was allocated to work on the unit and treated conditions within set criteria, admissions outside of this were triaged on the labour ward. Staff said women could wait up to 30 minutes however, women were admitted to the maternity ward if their care was not completed before ADAU closed.
- Between January and July 2016, the service achieved 90% of booking appointments for delivery before 12 completed week's gestation against a target of 90%.
- There was a process for women with Blood Borne Virus (BBV) infections. Results were notified to the BBV specialist midwife and screening co-ordinator. Women were referred to a specialist antenatal clinic. Through a MDT approach, a management plan was developed and neonatal alert sent to the paediatrician.

Meeting people's individual needs

- Staff valued women's emotional and social needs, for example, the service had developed the dragonfly logo. The aim of this was to develop visual aids to alert staff that a woman had had a previous pregnancy loss. There were memory boxes available with items to serve as a memory of the baby.
- Bereavement services included the provision of a private room and use of cold cots to keep the baby with parents for as long as the parents required. Staff offered women the chaplaincy service to provide extra support.
- Women using maternity services could access specialist midwives for the following aspects of care: domestic violence, teenage pregnancy, substance misuse and mental health. The service was recruiting a public health midwife for smoking cessation and obesity.
- Women had the opportunity to meet with a supervisor to discuss their birth experiences. Information promoted SOM and birth choice clinics and post birth reflection.
- New fathers and birthing partners were being offered the opportunity to stay overnight with their partners and new-born babies, as part of a national pilot scheme.
- There were two 'safe and active birth' midwives to promote active birth.
- Women could access antenatal education run by midwives and included active birth sessions with women's health physiotherapists. These were practical sessions where women could learn about positions for active birth and management of pregnancy associated musculoskeletal conditions.

Maternity and gynaecology

- There was a range of information leaflets available to women. Staff told us these leaflets were available in different languages if required. There was access to interpreters or use of a translation phone service for women who did speak English.
- Women could access a joint consultant led diabetes clinic with support and advice being available from a diabetic nurse and dietician. There was recent approval for a specialist diabetic midwife post.
- There were processes to identify women with learning disabilities. The service liaised with the learning disability nurse and staff encouraged family and key workers to be involved in the care pathway.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- Information to support the termination of pregnancy pathway included leaflets about medical and surgical pregnancy termination, to support women in making an informed choice.
- The service had its own dedicated area on the trust website. Pregnant women and their families could access this site to help orientate them to the service and the options available to them.
- The implementation of the new-born screening hybrid model showed that 99.6% of screens were completed in 4 weeks and 100% of screen completion to attended assessment within 4 weeks or 44 weeks gestational age.

Learning from complaints and concerns

- Between 27 October 2015 and 27 October 2016 there were 50 complaints about Maternity and Gynaecology. The trust took an average of 24.48 days to investigate and close complaints. This was in line with its complaints policy, which states complaints should be dealt with within 35 days, unless a different timescale has been agreed with the complainant. The trust had seen a steady increase in the number of complaints received over time. At November 2016, nine complaints were open and 14 had been re-opened. We reviewed a sample of complaints and found that women were informed of timescales, apologies had been given, meeting with consultants had been arranged, and action plans had been agreed.
- Of the 50 complaints, 21 related to FGH. The maternity ward received the highest number of complaints (6).
- Monthly and weekly governance and risk management meetings, seniors meetings and handovers discussed learning from complaints and concerns. Learning from complaints included; a pilot project for partners to stay overnight, changes to guidelines, closer monitoring of high-risk women during induction of labour and improved communication.

Are maternity and gynaecology services well-led?

Good

We rated well-led as 'good' because:

- There was a clear vision and strategy for the service, which was linked to the National Maternity Review 2016. Governance structures and processes had improved. There was an effective governance framework to support the delivery of the strategy and good quality care. Performance measures were reported and monitored and action was taken to improve services.
- The leadership structure had changed since the last inspection. Leaders understood the challenges in the service and could identify the actions needed to address these. Staff said leaders were visible and approachable.
- Improvement had been made to ensure staff and teams were working together to promote a culture of learning and continuous improvement. A culture of openness was evident.
- There were many examples of how women's views and experience was used to shape and improve the service and culture. Women and their families were involved in decision-making and in the planning and delivery of maternity care.

However:

- Although there was a plan, which set out the principles, and governance arrangements for a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust further work was required to effectively capture and monitor outcomes.

The trust acknowledged that partnership working was still evolving with developments needed to formalise the midwifery placements and extend the partnership to include paediatrics and anaesthetics.

- Results from the Cultural Assessment Survey May 2016 for obstetrics and gynaecology showed that some staff perceived that current organisational values needed to be better. The personal values for the service were overall positive and a divisional plan was being developed to address the organisational values.

Vision and strategy for this service

- 'Better Births Together' was the Maternity Strategy for 2016/17. The key focus was to provide, compassionate, high quality, evidence based and safe maternity services, which met the needs of all women and their families. This would be achieved by working as a multi-professional team with communities to improve physical, social, mental and emotional health for women entering pregnancy.
- The strategy included a newly developed integrated maternity pathway for women and families across Morecambe Bay to ensure individualised person centred care. The use of the pathway was one of the priority projects for 2016/2018.
- The creation of a new maternity building with theatres and delivery suite in response to the Kirkup Report had commenced with a completion date of December 2017.
- As part of the maternity improvement plan, the service had developed a strategic partnership with Lancashire Teaching Hospitals NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust. The clinical lead for obstetrics said that a memorandum of understanding was in place with both tertiary centres. The MOU set out the principles of the partnership and governance arrangements. Consultants and almost all of non-training grade doctors in obstetrics and gynaecology had honorary contracts with Central Manchester.
- The clinical director and clinical lead for obstetrics said they had attended clinical audit and effectiveness days and Human Factors training. Positive feedback was received. The attendance was extended to include midwifery staff and non-training grade doctors.
- In a paper presented to the Trust Board in September 2016 a schedule of clinical placements had been agreed with the first taking place on 7 October 2016. This would provide the opportunity for clinical observations, ward rounds and attendance at complex clinics in areas of interest for medical staff. The activity would form annual appraisal and personal development plans. The paper acknowledged that partnership working was still evolving with developments needed to formalise the midwifery placements and extend the partnership to include paediatrics and anaesthetics.

Governance, risk management and quality measurement

- Clinical governance business partners were introduced into post in February 2016. This was an independent role providing a bridge between the corporate governance team and the women and children's division. The business partner reported to the director of governance. The governance partners sat outside of the division and covered cross-bay.
- There was a full time risk midwife and clinical lead to support the governance process.
- There was a weekly patient safety summit chaired by the medical director and chief nurse to review all moderate and above incidents and near miss, cases. Re-grading of incidents occurred where required to ensure accuracy.
- Moderate and above incidents (even if no harm) triggered a rapid review by a multi-disciplinary team.
- A three-minute briefing took place each day and included clinical outcomes, learning from incidents, complaints and any concerns. The brief was available on notice boards, and placed in a folder for community midwives to access.
- There were four levels of governance meetings using the trust standardised WESEE approach (workforce, experience, safety, effectiveness and efficiency). Monthly meetings were held at ward level, by managers across the service and by matrons and heads of service. These meetings fed into the divisional governance assurance group who in turn produced a monthly report to the trust board. We reviewed a copy of a monthly report from August 2016 and saw it was RAG rated (red, amber and green) and included training, staffing, incidents, complaints, risks, financial performance and effectiveness.
- The divisional governance and assurance group was attended by obstetric and paediatric leads, nursing and

midwifery staff, director of midwifery and matrons. Attendance trackers were reviewed at each meeting to monitor attendance in line with the meetings terms of reference.
- There was regular review of the divisional risk register. Actions taken were visible and the process completed by removing risks from the register. Minutes showed staff discussed risks at ward meetings. Maternity managers we spoke with had a good understanding of the risks to the service.
- The wards managed low-level incidents. At the time of inspection, 70% of level1 and 2 incidents were reviewed in 20 days against a target of 80%. Plans were in place to improve timeliness.
- Performance and outcome data was monitored using a maternity dashboard. The dashboard followed the RCOG guidance. There were some outcomes such as admissions to intensive care and special care and Hypoxic-ischemic encephalopathy (HIE) not included. The governance team acknowledged that the dashboard was 'work in progress' and gave assurance that audit and incidents would flag areas of risk.
- Supervisors of midwives attended governance and risk meetings. The maternity risk management strategy described the framework of statutory supervision and the role of a supervisor of midwives.
- SoMs were involved in incident investigations. At the time of inspection there was one SoM investigation completed. The SoM investigation aligned with the trust investigation. SoMs were involved in investigations for other trusts.
- Band 5 midwives and new starters were encouraged to spend a day with the governance and audit team during their induction and supernumerary period.
- The clinical director said they had attended a clinical audit and effectiveness meeting at Central Manchester where guidelines and a never event was discussed. The learning was brought back and processes at Morecambe Bay quality assured.
- There were quarterly labour ward forum meetings. Minutes showed that obstetric, anaesthetic and paediatric issues were discussed. There was good multidisciplinary attendance.

Leadership of service

- The leadership structure had changed since the last inspection. The Women's and Children's Division was led by a clinical director (CD) who reported to the trust medical director. The director of midwifery and gynaecology (DOM) reported to the executive chief nurse. A divisional general manager supported the directors.
- The DOM said they attended the North West head of midwifery group for external support however, it was not clear what external peer review was provided.
- There were three maternity matrons and a gynaecology matron covering each site that were accountable to the DOM.
- The clinical lead for obstetrics and gynaecology was accountable to the clinical director.
- Staff said they had regular access to the matron and manger that was on site every day. The DOM was visible each week and had an office on the ward.
- Medical staff said they had good support from the clinical director. Consultant job plans were completed.
- Divisional leads had regular meetings with the matrons; the DOM met with them weekly and there were other regular meetings with the clinical director and the divisional general manager. Matrons said they were supported, well informed and could escalate their concerns to divisional leads.

Culture within the service

- Staff said they were engaged and well supported by managers. There was a feeling amongst teams that they were working more effectively with all grades of staff and cross-bay.
- We received information that some student midwives had experienced bullying. Students we spoke with during the inspection did not raise this and said that they had received good support from senior midwives. We discussed this with the DOM who was working closely with the university and the Royal College of Midwives initiative to address bullying and harassment.
- The clinical lead for obstetrics said there was joint working with Royal Lancaster Infirmary. This was evident in multi-disciplinary meetings in gynaecology, audit, perinatal mortality and morbidity meetings and clinical handovers. There was a joint anaesthetic audit meeting twice a year.
- All band 5 midwives rotated cross-bay. Middle grade doctors provided cover across sites if required. There were a number of new consultant appointments, which had improved working relationships.

- A trainee doctor said that senior help was readily available and there was very good working relationships with midwives. They said they would want to extent their time in post.
- Newly appointed staff said that they were aware of the previous issues but had witnessed no evidence of negative behaviours and felt that women received good quality care.
- All staff reported that a 'no blame' culture was more evident in the trust. Staff said they could report errors or omissions of care and use these to learn and improve practice. Staff were encouraged to reflect on incidents as soon as possible.
- 100% of staff had completed Equality Diversity and Inclusion training.
- A positive culture group was being introduced. Results from the Cultural Values Assessment May 2016 showed results for obstetrics and gynaecology were overall positive for personal values with some perception that current organisational values needed to be better. A divisional plan was being developed to address these areas.
- Staff sickness rates between April 2015 and March 2016 for Furness General Hospital was 5.4% against the NHS North West target of 4.3%.
- Between April 2015 and March 2016, the trust reported a turnover rate in the Women's and Children's Division of 9.38% for all staff groups. The trust reported that turnover was reducing in key areas and hot spots were being acted on at a divisional level.
- Data provided by the trust from May 2015 to April 2016 showed women and children's division attendance was 95%. This was slightly lower than the trust target of 96% but was an improvement on the previous year's figure of 94.2%.

Public engagement

- The service took account of the views of women through an active Maternity Services Liaison Committee, known as 'Maternity Matters in Furness'. The minutes from January to July 216 showed areas such as breastfeeding, performance, antenatal education and patient experience were discussed.
- Members of the MSLC told us there had been a significant and positive change in public engagement within the previous year.
- Maternity services were part of an 'Always Event' pilot site by NHS England in November 2015. The project was co-designed with those who used maternity services and frontline NHS staff to identify an area of improvement that mattered to women and families. This included a pilot for partners to stay for 24 hours after the birth.
- Open and honest care stories were included in the monthly women and children' newsletter. Stories came from "listen with mother" birth afterthoughts service, which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- The SoMs worked closely with the MSLC chair. For example, a mystery shopper audit was developed to review how long it took to contact a SoM for debrief.
- The service presented a conference in the North West to create greater awareness of cardiomyopathy and pregnancy for obstetricians and midwives.
- There were many examples of service user involvement, such as co-designing the new maternity unit, interviews of recruitment of new staff including midwives and matrons and the development of guidelines and strategies.
- There were four user representatives on a group to develop the breastfeeding strategy. The chair of the MSLC was attending a MDT infant feeding 'Big Conversation' to represent a wide range of service user experience.
- There was service user representation on the National Maternity Review and the Better Births Transformation programme.
- The Down Syndrome Association provided a "tell it right" workshop for MDT staff in relation to breaking bad news.

Staff engagement

- The practice development midwife told us that the strategic partnership had led to a 13-month development programme for labour ward co-ordinators. Co-ordinators would work closely with the maternity unit at Lancashire.
- The Director of Midwifery met with matrons and ward managers each week.
- A site senior meeting took place each fortnight. Medical, nursing and midwifery staff attended this. Operational issues such as staffing, equipment, and training were discussed.

- Whiteboards were up in all departments covering information on the division's top three priorities. There was a divisional newsletter, which included good news stories and celebrating success.
- The trust provided data from the June 2016 staff survey for women and children's division. The survey showed 84% of staff would recommend the trust as a place to recommend treatment and 66% would recommend the trust as a place to work. Although there was a low response rate, these figures had significantly improved from September 2015, where the responses were 67% and 40% respectively.
- Staff were involved in Listening into Action projects to improve the quality of maternity services. There were a number of projects such as developing a strategy for breastfeeding, scanning capacity and fluid rehydration for Hyperemesis (severe nausea during pregnancy).

Innovation, improvement and sustainability

- The service showed good progress against its maternity improvement plan. For example, the development of the maternity strategic partnership was progressing and monitored by the Maternity Strategic Partnership Committee. A paper to the Trust Board (September 2016) acknowledged this work was still evolving with developments needed to formalise the midwifery element of the placements with Central Manchester and Lancashire and extending the partnership to include paediatrics and anaesthetics.
- The service was one of three trusts who were successful in securing funding to pilot a maternity experience communication project. This was a patient based, communication improvement-training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements were made for women using maternity services.
- The trust had recently appointed 'safe active birth' specialist midwives. Staff told us they would be focusing on developing pathways to help reduce the caesarean section rate. They had a regular slot on the mandatory study days to support and promote their approach to midwives across the trust.

Services for children and young people

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

Information about the service

Services for children and young people at Furness General Hospital (FGH) consisted of a children's unit, which included a 14 bedded inpatient ward, an eight bedded day case unit, a four bedded assessment unit, a children's outpatient department, and a four bedded special care baby unit (SCBU).

Between April 2015 and March 2016 there were 8,378 admissions to the children and young people's service across the trust.

During the inspection we spoke with 12 members of staff, including nursing staff, medical staff, play therapists, support workers, and administration staff. We interviewed the service leads and matrons. We spoke to eight parents/carers and four children and reviewed nine sets of records.

Summary of findings

Following our previous inspection in 2015, children and young people's services were rated as 'requires improvement'. Issues were found with the reviewing of incidents, high paediatric consultant vacancies, and lack of job plans, and consultant paediatricians raised concerns about bullying and concerns not being acted on by senior leaders.

At this inspection we found that these issues had been resolved.

We rated the children and young people's services as 'good' because:

- Staff were aware of their responsibility to report incidents and appropriate systems were in place. Staff received feedback about incidents and learning was shared.
- Staff were clear about their responsibilities if there were concerns about a child's safety. Safeguarding procedures were understood and followed. Staff had completed the appropriate level of training in safeguarding and received safeguarding supervision.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition and appropriate transfer arrangements were in place for those children requiring more specialised care.
- Consultant paediatricians were on site 24 hours a day, seven days a week.
- Staff had access to evidence based policies which were compliant with national guidance.

Services for children and young people

- There was a programme in place for local and national audit.
- Feedback from children, young people and their parents was positive.
- Services were planned to meet people's needs. Facilities were provided for parents.
- There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.

Are services for children and young people safe?

Good

At our last inspection it was identified that there were high numbers of nursing and medical vacancies and the abduction policy was not tested. At this inspection, nursing and medical staffing had improved and the abduction policy had been tested.

We rated safe as 'good' because:

- There were systems in place for incident reporting, staff knew how to use them and learning was shared.
- Safeguarding systems were in place and staff knew how to report concerns. Staff were trained to the appropriate level and had supervision.
- All areas were visibly clean and appropriate infection control practices were in place.
- Medicines and records were stored securely.
- Mandatory training attendance was good and within the trust target.
- A paediatric early warning system was used for early detection of any deterioration in a child's condition and appropriate transfer arrangements were in place for those children requiring more specialised care.
- Consultant paediatricians were available on site 24 hours a day, seven days a week. Five out of ten posts were filled with locum consultants.

However:

- There was no dedicated pharmacy cover for the ward, meaning that prescriptions were not reviewed.
- There had been high levels of maternity leave and sickness amongst nursing staff on the children's unit, some shifts were not compliant with Royal College of Nursing (RCN) guidance for nurse to patient ratios.

Incidents

- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and

should have been implemented by all healthcare providers. Between September 2015 and August 2016 the trust reported no incidents which were classified as Never Events for children's services.
- In accordance with the Serious Incident Framework 2015, the children's services directorate reported no serious incidents (SIs) which met the reporting criteria set by NHS England during September 2015 and August 2016.
- Between August 2105 and July 2016 there were 190 incidents reported, all were no harm.
- Staff were aware how to report incidents via the electronic reporting system and were encouraged to do so.
- Staff told us and we saw evidence in team meeting minutes that they received feedback and learning from incidents via email and at team meetings.
- We were given an example of a change in practice as a result of an incident. An inaccurate weight had been recorded for a child, two people are now required to check weights.
- We reviewed senior leaders meeting and divisional governance meeting minutes. Incidents were a standing agenda item for discussion.
- Perinatal morbidity and mortality meetings took place quarterly. However, there were no morbidity and mortality meetings held for children and young people, which meant that there was no internal review and lessons learned. The regional Child Death Overview Panel (CDOP) would review any child deaths.
- Staff were aware of 'Duty of Candour' and the need to be open and honest with parents. The incident reporting system contained a trigger for Duty of Candour. Staff told us incidents would be discussed with parents and recorded in the records.

Cleanliness, infection control and hygiene

- All areas that we visited were visibly clean. Hand gel and handwashing facilities were available with notices asking visitors to clean their hands. We saw staff washing their hands appropriately.
- Parents we spoke with all said they felt the ward areas were clean and they saw staff washing their hands.
- Staff adhered to the bare below the elbows policy and were seen wearing appropriate protective equipment to carry out procedures and personal care.
- Data provided by the trust showed that all areas where children were seen had achieved the trust target of 95% for hand hygiene apart from the SCBU in July 2016. The children's unit had scored 97% in May 2016, 100% in June 2016 and 95% in July 2016. The SCBU had scored 95% in May 2016, 95% in June 2016 and 88% in July 2016. Children's outpatients had scored 100% in May, June and July 2016.
- Environmental audits showed that the children's services had consistently scored above the trust target of 95%.
- Data provided by the trust showed that children's services staff had achieved 100% attendance at infection prevention and control training.
- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C.Difficile) within the last year.

Environment and equipment

- The children's unit comprised an inpatient ward, assessment unit and day case unit. These units were all within the same area meaning visibility and access to other members of staff was good.
- In the special care baby unit (SCBU) one side of each cot was against the wall which did not allow for all round access.
- Resuscitation equipment was available on the children's unit and the SCBU. Children's outpatients did not have a resuscitation trolley. They had oxygen, suction, airways and an anaphylaxis pack. Staff would access the trolley on the children's unit if needed. Daily checks were completed and we saw evidence to confirm this. However, on the children's unit we found a piece of equipment that was past it's expiry date and on the SCBU the gloves and saturation monitor were not present on the top of the trolley as stated in the checklist. We brought these to the attention of staff at the time of the inspection.
- Access to theatres was from the back of the ward meaning that children did not have a long distance to travel before they arrived at theatre. Child friendly artwork was on the walls of the corridor to the theatre. Recovery took place in the same area as adults with child friendly curtains used to screen them when adults were present in the same area.
- All equipment we saw was up to date with safety testing.

Medicines

- If medicines are not stored properly they may not work in the way they were intended, and so pose a potential

risk to the health and wellbeing of the person receiving the medicine. Fridge temperatures were checked daily, minimum and maximum readings were recorded. We saw completed checklists to indicate checks had been done. The fridge temperature recording sheet identified the recommended temperature range and the process to follow if the temperature fell outside the required range.

- Staff handled, stored and recorded medicines, including controlled drugs, in line with national guidance from the Royal Pharmaceutical Society of Great Britain. We observed medicines being stored safely and controlled drugs kept in separate locked cupboards with appropriate checks recorded.
- There was no dedicated pharmacy cover for children's services which meant that prescription charts were not checked by a pharmacist, however we did not see any evidence of any incidents because of this.
- We reviewed five prescription charts. All had a weight recorded which allowed for accurate medication prescribing. All charts had any known allergies documented.
- Prescription audits were done weekly. The ward manager told us the quality of prescriptions had improved as a result of these.

Records

- We reviewed nine sets of records. Records were multi-professional which supported integrated care. Records were clear, accurate and legible. However, in four of the records there was no documentation of the grade of doctor reviewing the patient on some occasions. This was not in line with professional guidelines. Nursing staff used stamps with their name and NMC number next to their signature.
- The electronic patient administration system used a flag system to indicate if a child was subject to a child protection plan, was looked after or had learning disabilities.
- The World Health Organisation (WHO) surgical safety checklist is a tool to improve the safety of surgery by reducing deaths and complications. We saw that those children who were surgical patients had completed WHO checklists within the records.
- Care plans contained within the nursing records were pre-printed care plans that were not individualised. Best practice would be for the care plans to be individualised and reviewed regularly.
- Records were kept securely in locked trolleys.
- On our previous inspection it had been identified that the majority of records did not contain a growth chart. During this inspection only one out of the nine records we reviewed did not contain a growth chart.

Safeguarding

- The trust had a safeguarding children policy that had regard to the statutory guidance Working Together to Safeguard Children (2015).
- Staff were aware of the process to follow if they had safeguarding concerns. Staff we spoke with knew the safeguarding leads and each area had safeguarding champions. There was a dedicated safeguarding team including a named nurse and named doctor.
- We saw the safeguarding page that staff had access to on the intranet. This included information on female genital mutilation (FGM), lessons learned from reviews, domestic violence services, contact details for staff if they had any concerns, a referral pathway and guidelines. Staff we spoke with were aware of FGM and child sexual exploitation (CSE).
- An abduction policy was available and was due for review in 2017. This contained a flowchart and clear processes to follow were identified. The abduction policy had been recently tested with good results.
- Access to the wards was via an intercom, this was used for people entering and leaving the wards, therefore minimising any unauthorised access.
- Safeguarding supervision was provided by the safeguarding team and safeguarding champions for each area. Attendance was yearly. Data seen showed that 76% of children's services staff had attended safeguarding supervision.
- Consultant paediatricians attended peer review meetings monthly.
- Figures provided by the trust showed that 98% of nursing staff and 75% of medical staff in the children and young person's service had completed safeguarding adults and children Level 1 training and 100% had completed Level 2 safeguarding training. This was better than the trust target of 95%.
- The intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (2014) sets out that all clinical staff who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young

person should be trained to Level 3 in safeguarding. Data provided by the trust showed that 98.7% of nursing staff and 71% of medical staff had completed safeguarding Level 3 training. The trust target was 95%.

Mandatory training

- Mandatory training was available in subjects such as fire safety, conflict resolution, equality and diversity, information governance and manual handling.
- Staff told us they had enough time to complete training. Data provided by the trust showed that children's services were meeting the trust target of 95% for training attendance.
- Children's services staff attended specific training days; paediatric and neonatal development activity(PANDA). These days included safeguarding training, paediatric life support, neonatal life support and also covered some mental health problems such as self harm.
- Matrons reviewed the training management system weekly and produced monthly assurance reports concerning staff training.
- All new starters including agency staff attended a corporate induction programme and a local workplace induction.

Assessing and responding to patient risk

- Children's services used an early warning score tool, The Children's Physiological Track and Trigger System (CPOTTS). There were different charts for different age ranges and they included information to assist nursing and medical staff as to the action to take in response to deteriorating scores. Charts we reviewed showed evidence of appropriate responses to changes in scores.
- Regular audits of the CPOTTS charts were undertaken. A gap had been identified when it was recognised that the clinical support workers had not had any formal training in the use of the charts. The Band 8 practice educator had set up a training day to be held in November. Support workers always had their observations countersigned by a registered nurse.
- Safety huddles were held on the children's unit. We observed a safety huddle, medical and nursing staff were present along with play staff, a member of the safeguarding team and the matron. Discussions included patient acuity, staffing, patients requiring CAMHS support, safeguarding concerns, infection prevention concerns, high dependency patients, any potential discharges and the situation cross site at Royal Lancaster Infirmary RLI. At the safety huddle it was noted that they would be non-compliant for staff to patient ratio of 1:4 once the patients were admitted for theatre. The ward manager and matron therefore provided support clinically.
- Patients requiring transfer to intensive care were stabilised in a high dependency cubicle. Staff had training to use the continuous positive airway pressure (CPAP) machine that had been purchased for this room. Staff would liaise with the regional paediatric transport service for clinical advice on the management of a critically ill child or for transfer to an intensive care facility.
- Risk assessments were completed on admission. These included nutrition, infection risk and sepsis screening.
- The children's ward regularly admitted children with mental health issues who needed child and adolescent mental health services (CAMHS) input. Assessments were completed to determine whether one to one support was needed which would be provided by an agency.

Nursing staffing

- The children's unit used the RCN document 'Defining staffing levels for children and young people's services' 2013 to plan staffing levels. However, this document recommends a nurse to patient ratio of one to three for children under two years old and one to four for children over two years old. The children's unit worked to a ratio of one nurse to four patients, this meant that the ratios for under two's may not be met.
- We reviewed staff rotas and bed occupancy data for three months from July 2016 to September 2016 and found that on 21 days out of 92 the RCN ratios were not met on every shift. Whilst the RCN document 'Defining staffing levels for Children and young people's services 2013' was used to plan the workforce establishment of the unit, the nursing staff worked to the Hurst tool when recording acuity 3 times per day. This gives a score of 1, 2 or, 4 for each patient, dependent upon condition, enabling matching of nursing levels with patient acuity. The unit held safety huddles 3 times per day, one being a multidisciplinary huddle. At each huddle the acuity was discussed, and the potential need to escalate the situation would be

assessed, with action taken appropriately. One possible action would be the ward manger or matron working clinically to maintain safety. On 21 days out of 92 the Hurst ratios were not met on every shift.

- The children's unit at FGH had experienced high levels of maternity leave and sickness and had over recruited to nursing positions to compensate for this.
- Data provided showed that for August 2016 fill rates were 80% for days and 85% for days for trained staff on the children's unit. Fill rates for SCBU were 96% for days and 100% for nights.
- Staff were moved between wards and sites to cover for shortages. Staff on the SCBU told us that on occasions a member of staff would be moved to help on the children's unit which would leave one member of staff covering SCBU. However, we reviewed three months of staff rotas from July 2016 to September 2016 and could find no evidence of staff movement leaving one member of staff on the unit.
- BAPM guidance requires one nurse to four babies for special care, one nurse to two high dependency babies and one nurse to one intensive care baby. We reviewed staff rotas for July 2016 to September 2016 and the SCBU was compliant with this guidance.
- There had been problems recruiting to the post of ward manager on the children's unit. The manager for SCBU was covering and managing the children's unit for six months. This arrangement was due to be reviewed after six months.
- There were no paediatric trained nurses in theatres. The RCN (2013) says that at all times there should be a minimum of one registered children's nurse on duty in recovery areas.

Medical staffing

- The paediatric service at FGH was consultant delivered. A consultant was available on site 24 hours a day, seven days a week.
- The consultant was supported by junior doctors and there was a non- resident consultant on call at all times to provide support if needed.
- There was a high locum usage at FGH as there had been difficulty recruiting consultant paediatricians. This had been identified on the divisional risk register.
- Nine consultant posts out of ten were filled, four with permanent staff members, four locums and one trust contract, which was to be made permanent. Two consultants had recently been recruited and were waiting for start dates. There was a recruitment strategy in place and further adverts had been placed.
- Nursing staff commented that they had a good set of medical staff at present and that the clinical lead managed them well.

Major incident awareness and training

- A paediatric major incident plan was available that provided clear instructions for the process for staff to follow in the event of a major incident.
- Data provided by the trust showed that 100% of children's unit and SCBU staff had attended Emergency Planning and Preparedness Response facemask fitting training
- The children's unit increased their nursing establishment to cover the winter months. Staff were encouraged to take annual leave in the summer months.

Are services for children and young people effective?

Good

We rated effective as 'good' because:

- Policies and guidelines were up to date, based on national guidance and staff were able to access them on the intranet.
- There was evidence of audit at local and national level, with action plans produced in response to the results.
- Appropriate pain assessment tools were in use and evident in the records.
- Staff received appraisals, however they did not receive clinical supervision.
- Our observation of practice, review of records and discussion with staff confirmed effective multi-disciplinary team (MDT) working practices were in place. There were processes in place for transition.

However:

- Patient outcomes were somewhat worse than the national average. Plans were in place to address this.

- Consent documentation referred to Fraser guidelines rather than Gillick competence and it was not clear how a young person's competence had been assessed.

Evidence-based care and treatment

- Staff had access to policies, procedures and guidelines on the trust intranet.
- Policies and procedures were evidence based and based on national guidance such as National Institute for Health and Care Excellence (NICE) guidance. We saw policies for jaundice, early onset sepsis, paediatric UTI's and constipation that were all in line with NICE guidance. All policies we reviewed were up to date.
- The children's services did not participate in accreditation schemes such as You're Welcome (DH) or Baby Friendly (UNICEF).
- The SCBU was working towards the Bliss baby charter. The Bliss baby charter is a practical guide to help hospitals provide the best possible family centred care for premature and sick babies. This approach places parents at the centre of their baby's care.
- A clinical audit programme was in place for 2016-2017 including national and local audits. These included audits of NICE guidance such as fever in under 5's, headaches in over 12's and obesity.

Pain relief

- Records we reviewed contained pain assessments.
- Child friendly pain assessment tools were used including one for young children and those children unable to communicate their pain verbally.

Nutrition and hydration

- Feedback from children and parents was that the food was good.
- The menus had been changed after feedback from teenagers. We saw a sample menu and there was a range of healthy interesting choices.
- A Listening into Action project had been started for infant feeding and was looking at developing an infant feeding strategy.
- In the records we reviewed, appropriate nutrition and hydration management plans were provided for those patients that needed them.

Patient outcomes

- Between March 2015 and February 2016 there was a higher percentage of under ones readmitted following an emergency admission (5.8%) compared to the England average (3.4%), and a higher percentage of patients aged 1-17 years old readmitted following an emergency admission (3.9%) compared to the England average (2.8%).
- Between April 2015 and March 2016 the trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma, with a readmission rate of 9.6% against an England average of 16.6%.
- The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy. Data showed a readmission rate of 20.6% against an England average of 29.3%.
- Staff were aware of their readmission rates and were piloting a study in to how they could prevent readmissions. Some children were seen on the assessment unit and discharged but these children would be counted as an admission. Pathways for sick children with advice for professionals and parents had been developed and were due for release the week of our inspection.
- In the 2014/2015 National Paediatric Diabetes Audit the trust performed worse than the England average, 15% of patients had a HbA1c value of less than 58mmol/mol (indicating controlled diabetes) compared to the England average of 22%. A mean HbA1c value of 72 was similar to the England average of 71.
- An audit had been undertaken in to the management of children with high HbA1c and an action plan had been developed to raise awareness in the team, improve documentation in clinic consultations, follow up within certain timescales and increase use of dieticians.

Competent staff

- Data showed that 83% of staff in the women's and children's division across the trust had received an appraisal.
- No formal clinical supervision took place.
- Staff rotated from the children's ward to the emergency department, this meant that those staff were gaining experience in emergency medicine.
- The paediatric unit staff were not specifically trained to meet the needs of children and young people with mental health needs but they had received some training in areas such as self harm.

Services for children and young people

- Band 6 nursing staff had advanced paediatric life support (APLS) training. Data provided by the trust showed that 50% of nursing staff on the children's unit had APLS training and 100% of medical staff. The Royal College of Nursing (RCN) recommends one practitioner trained in APLS to be on shift at all times. The children's unit was meeting this standard.
- Clinical educators and practice educators supported the staff.
- Staff were competent to use the equipment in the high dependency cubicle as they had attended the appropriate training.

Multidisciplinary working

- Medical staff attended nursing handovers on the children's unit and nursing staff attended medical handovers.
- We observed a safety huddle that was attended by medical and nursing staff, a play therapist, a safeguarding nurse and the matron.
- Weekly meetings were held with CAMHS and social care for those CAMHS patients admitted long term.
- There were good relationships with other specialities, such as obstetrics.
- Discharge planning meetings were held for patients with complex needs, with good liaison between the ward staff and health visitors or school nurses.
- The play specialist went in to schools to present their role and explain what happens when children go in to hospital. They also worked closely with the diabetes nurse and psychologist.

Seven-day services

- Consultant paediatricians were available on site 24 hours a day, seven days a week.
- Play therapy staff only worked Monday to Friday, meaning there was no play staff cover at the weekend.
- X-ray and diagnostic facilities were available seven days a week.

Access to information

- Staff had access to policies and guidelines on the trust intranet.
- Records were accessible for all staff.
- GP's were informed of discharges, along with health visitors and school nurses.

Consent

- Initial assessment documentation contained a question for Fraser guidelines. However, Fraser guidelines relate specifically to contraception and sexual health. Gillick competence is the principle used to judge capacity in children to consent to medical treatment.
- The documentation did not contain any rationale as to how the decision was reached.
- We reviewed three sets of records where Gillick competency would have been relevant. One did not have any assessment made and the other two had been assessed as not having Gillick competency at the ages of 13 years and 15 years. However, it was unclear how this decision had been reached.

Are services for children and young people caring?

Good

We rated caring as 'good' because:

- Feedback from children and parents was positive, with comments such as staff being nice, friendly and approachable.
- Staff were observed treating people with dignity and respect.
- Parents and the young people were involved in their plan of care.
- Play therapists supported children and young people through procedures.

Compassionate care

- Feedback that we received from children and parents was positive.
- Comments included staff being nice, kind, approachable and friendly.
- We observed staff treating children and parents with dignity and respect.
- We observed some parents talking to the play specialist who were very grateful for the care their child had received.
- Parents in the outpatients department told us that staff respected confidentiality and always gave simple explanations. They felt able to ask questions if they did not understand something.

Services for children and young people

- I want great care feedback was displayed on the ward. It showed that for September 2016, 94.7% of respondents would recommend the children's unit and 100% would recommend the assessment unit.

Understanding and involvement of patients and those close to them

- Parents and children told us that the staff kept them informed at all times and involved them in their care.
- Patients that were admitted as day cases told us they had received all the information they needed before they came to the ward.
- Children's unit staff had received positive feedback from the mother of a child with special needs saying it had been a fantastic experience as she had been able to prepare her child fully prior to admission with the help of the ward staff.
- Staff spoke to children directly and used simple language that they could understand.

Emotional support

- Play therapists supported the children and young people through procedures.
- A poster was displayed on the ward informing young people that they could talk to staff privately if they needed to.
- Positive comments seen from I want great care included having good separation between children and teenagers.

Are services for children and young people responsive?

Good

We rated responsive as 'good' because:

- The children's unit had a teenage room, meaning young people could be separate from children.
- The assessment unit allowed children and young people to be assessed without the need for admission. A rapid access clinic had also been developed.
- National referral to treatment times were consistently met.
- Children with complex needs carried a passport which included a list of their medical conditions, medication and normal observations.
- Information was available for patients and parents to make a complaint and there was evidence of changes in practice in response to complaints received.

Service planning and delivery to meet the needs of local people

- The children's unit admitted young people up to the age of 16 years 364 days. Those aged 16-17 were given a choice as to whether they would prefer to be on an adult or children's ward. 17-18 year olds were nursed on adult wards with appropriate support for those with additional needs. Those young people with complex needs that were under the care of a paediatrician could be admitted to the children's ward up to the age of 19 years old.
- The children's unit had a play area for younger children and a teenage room that contained sofas, a TV, DVD's and games console.
- The children's unit had a parents sitting room where they could make hot drinks and had a fridge and microwave. It also contained a shower room.
- The SCBU had a room for parents to make hot drinks.
- As part of the Better Care Together strategy, paediatricians had started to do clinics in the community in GP practices.
- The children's unit displayed comments received and actions taken for 'you said, we did'. Examples included, not having enough cups in the parents room so more were purchased, the play room was too noisy at night so it was closed at night.

Access and flow

- Children were referred to the assessment unit from the GP or emergency department. This reduced the number of unnecessary inpatient admissions.
- Between April 2015 and March 2016 the median length of stay for patients under the age of one was similar to the England average.
- Between April 2015 and March 2016the median length of stay for patients aged 1-17 years old was lower than the England average.
- The NHS constitution (2010) states that people with a referral from a GP should start their treatment within 18 weeks. The target is that at least 92% of people should spend less than 18 weeks waiting for treatment. Data provided by the trust showed that they were meeting this target and had not fallen below 96% from August 2015 to August 2016.

Services for children and young people

- Every child admitted with an acute medical condition was seen within 14 hours by a consultant, in line with RCPCH guidance (2015).
- A rapid access clinic had been started for those children needing to be seen by a paediatrician but not needing admission. One slot on the outpatient appointment rota was held for these patients.
- No CAMHS support was available out of hours meaning children admitted on a Friday may not be seen by a mental health practitioner until after the weekend. Delays in obtaining beds in specialist units resulted in some children staying on the children's ward for a number of days. This issue was on the risk register and had been escalated to the clinical commissioning group (CCG).

Meeting people's individual needs

- Leaflets were available for children with learning difficulties.
- Children with complex needs carried a passport. . This included a list of the child's conditions, medications, methods of communication and their normal observations. A copy was kept with the child's records and the parents carried a copy. Input from parents with children with special needs was sought in the development of the passport.
- Staff gave an example of how they had allowed a mother of a child with complex needs to come to the ward to take pictures of the bed, ward and nursing staff to show to the child before they were admitted. The child was therefore much more relaxed when admitted.
- Children's services used the 'Ready Steady Go' documentation for transition. Children with chronic conditions such as diabetes would be under the care of paediatricians and adult physicians when they reached 16 years old and would alternate between the children's clinic and the adult clinic before full transition to the adult physician.

Learning from complaints and concerns

- In all areas that we visited, we saw posters informing patients/parents how to make a complaint.
- Between April 2015 and March 2016 there were seven complaints about children's services. All seven complaints referred to the children's ward and three of the complaints related to parents being unhappy with care and treatment received.
- Staff told us that the main complaints they received were about waiting times for going to theatre.
- In response to complaints received, practice had been changed and parents could collect their children from theatre recovery.

Are services for children and young people well-led?

Good

At our previous inspection it was found that there were no formal job plans in place for paediatricians, the division undertook rapid reviews on incidents meaning that not all significant incidents were subject to a thorough investigation, and consultants felt that their concerns were not acted upon by senior managers. At this inspection we found that all consultants had signed job plans, incidents were investigated appropriately, and there were no concerns with the leadership.

We rated well-led as 'good' because:

- There was a clear vision and strategy. Staff we spoke with were aware of these.
- Governance meetings were held monthly and there was a comprehensive risk register which was regularly updated. There were governance systems in place to ensure that quality, performance and risks were managed and information could be cascaded between senior management and clinical staff.
- Staff spoke positively about the culture and the leadership. Leaders were visible and approachable.

Vision and strategy for this service

- The Women's and Children's Division had a strategic business plan for 2016/2017 which had regard to the trust strategy. The division strategy was to move care out of hospital, reduce variations in quality and provide patient centred care.
- The vision was for more care to be community based and to reduce the number of admissions.
- Staff we spoke with were aware of the vision and strategy.

Governance, risk management and quality measurement

- Divisional governance meetings were held monthly. Discussions included incidents, audits, complaints and risks.
- Divisional performance reports were presented to the board.
- A governance newsletter was produced to keep staff informed about governance issues.
- A weekly patient safety summit was held to discuss incidents and look at root cause analysis (RCA).
- The division had a comprehensive risk register which was reviewed regularly and action plans updated. Service leads identified their top three risks as recruitment of consultant paediatricians, community paediatrics and CAMHS.
- The matrons produced quality assurance reports monthly. They did regular audits such as hand hygiene and audits of CPOTT charts. Results of these were shared with staff.

Leadership of service

- The ward manager at the time of inspection was the ward manager of the SCBU. She had been covering for the children's unit since the beginning of September and was expected to be in post for six months until the situation was reviewed.
- Ward staff spoke positively about the manager and said that things had improved since she had been in post.
- Band 6 nurses were encouraged to undertake a Leading Empowered Organisations course.
- Staff we spoke with knew who the chief executive of the trust was but most said they did not see the executive team. Staff received a weekly bulletin from the chief executive.
- Staff told us they knew who the service leads were, most said that they saw the general manager and the associate chief nurse but not the clinical director. However, staff in outpatients told us that the clinical director had visited the department and was supportive and approachable.
- Staff spoke positively about the clinical lead and said that since they had been in post there had been improvements.
- There were good relationships between paediatric and obstetric staff.

Culture within the service

- Staff placed the children and families at the centre of their work.
- Relationships between staff members were positive.
- Staff told us that morale could be low when staff members were asked to cover other areas or travel to RLI. It could cause some anxiety and stress due to unfamiliarity and not feeling well supported.
- At our previous inspection it was found that morale amongst the medical team was low and that they felt there was a bullying culture. At this inspection we did not find this to be the case. Staff told us that since the clinical lead had been in post things had improved and there was more drive amongst the medical staff.

Public engagement

- The children's outpatients department collected feedback from children with the use of 'tops and pants washing line'. Children were encouraged to provide comments about those things they didn't like, in the shape of a pair of pants, and those things they did like in the shape of a top.
- The children's services used 'I want great care' to get feedback from patients and their families. Forms were available in a child friendly format with smiley faces.
- There was an annual ward 'take over day'. Young people were invited to come to the ward and see how it was run. They could provide suggestions for improvement.
- The children's unit had used the 15 steps challenge to engage with young people. The 15 Steps Challenge is a way of thinking about our first impressions of healthcare.
- The play therapist went in to schools to tell them what to expect if they were admitted to the children's unit.

Staff engagement

- Staff told us that since the appointment of the ward manager in to post they felt there was someone they could go to for guidance.
- The trust had implemented Listening into Action (LiA) to listen to and support staff to make changes.

Innovation, improvement and sustainability

- Staff were looking at ways to improve clinic access to those in more rural communities. Holding clinics in GP practices had started with good attendance and they were looking at the possibility of telemedicine.

End of life care

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

Information about the service

Furness General Hospital (FGH) is part of University Hospitals Morecambe Bay (UHMB) NHS Trust. Patients at the end of life were nursed on general hospital wards. Between April 2015 and March 2016 there had been 25,360 in-patient admissions and 1,438 in-patient deaths across the three hospital sites within the trust as a whole. Between April 2015 and March 2016 there had been 960 referrals to the specialist palliative care team (SPC). Of those referrals 36% were for patients with a non-cancer diagnosis and 64% were for patients with cancer. The SPC team was made up of 1.7 whole time equivalent (WTE) consultant in palliative medicines posts, this included the lead consultant who was based at the Royal Lancaster Infirmary (RLI) and a new consultant post based at FGH for two sessions (one day) a week. There were four SPC clinical nurse specialists across the trust as a whole, two of which were based at FGH including the lead nurse who had clinical responsibilities at FGH and managerial responsibilities across the trust as a whole. The trust had a bereavement team which consisted of a bereavement nurse and a bereavement officer at both FGH and RLI.

During this inspection we visited a number of inpatient wards including stroke, acute medical unit, elderly care, respiratory, general medicine, cardiology, oncology, gastroenterology and general surgery. In addition we visited the chapel, multi-faith room, the bereavement office, and the hospital mortuary. We observed care and viewed eleven care records including two where patients were being cared for using the care of the dying patient (CDP) care plan. We spoke with three patients and three relatives. We also spoke with a range of staff including the SPC consultant and lead nurse, SPC clinical nurse specialists (CNS'), a bereavement nurse and bereavement officer, the chaplain, a mortuary technician, a porter, ward based medical and nursing staff and a discharge coordinator. In total we spoke with 16 staff members. We looked at policies and procedures and reviewed performance information about the trust.

End of life care

Summary of findings

During our previous inspection of FGH, in July 2015, we rated end of life care services as 'good'. During this inspection we rated the end of life care service as 'outstanding' because:

- The trust had clear leadership for end of life care services that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.
- End of life care services were very well led. There was a clear vision and strategy that focused on all people are treated with dignity, respect and compassion at the end of their lives.
- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- There was very good public and staff engagement
- There was a commitment by the trust and this was underpinned by staff that patients were cared for in a dignified, timely and appropriate manner
- There were examples of innovation across the service. During 'Dying Matters week' the trust had introduced death café's with an aim to raise the profile end of life care. This included the development of the bereavement service.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of 'death café's' where issues relating to death and dying were talked about openly.
- The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely manner, therefore individual needs were met.
- Staff had access to specialist advice and support 24 hours a day. Out of hours advice was provided by the on call team from St John's and St Mary's Hospice, which included the consultants and on call team for end of life care.
- The Chaplaincy and bereavement services supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.
- The mortuary was clean and well maintained, infection control risks were managed with clear reporting procedures in place.
- The bereavement service had been nominated for a compassionate care award in 2015.
- The survey of bereaved relatives results were positive in relation to dignity and respect afforded to patients.
- The trust had recently introduced a Hospital Home Care Team, so that patients could be transferred to their own homes and supported by trust staff, where care packages were difficult to access in the community.
- An 'ease of access to hospital' group had been developed by the trust which included representation from the bereavement and chaplaincy service where initiatives were in place to improve access to the mortuary.
- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed well and the trust were making use of audits and learning from incidents to drive improvements.
- Mandatory training was in place and attendance by the specialist palliative care nurses exceeded the trust target.
- The care of the dying patient (CDP) document in use throughout the trust.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system) at one of its two acute hospital sites. The service was due to go live at the other acute site in the near future. This system enabled recording and sharing of people's care preferences and details about their care at the end of life.
- There was good evidence of multi-disciplinary working and involvement of the specialist palliative care team throughout the hospital and comprehensive use of the Gold Standards Framework (GSF) in a number of wards where there was clear evidence of accreditation positively impacting on end of life care.

However:

End of life care

- Specialist palliative care was not provided across a seven day face-to-face service.
- An action plan was in place to address areas of the NCDAH where the trust had performed lower than average; however this did not include key responsibilities and timelines for achievement.

Are end of life care services safe?

Good

We rated safe as 'good' because:

- DNACPR (do not attempt cardio-pulmonary resuscitation) records were generally completed wel,l and the trust was making use of audits and learning from incidents to drive improvements.
- Staff understood their responsibilities to raise concerns and to record safety incidents.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- Equipment was generally available for the care of patients at the end of life.
- Mandatory training was in place and attendance by the specialist palliative care nurses exceeded the trust target.

Incidents

- There had been no end of life care related never events reported in the last 12 months (a never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- Staff told us that if an incident was related to a patient at the end of life then the palliative care team would be involved in the investigation and subsequent learning as a result.
- For example, we were told of an incident where DNACPR (do not attempt resuscitation) decision making had created confusion for staff. This incident had led to reflection, discussion and input from the specialist palliative care team and ultimately had contributed to improvements in education for clinical staff around DNACPR decisions and conversations.

- Staff we spoke with had an awareness of their responsibilities in relation to Duty of Candour.

Environment and equipment

- There was a mortuary at Furness. We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. The mortuary was manned by one staff member with support as needed from porters within the hospital and from mortuary staff at the Royal Lancaster Infirmary (RLI). Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The mortuary fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were available when they needed them.

Medicines

- Medicines were prescribed using clinical guidelines on the trust's intranet. The guidance included different treatment options for a range of symptoms that could be experienced at the end of life.
- Medicines for use at the end of life, including those for use in a syringe driver were readily available on the wards. Nursing staff said that end of life care medicines were accessible, including outside of normal working hours.
- We saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice and had attended training relating to anticipatory prescribing. They also told us that the specialist palliative care team were available to provide advice and support around appropriate prescribing, particularly in complex cases.

Records

- The trust had developed a care of the dying patient (CDP) care plan that provided prompts and guidance for ward based staff when caring for someone at the end of life. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed comprehensively.
- Care plans reflected national guidance and included risk assessments such as those for the risk of falls or pressure area damage.
- The trust used both paper and electronic record systems. The electronic system included the option for the use of alerts for patients at the end of life or where there had been involvement of the specialist palliative care team. This meant that if the patient accessed services through A&E staff would be alerted.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system) at one of its two acute hospital sites. The service was due to go live at the other acute site in the near future. This system enabled recording and sharing of people's care preferences and details about their care at the end of life.
- The trust used a DNACPR (do not attempt cardio-pulmonary resuscitation) form that was used across North Lancashire and Cumbria. They had audited the use of the forms in April 2016 and had identified areas for improvement including the recording of discussions around DNACPR.
- We viewed 11 forms and found that these were generally completed well. All 11 forms were kept at the front of the patient's notes, included clear documentation and clinical reasoning for the DNACPR decision. Decisions were appropriately recorded as approved by a senior clinician. Discussions with patient's and relatives were clearly recorded on the forms and in sufficient detail in the patient's notes in eight out of the 11 forms we viewed.
- Training on the legal aspects of resuscitation and DNACPR decision making was provided to medical staff. The trust had identified the need to improve decision making and conversations with patients and family members around DNACPR. The consultant in palliative medicine told us they had been involved in delivering training for senior clinical staff aimed at improving DNACPR conversations.
- Records within the mortuary were comprehensive and included processes for appropriate checking.

Safeguarding

- The trust set a target of 95% for completion of mandatory safeguarding adults and children (level 1

and level 2) training and at July 2016 the trust completion rate was 91% for level 1 and 92% for level 2. All of the specialist palliative care nurses had attended safeguarding level 1 and level 2 training.
- Staff were aware of the relevant safeguarding policies and procedures that were in place across the trust and had an understanding of their responsibilities in relation to this.
- All specialist palliative care staff working at Furness General Hospital had attended mandatory safeguarding training for both vulnerable adults and children.

Mandatory training

- The trust set a target of 95% for completion of all mandatory training. Subjects where the target was met or exceeded included equality and diversity, health and safety, infection control and information governance.
- Other areas of mandatory training included fire safety, moving and handling and basic life support. All specialist palliative care staff working at Furness General Hospital were up to date on all aspects of their mandatory training.
- The trust used a combination of face to face and electronic learning packages for staff in relation to end of life care. For example, as part of Gold Standards Framework accreditation (the Gold Standards Framework is a model that promotes good practice in the care of patients at the end of life), ward based staff had received training specific to the model and the care of patients at the end of life. However, end of life care training was not considered mandatory within the trust.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect and an understanding of bereavement. One porter we spoke with told us that the training they received had helped them to feel more confident when transferring the deceased.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the care of the dying patient framework when they were expected to die within a few days.
- The Gold Standards Framework (GSF) also provided a guide for staff to support the recognition of patients in the dying phase of life. This enabled staff to manage end of life care risks more proactively, for example in relation to keeping patients comfortable and ensuring that opportunities for meeting their wishes were taken.
- Ward staff told us they had access to the specialist palliative care team who responded quickly when needed. However, not all staff we spoke with were sure about out of hour's arrangements for specialist support and advice.

Nursing staffing

- The specialist palliative care team across the trust included a lead specialist nurse and three clinical nurse specialists. The lead nurse and one of the clinical nurse specialists were based at Furness General Hospital.
- In addition to specialist palliative care nurses the trust had bereavement nurses in post, with one based at Furness General Hospital. They supported nursing staff on the wards when dealing with end of life care situations and in particular with how to support relatives at the end of life.
- Specialist palliative care nurses worked closely with ward based nurses and some wards had end of life care link nurses. Ward 9 had achieved GSF accreditation and nursing staff on the ward had a thorough understanding of end of life care issues and care planning and support for patients.
- Nursing staff on AMU (medical admission unit) told us they had adequate staffing levels to provide quality nursing care at the end of life, however staff on ward 7 (respiratory and general medicine) told us it was sometimes difficult to balance the needs of patients at the end of life with those more acutely unwell due to ongoing staffing difficulties. Staff told us they prioritised care for patients at the end of life as much as possible.
- Specialist palliative care staff regularly attended ward rounds to provide support to ward staff around end of life care issues.

Medical staffing

- Since the trust's previous inspection in 2015 a palliative care consultant had been appointed to provide two

clinical sessions (one day) at Furness General Hospital. Staff we spoke to said that this had provided a noticeable improvement in access to specialist support at the end of life. In total there were three consultants in palliative medicine across the trust, equivalent to 1.7 WTE (whole time equivalent) posts with cross cover across sites as needed.

- There was on call palliative care consultant cover and out of hours advice was available from local hospices.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals. All referrals were responded to within 24 hours.

Major incident awareness and training

- The trust had a major incident plan that included a system for chaplaincy support and arrangements for the use of the mortuary.
- Staff had an understanding of the major incident plan.

Are end of life care services effective?

Good

We rated effective as 'good' because:

- An evidence based care of the dying patient (CDP) document was in place and in use throughout the hospital.
- There was good evidence of multi-disciplinary working and involvement of the specialist palliative care team throughout the hospital.
- There was comprehensive use of the Gold Standards Framework (GSF) in a number of wards and there was clear evidence of accreditation positively impacting on end of life care.
- The trust had participated in the National Care of the Dying Audit (NCDAH) and there was evidence of improvement in some areas of end of life care from a previous audit.
- There was evidence of good end of life care training and support for porters.
- Staff had a good understanding of issues relating to mental capacity and end of life care and there was evidence of ongoing development around DNACPR in relation to this.

However:

- Specialist palliative care was not provided across a seven day face to face service.
- An action plan was in place to address areas of the NCDAH where the trust had performed lower than average; however this did not include key responsibilities and timelines for achievement.

Evidence-based care and treatment

- The trust had introduced a 'caring for the dying patient' (CDP) care plan. The plan had been adapted from strategic clinical network guidance and was based on national guidance. Sources included the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- Policies and procedures relating to care of the dying patient and the use of the Gold Standards Framework (GSF) were available on the trust intranet and staff we spoke with knew how to access these.
- Ward 9 at Furness General Hospital had been awarded Gold Standards Framework (GSF) accreditation in 2015. The Acute Medical Unit, ward 7 and ward 4 were in the process of working towards achieving GSF accreditation.
- Staff we spoke with discussed how the use of GSF had benefitted both staff and patients. They told us it provided a framework to support the earlier identification of patients at the end of life and enabled better coordination and collaboration between teams.

Pain relief

- Members of the specialist palliative care team had attained courses and qualifications in symptom control and pain management.

End of life care

- Doctors we spoke with were aware of the guidance around prescribing for key symptoms at the end of life. They knew they could access the guide on the intranet and also seek support from the specialist palliative care team.
- Patients and relatives we spoke with told us that staff were quick to respond when patients experienced symptoms and that nursing staff were proactive in assessing levels of pain and other symptoms on a regular basis.
- Care plans included pain assessment prompts and clear records of pain assessments.
- 'Just in case' medicines were prescribed appropriately for patients at the end of life.
- Results from the 2016 National Care of the Dying Audit in Hospitals (NCDAH) showed that 77% of patients had a record of anticipatory medicines for pain at the end of life being prescribed. This was somewhat higher than the national average of 71%.

Nutrition and hydration

- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care. For example, regular mouth care was incorporated, as well as involvement of the family and the need to be led by the patient in terms of what they could and couldn't eat and drink.
- We viewed examples of patient assessments of hydration needs at the end of life. The National Care of the Dying Audit in Hospitals (NCDAH) March 2016 showed that the trust performed below the national average in this area at 56% compared with the national average of 67%. Results from the audit did show that the trust was on a par with the national average where there was documented evidence of patients being supported to drink in the last 24 hours of life.
- We viewed examples of patient assessments of nutrition needs at the end of life. The NCDAH March 2016 showed that the trust performed below the national average in this area at 49% compared with the national average of 61%. The trust was also lower than average in terms of the audit demonstrating evidence of patients being supported to eat in the last 24 hours of life at 29% compared with the national figure of 36%.
- The specialist palliative care team had drafted an action plan to address areas of the audit that were below average. This was generally focussed on a continued roll out of the Care of the Dying Patient document and supporting wards to achieve Gold Standards Framework accreditation. However, the action plan did not include key people responsible for implementation or timelines for achievement.
- Patients and relatives we spoke with told us they had been involved in discussions about food and drink and ways to meet patient's needs and maintain comfort.

Patient outcomes

- UHMB had participated in the National Care of the Dying Audit of Hospitals (NCADH) 2013/14. The trust did not achieve six of the seven organisational targets in the audit and performed worse than the England average for seven of the ten clinical indicators.
- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and there was evidence of improved performance in relation to organisational indicators where seven of the eight had been achieved. The area not achieved related to providing the specialist palliative care services across seven days as opposed to the five days currently. The trust performed better than the England average for two of the five clinical indicators. For example, they scored higher than average in recognising that death was imminent in 89% of patients compared with the national average of 83%. They also performed better than average in discussing imminent deaths with relatives.
- The trust had produced an action plan to address areas where performance was lower than average. For example, areas such as improved nutrition and hydration assessments were being addressed as part of the roll out of the Care of the Dying care planning document.
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team.
- The trust participated in the Gold Standards Framework accreditation scheme, ward 9 at Furness General Hospital had achieved accreditation and ward 7 and the medical admissions unit were working towards it.

Competent staff

End of life care

- The palliative care nursing team were well qualified and had completed training in areas such as symptom management and advanced communication skills. The team received regular clinical supervision with a clinical psychologist every month.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included training on symptom control, spiritual support, bereavement support and communication skills.
- All the Specialist Nurses are independent prescribers and regularly attended the NMP Forum held by the NMP Lead as part of Continuing Professional Development.
- An end of life facilitator post had come to an end in July 2015 as its funding had run out. This post had been focused on the implementation of the Care of the Dying Patient (CDP) plan and the use of the Gold Standards Framework. Since this post ended elements of this role had passed to the specialist palliative care nurses. In addition practice educators within the trust worked alongside specialist staff to support training for ward staff around end of life care.
- Junior doctors we spoke with told us they had attended end of life care training within the trust including communication training and anticipatory prescribing at the end of life.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- The trust provided training around DNACPR (do not attempt cardio-pulmonary resuscitation) decisions for junior doctors and for senior consultants. This was an area where the consultant in palliative medicine had been involved to support improvements in the involvement of patients and family members in decision making.
- Porters received training on induction and on an ongoing basis from mortuary staff around the transfer of the deceased to the mortuary. This included aspects of dignity and respect and well as communication with the bereaved.
- At July 2016, the trust reported that 71 % of leadership and 82% of all other staff had received an appraisal compared to a trust target of 100% for leadership and 95% for other. Members of the specialist palliative care team we spoke with told us they had received an appraisal in the last 12 months.

Multidisciplinary working

- Weekly MDT meetings were held at the local hospice where trust specialist palliative care staff would attend to discuss their most complex patients.
- Cross Bay MDT meetings were held bi-monthly where specialist palliative care staff from both Furness General Hospital and Lancaster Royal Infirmary would meet. This included palliative care consultants and nurses, bereavement nurses and chaplaincy staff.
- There was access to general allied health professionals such as occupational therapy, physiotherapy and speech and language therapy. However, these professionals were not generally represented at specialist palliative care MDTs.
- Specialist palliative care staff would attend regular ward based meetings including 'board rounds' as part of their routine visits to review patients on the wards. This enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.
- The specialist palliative care team worked closely with cancer and non-cancer specialist teams and palliative care consultants would attend regular MDTs to provide input.
- The trust had introduced EPaCCS (electronic palliative care co-ordination system) at one of its two acute hospital sites. The service was due to go live at the other acute site in the near future. This system enabled recording and sharing of people's care preferences and details about their care at the end of life.

Seven-day services

- The trust provided access to Specialist Palliative Care 9-5 five days a week and therefore did not provide a seven day face to face service. A business plan was put forward to the Executive Committee two years ago but was unsuccessful at the time. There were plans in place to submit a further proposal aligned with local and regional strategic plans.

End of life care

- There was on-call palliative care consultant cover out of hours across both acute and hospice services. In addition a 24 hour advice line was available out of hours should staff require specialist advice. However, not all staff we spoke with were aware of this option.

Access to information

- The CDP document provided a guide to clinical staff in the assessment and identification of patients' needs. Information was recorded in a clear and timely way so that staff had access to up to date clinical records when caring for and making decisions about patient care.
- Staff had access to a number of resources through the trust intranet. Staff we spoke with said this information was accessible and easy to use.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place relating to consent. This included advance decision making, mental capacity guidance and best interest decision making and the use of Independent Mental Capacity Advocates (IMCAs).
- Staff we spoke with had a clear understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards.
- Two of the eleven DNACPR (do not attempt cardio-pulmonary resuscitation) records we viewed were for patients who did not have mental capacity. In one case there was clear evidence of involvement of the family in best interest decision making, in another a referral had been made for an IMCA.

Are end of life care services caring?

Outstanding ☆

We rated caring as 'outstanding' because:

- The bereavement service within the trust was highly valued and there was evidence of trust investment in the service and offering bereavement support to patients and families was seen as a priority.
- We heard about different situations where staff had worked collaboratively to ensure patients' needs and choices were met at the end of life. For example, by supporting a patient from overseas to return home in the last weeks of life and for ensuring a multi-disciplinary and collaborative approach to organising a ward based wedding for a patient in the last days of life.
- A bereavement survey carried out within the trust showed consistently higher than average results in areas such as the emotional support given to relatives and the dignity and respect afforded to patients.
- There was a strong visible person-centred culture and staff were motivated and inspired to offer care that was kind and promoted people's dignity.
- It was evident throughout the inspection how staff went the extra mile to provide care for patients who were nearing the end of their life and the level of dedication was obvious to all including friends, families and patients who could not fault the caring nature of the staff.
- The bereavement team provided the Caring for the Dying patient packs and the care after death checklist. The service provided a single point of contact for families.
- The support available for families following the death of their relative was outstanding.
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. The mortuary department provided an out of hours support for families who requested a viewing of their relative.
- We saw a dedicated chaplain as well as access to chaplaincy volunteers who demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect.
- There was a strong visible person-centred culture and staff were motivated and inspired to offer care that was kind and promoted people's dignity.
- Patients were cared for holistically and there was very strong evidence of spiritual and emotional support being recognised for its importance within the trust.
- We saw that privacy and dignity was maintained and opportunities were taken to further inform the patient and their family of the situation. We observed that patients and relatives were central to this process.
- All patients admitted to Furness General Hospital were given the opportunity to discuss their wishes for their future care with staff.
- Patients were cared for holistically and there was strong evidence of spiritual and emotional support being

recognised for its importance within the trust. This was apparent through the development of 'death cafés', where issues relating to death and dying were talked about openly.
- The bereavement service within the trust was highly valued and there was evidence of trust investment in the service and offering bereavement support to patients and families was seen as a priority.
- A bereavement survey carried out within the trust showed positive results in areas of dignity and respect afforded to patients.
- A remembrance service was held by the chaplaincy every three months for those bereaved.

Compassionate care

- Staff were seen to be caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.
- Patients and relatives we spoke with shared their experiences of end of life care at Furness General Hospital. We were told that staff were courteous and helpful and took time to speak with patients and relatives. People were satisfied with the care provided.
- A bereavement survey carried out within the trust demonstrated positive feedback from relatives in terms of their experience of care within FGH. For example, 94% of respondents reported receiving good levels of emotional support, compared with a national average of 69%; 97% of respondents stated that dignity and respect had been maintained, compared with a national average of 83%; and 100% of respondents stated they were treated with kindness and understanding, and that their and their relative's wishes had been respected by doctors and nurses.
- Specialist palliative care nurses and bereavement nurses had been trained in advanced communication skills. Communication skills training was available for all staff.
- The trust had developed a bereavement service including bereavement nurses and officers to support relatives through the practical and emotional aspects of bereavement. Support for relatives and patients around bereavement was embedded into practice within the trust and there was a culture of promoting care that was in line with patient and family wishes and delivered through compassion and kindness.
- There was a bereavement nurse on site at FGH to provide support to families and carers at the time of death. This could be directly or through enhanced support to nursing staff on the wards.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafes. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death cafés for the public as part of 'dying matters week' and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- Staff we spoke with told us that the implementation of death café's had contributed to them being more confident to openly discuss death in a more sensitive way.
- Families and friends of patients at the end of life could access car parking concessions and open visiting was available.
- Where possible patients at the end of life were cared for in a side room. Staff told us that this was sometimes

difficult as side rooms were also used to manage infection control. However, staff we spoke with told us that generally patients at the end of life at FGH could be nursed in a side room.

- Wards had quiet rooms available for relatives to use. Those relatives we spoke with told us that staff had gone out of their way to make them comfortable and provide support, including access to refreshments and where possible ensuring they had somewhere comfortable to rest. Ward 9 had developed a palliative care room where patients and relatives could spend time together in a peaceful environment. The room was a self-contained unit with room for a patient bed and seating area with a bed for relatives. There was also a kitchen area which included facilities for refreshments.
- We were given examples of where staff went the extra mile to support patients and their families at the end of life. A wedding had been held on ward 9 earlier in the year. The chaplain told us that ward staff pulled together to make sure the wedding happened within 24 hours of the request being made. Specific action included chaplaincy staff organising paperwork and medical staff buying flowers.
- Another example was where a patient from Poland had been identified as being in the last weeks of life and expressed a wish to go home to Poland. Staff worked together to ensure this happened, including liaising with the airline, organising airport transport and ensuring medicines were available and that care was transferred safely to medical staff in Poland.
- The trust was nominated, and was a runner-up, in the Health Service Journal's 2015 awards, 'compassionate care' category, for its bereavement and palliative care service.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care. The use of the Gold Standards Framework (GSF) promoted patient and family involvement and discussion around end of life care wishes and choices.
- Relatives we spoke with told us they felt involved in their loved ones care. Results from a bereavement survey carried out by the bereavement service showed that 98% of relatives stated that they felt involved in decisions about care.
- We observed staff speaking with patients and relatives about their care. Staff told us that the palliative care and bereavement teams were available to provide support around this.

Emotional support

- In 2013/14 the trust's score in the NCDAH for assessment of spiritual needs fell below national averages. In the 2016 audit we saw that this had improved and demonstrated that 30% of patients had been offered access to spiritual support which was higher than the national average of 27%.
- A remembrance service was held by the chaplaincy twice a year for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one, support was offered at this time.
- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.
- Bereavement nurses worked closely with ward staff to provide support to both patients and relatives around issues of loss and other support needs. There was a library of books available for families to borrow, for example in relation to supporting children through bereavement and loss.
- The chaplaincy service provided spiritual support for patients and their families. A team of volunteers worked with the on-site chaplain to provide this. The aim of the service was to visit each bed in the hospital once a week to offer support and raise the profile of the service.
- The trust's bereavement service found that 92% of respondents felt they had received appropriate support to deal with their feeling surrounding the death from medical staff. 100% of respondents felt they had received appropriate support from nursing staff in this area.

Are end of life care services responsive?

Good

We rated responsive as 'good' because:

End of life care

- The specialist palliative care service worked collaboratively with other services and organisations to ensure that services were planned and delivered to meet the needs of local people.
- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent.
- There was a higher than average proportion of patients dying in their usual place of residence.
- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.
- The trust had developed an 'ease of access to hospital' group which included representation from the bereavement and chaplaincy service. Examples of where changes were being initiated included improving signage to the mortuary to improve access so that it was no longer a hidden service within the hospital.
- Bereavement and chaplaincy services had been developed to respond quickly to patients' needs and were central to raising the profile of end of life care within the trust and the local community.

Service planning and delivery to meet the needs of local people

- A 'cross bay' end of life care group was in operation, involving representatives from both NHS and other services across Lancashire North and Cumbria. There was representation at these meetings from both specialist palliative care and board level within UHMB.
- Services were planned to meet the needs of the local demographic and a primary aim of the end of life group was to raise awareness of end of life issues and ensure that patients received care in line with their wishes and preferences.
- Following the implementation of the Gold Standards Framework for end of life care in acute hospitals across two wards within the trust, of which one was at Furness General Hospital, the service was in the process of rolling out the GSF to other wards and embedding it as the model of end of life care within the trust.
- The GSF promotes early identification of patient's at the end of life so as to allow for improved discussions with them and their families about their wishes and choices at the end of life. In addition the GSF provides a framework for non-specialist staff to deliver end of life care alongside specialist support in a cohesive and consistent way. Staff at FGH, working on wards accredited and those seeking accreditation demonstrated a clear understanding of the advantages of using such a framework and promoting good quality end of life care in general ward settings.
- There was a strong drive within both the specialist team and on general wards to support patient's to die in their preferred location. The trust did not collate data that would demonstrate the percentage of patients who died in their preferred location. However there was evidence that patient's from the CCG's (clinical commissioning groups) of the UHMB region were more likely to die in their usual place of residence than the national average. For example, the national average for patients dying in their usual place of residence between April 2015 and March 2016 was 45.8%. The local average for patients was 47.3% (Cumbria CCG) and 50.3% (Lancashire North CCG).

Meeting people's individual needs

- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible, with staff reporting that they would respond on the same day for urgent referrals.
- Discharge coordinators were available to support the process of getting people home, including for those patients at the end of life. Staff consistently told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- The trust had developed a 'Hospital Home Care Team' service that was designed to reduce the number of in-patients who were medically fit for discharge and could leave hospital by 50%. This service included the provision of community end of life care with the support from hospice at home and district nursing teams in the persons own home when care packages could not start in a timely way. Following a 90 day initial trial the trust extended the service in October 2016.
- Cross department partnership work and developments around dementia, palliative care, adult and ante natal bereavement was implemented by the chaplaincy team.

End of life care

- There had been a focus within the trust to raise the profile of chaplaincy and promote its ability to engage with the spiritual needs of patients, families and staff, and create opportunities for partnership and strategic work. The chaplaincy team also engaged with other faith leaders to ensure that the needs of patients from different faiths would be met. This work included formalising links with key faith groups through service level agreements.
- The bereavement team told us that the bereavement leaflet had recently been translated into the braille.
- The trust had rolled out the 'Deciding Right' advance care planning framework and advance care plans were in use within the trust.
- A 'butterfly' scheme was in place to help ensure that all staff were aware of which patients had dementia and required additional support. A 'dragonfly' scheme had similarly been introduced to raise awareness of those patients at the end of life. An information card had been produced for non-clinical staff such as porters and housekeepers, explaining the difference between the symbols.
- We viewed a chapel and multi-faith prayer room and saw plans in progress for extending the prayer room and improving facilities for patients, staff and visitors of multi-faiths.

Access and flow

- Referrals to the specialist palliative care team came through by phone and in writing but that a good deal were picked up through routine ward visits. Ward staff told us the team always responded promptly and that urgent referrals were seen within a short space of time on the same day.
- We spoke with two doctors who told us they had referred patients to the team, both reported that the response was prompt and the support from the team had been valuable and beneficial to patients.
- In total in 2014/15 there had been a total of 960 referrals to the specialist palliative care teams across both Furness General Hospital and Royal Lancaster Infirmary. Of those 64% were for patients with a cancer diagnosis and 36% were for patients with a non-cancer diagnosis. There had been a 4% reduction in non-cancer referrals since the previous year.
- The trust did not audit data relating to patient's preferred place of care and whether or not this was achieved, or how quickly patients were discharged home at the end of life when this was identified as their preferred place. However, information provided across the trust showed that of 72 patients where rapid discharge home to die had been identified, this was achieved in 61 cases over a six month period between April 2016 and October 2016. Of the eleven who had stayed in hospital 4 had identified hospital as their preferred place of care.
- The trust had developed an 'ease of access to hospital' group which included representation from the bereavement and chaplaincy service. Examples of where changes were in the process of being initiated included improving signage to the mortuary. This was aligned with the death café model where efforts were being made to talk more openly about death and dying. With this in mind there was a focus on making sure that the mortuary was accessible and not a hidden service within the hospital.

Learning from complaints and concerns

- Information was available for patients on how to complain or feedback about the service experienced. People were signposted to the Patient Advice and Liaison Service (PALS) where concerns were unable to be resolved at ward level.
- Bereavement nurses were available to provide support to patients and families in situation where they were dissatisfied with the care experienced. This role provided a support to ward staff as well when dealing with complex end of life care situations.
- Between April 2015 and March 2016 there were no complaints about end of life care services.
- Members of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.
- Mortality review meetings were conducted with input from the specialist palliative and bereavement teams where opportunities to address concerns around the quality of end of life care were taken and learning explored.

Are end of life care services well-led?

Outstanding ☆

We rated well-led as 'outstanding' because;

End of life care

- The trust had clear leadership for end of life care services that was supported at a senior level within the organisation. There was active involvement strategically from the deputy chief nurse and executive leadership at board level.
- End of life care services were very well led. There was a clear vision and strategy that focused on all people being treated with dignity, respect, and compassion at the end of their lives.
- We saw evidence of proactive executive involvement in terms of the development of the end of life care strategy.
- There was very good public and staff engagement
- There was a commitment by the trust, and this was underpinned by staff, that patients were cared for in a timely, dignified and appropriate manner
- There were examples of innovation across the trust. During 'Dying Matters week', the trust had introduced death cafés, with an aim to raise the profile end of life care. This included the development of the bereavement service.

Vision and strategy for this service

- Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan on how they intended to address the areas identified for improvement. This included ongoing roll out of the Care of the Dying Patient (CDP) plan and the Gold Standards Framework (GSF) accreditation.
- A clear vision had been established where 'all people who die in the Morecambe Bay area are treated with dignity, respect and compassion at the end of their lives and that regardless of age, gender, disease or care setting they will have access to integrated, person-centred, needs based services to minimise pain and suffering and optimise quality of life'.
- A three year strategy had been developed in June 2016 and included key priorities using the North West end of life model where objectives were classified according to different phases of the last year of life. This ranged from services available to patients with advancing disease, those with increasing decline, those in the last days of life, the first days after death and bereavement.
- The strategy had been developed within the framework of 'Better Care Together'. This is a collaborative model where health care, social care and voluntary sector partners worked together to develop integrated community based services where patients would be cared for in their local communities as much as possible.
- Examples of areas that the collaborative partnership was working on included the development of a proposal for a seven day specialist palliative care service.
- Another specific area for strategic development that staff spoke of was the ongoing development of end of life care services within generalist settings. The ongoing roll-out of the GSF was a fundamental tool in this development. Initial implementation had been funded as part of a specific project that had since ended so staff were focused on ways to ensure sustained development over time. Succession planning for the specialist palliative care team was also of particular focus.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate of medicine.
- There was a trust wide risk register, which included a separate risk register for end of life care, but there was not one specific to end of life care. At the time of our inspection there were two risks specific to end of life care identified.
- Specialist palliative care staff attended specialist 'cross bay' meetings where governance issues were discussed. These meetings were attended by representatives from other organisations within the region. The assistant chief nurse for the trust also participated in these meetings.
- There was representation from the SPCT at regular mortality review meetings. Their remit was to support the review of the quality of care and decision making at the end of life. This process included the identification of areas for improvement and a discussion about learning and changes to future practice as a result.
- The service takes part in regular audits, locally and nationally. This included the external NCDAH and internal bereavement surveys. We saw an action plan had been compiled from the 2016 NCDAH and included action to ensure the ongoing roll out of the CDP (care of the dying patient document) and GSF accreditation. There were also plans to undertake internal audits relating to the use of the CDP and anticipatory prescribing of end of life care medicines.

End of life care

- The bereavement service had undertaken a bereavement survey where surveys had been sent out to relatives of patients who had received end of life care within the trust. This was broken down to reflect findings at bot Furness General Hospital and Royal Lancaster Infirmary. An action plan following this was in the process of development at the time of our inspection.

Leadership of service

- There was clear leadership in end of life care across the trust. The medical director was the executive end of life care lead and there was evidence of clear nursing leadership with management and involvement from the deputy chief nurse in relation to the specialist nurses, bereavement service and chaplaincy.
- The senior consultant in palliative medicine was the clinical lead and worked across boundaries with both the CCG and local hospice.
- The lead specialist palliative care nurse was based at Furness General hospital although had a remit across the whole trust and also managed the specialist palliative nursing team at Royal Lancaster Infirmary.
- Bereavement nurses and chaplaincy staff had leadership roles in terms of end of life care and raising awareness of aspects of their service across the trust. This involved attending meetings and working collaboratively across services and departments to raise awareness of end of life care issues.
- There was a clear commitment to quality end of life care across wards within the hospital and we saw ward managers and staff alike focused on improving and developing end of life care in general ward settings.

Culture within the service

- Staff were consistently positive about delivering quality care for patients at the end of life.
- There was a commitment at all levels within the trust to raise the profile of death and dying and end of life care. This included improving ways in which conversations about dying were held and engaging with patients and their families to ensure their choices and wishes were achieved.
- Staff were proud of their work around end of life care. The specialist palliative care, bereavement, chaplaincy and mortuary staff demonstrated an enthusiasm and passion for continuously improving services to meet the needs of patients and families.

Public engagement

- The chaplaincy had co-ordinated the public work of the trust for Dying Matters Week 2016 by delivering death cafes to the public within the local community and engaging in social media. The death café model is based on creating opportunities about more open discussions about death and dying to raise awareness and create a more open culture.
- There are plans in place to develop this work more widely as part of the 'Better Care Together' community model of care.
- Bereavement surveys were sent out to relatives of patients who had received end of life care within the trust.

Staff engagement

- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- Specialist palliative care staff attended regular team and 'cross bay' meetings where they had the opportunity to input into the development of the service.
- All specialist palliative care staff had received an annual appraisal and a personal development plan as a result.
- The chaplaincy team regularly engaged ward staff in 'death café's' where the focus was on engaging them in conversations about death and dying with the aim of raising awareness, improving conversations and engaging staff in discussions around end of life care.

Innovation, improvement and sustainability

- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death café's for the public as part of dying matters week

and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.

- Discharge coordinators were available to support the process of rapid discharge at the end of life and the trust had recently implemented a community service where patients could be supported by trust staff in their own homes where care packages were difficult to access in the community.
- The trust had developed an 'ease of access to hospital' group which included representation from the bereavement and chaplaincy service. Examples of where changes were in the process of being initiated included improving signage to the mortuary. This was aligned with the death café model where efforts were being made to talk more openly about death and dying. With this in mind there was a focus on making sure that the mortuary was accessible and not a hidden service within the hospital.
- In July 2015 funding ceased for end of life care coordinator roles within the trust. These roles had been in place to implement and roll out the care of the dying patient (CDP) document and continued implementation of the Gold Standards Framework (GSF) across the trust. These responsibilities had since been passed to the specialist palliative care team with their additional roles and responsibilities. While we saw that work was continuing with the roll out of GSF and the CDP there was evidence of some delays in implementation due to staffing difficulties. The timeline for ongoing implementation was unclear and while ward staff informed us that the specialist palliative care team were supportive, dedicated time for implementation was limited.
- Changes to the specialist palliative care team across the trust were forthcoming with near future retirements of post-holders. We were told that recruitment had begun for these posts and discussions had been held, however clear contingency plans were yet to be in place.

Outpatients and diagnostic imaging

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

Information about the service

The University Hospitals of Morecambe Bay NHS Foundation Trust provided outpatient and diagnostic services at the Royal Lancaster Infirmary, Furness General Hospital, and Westmorland General Hospital, Ulverston Community Health Centre offered outpatients and radiology services, however we did not inspect these services. These services were managed by the same team at Furness General Hospital. Ulverston Community Health Centre had 13,533 appointments between April 2015 and March 2016.

Between April 2015 and March 2016 there were 700,277 first and follow up outpatient appointments at the trust. 189,676 first and follow up appointments were at Furness General Hospital. Outpatient services were part of the core clinical services directorate. There were nurse led clinics for dermatology, diabetes, lung clinics, gastroenterology clinics, respiratory and rheumatology clinics.

Outpatients offered 'one-stop' clinics for Cardiology, Respiratory, Thyroid and Urology. There were a small number of children's services in Rheumatology clinics.

The service had a Community Patient Contact Centre (CPCC) which acted as the patient focal point for correspondence, discussions, and planning around bookings for their non-elective appointments. The patient contact centre dealt with around 12,000 calls a month.

The outpatient service was responsible for the management of room scheduling and staff support to clinicians to enable the running of outpatient based treatment functions within UHMB.

We visited the main outpatient department, ophthalmology outpatients, occupational therapy outpatients, diagnostic imaging and pathology.

Diagnostic imaging services were mainly provided from three locations: Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital with a limited service at Ulverston Community Health Centre and Queen Victoria Hospital at Morecambe. Diagnostic imaging at FGH provided plain film x-rays, ultrasound, CT, MRI, Nuclear medicine, breast screening including interventional treatments,a radio pharmacy, fluoroscopy, and limited interventional radiology. One symptomatic breast assessment clinic per week is performed at FGH.

The acute clinical work including fluoroscopy was concentrated at the two main sites, Royal Lancaster Infirmary and Furness General Hospital, which offered a range of diagnostic imaging, image intensifiers in theatres, and interventional procedures.

The trust MRI provision was supplemented by private mobile MRI services at Royal Lancaster Infirmary, Furness General Hospital. Diagnostic imaging services were managed by the trust core service management team including a clinical director who was also a consultant radiologist.

Diagnostic imaging services were available from 8.15am to 6pm on weekdays for outpatients. Patients referred by their GPs could access walk in sessions on week days between 7.30am and 7.30pm. CT and ultrasound were provided on weekend mornings and MRI scans on weekend afternoons.

Outpatients and diagnostic imaging

For inpatients and trauma there was a 24 hour, seven days a week plain film, MRI, CT, and ultrasound service. A breast screening service was provided on weekdays. MR cover provided urgent cord compression slots over the weekend.

Pathology services offered biochemistry, haematology including transfusion, microbiology, and phlebotomy. Histology and immunology were provided by neighbouring acute trusts. The pathology service managed around five million tests a year and all equipment had recently been transferred to a managed service.

The pathology service provided a full range of patient diagnostic and reporting services to support effective patient diagnosis and treatment plans. Blood and analysis services were provided to emergency and theatre areas.

During the inspection at Furness General Hospital we spoke with nine patients and three relatives. We also spoke with 25 staff including nurses, health care assistants, allied health professionals, and doctors. We observed the diagnostic imaging, outpatients and pathology environments, checked three paper based patient records and six electronic medical records, equipment in use and looked at information provided for patients.

We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Summary of findings

We rated Outpatients and diagnostic imaging services as 'good' because:

- During our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had reduced the use of paper records and implemented an electronic records system for most outpatient areas. This was still being rolled out across all departments but we found there had been significant improvements in the availability of case notes. Staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.
- Since the last inspection we found that there had been some improvements in diagnostic imaging staffing. When we inspected this time the department continued to work with vacancies but a new rota system enabled the department to make improvements.
- During our last inspection we noted that there was no information available in the departments for patients who had a learning disability or written information in formats suitable for patients who had a visual impairment. We saw this time that there was a range of information available in different formats and staff had involved the public and groups including vulnerable people in producing information for use by patients.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.
- Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance.

Outpatients and diagnostic imaging

- Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department along with preceptorship for all new staff to the department.
- We found that access to new appointments throughout the departments had improved.
- Overall staff felt engaged with the trust and felt that there had been some improvements in service delivery since our last inspection. There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at management and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.

However:

- There remained a shortage of some staff groups including occupational therapists, radiographers and radiologists. Some staff raised concerns about the sustainability of the team under prolonged staffing pressures.
- Some referral to treatment targets in a small number of specialties were missed and follow up appointments continued to suffer backlogs and delays.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as 'good' because:

- The departments used an electronic system to report incidents. All the staff we spoke knew how to use the system if they needed to. Managers and governance leads investigated incidents and shared lessons learned with staff.
- The trust had reviewed its staffing investment to develop the allied health professional workforce to meet the growing demand for services. Diagnostic imaging were working proactively to train staff to work across modalities and to take on extended roles. National shortages meant that recruitment was difficult but there had been some improvements.
- Staffing levels in outpatients were flexible to meet the different demands of clinics and patients. There were sufficient staff to make sure that care was delivered to meet patient needs.
- Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with staff. Cleanliness, hygiene and maintenance of equipment in the departments all met acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.
- Staff were aware of the various policies designed to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed.
- During our last inspection we had identified some improvements with the timely availability of case notes and test results in the outpatients department. We found there had been sustained improvements following the rollout of the 'Paper Lite' project which ensured that electronic information was available for patients. This project was almost fully implemented and staff were very positive about the improvements in

efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information. We also found that improvements in the processes for reporting and learning from incidents were maintained.

- Staff in all departments were aware of the actions they should take in the case of a major incident.

However:

- We found that although recruitment had been successful in some areas, there remained a shortage of occupational therapists, radiographers and radiologists.

Incidents

- The departments had systems to report and learn from incidents and to reduce the risk of harm to patients. The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and knew how to report incidents. They also confirmed they had received training in completion incident forms through the online system. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- Never events are serious incidents which are wholly preventable. There were no never events in outpatients between September 2015 and August 2016.
- Root cause analysis was completed by the risk team once an incident had been entered onto the electronic system. Each incident had a 24-hour rapid review before proceeding to a full root cause analysis. Some staff had undertaken risk incident training and team leaders told us there were good links with the risk office at the trust.
- Outpatients and diagnostic services staff attended a patient safety summit which was a meeting held to discuss incidents and root cause analysis. Staff discussed serious incidents at a trust serious incident requiring investigation (SIRI) meeting. The outpatient services reported no serious incidents between September 2015 and August 2016.
- There were 251 reported incidents across the trust in outpatients between August 2015 and July 2016. Three of these were classed as severe, 9 of these were classed as moderate and 218 were classed as low risk or no harm and 21 were classed as near miss incidents.
- We reviewed outpatient meeting minutes from February 2016 and May 2016 and found that patient safety incidents were a standing agenda item at the meetings.
- Managers and staff told us staff were encouraged to report incidents. They received feedback from incidents and learning from incidents through a lessons learnt bulletin and through team brief which was sent out monthly. Managers confirmed they would share lessons learnt as required.
- Clinic staff told us they had reported some incidents in the outpatient department relating to clinicians not being available for clinics. Since clinicians were managed by their specialty directors, staff told us if this happened they would complete an incident form and this would then be sent to the speciality service providing the clinics.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'and provide reasonable support to that person. Staff had been trained and were aware of their responsibilities in terms of the Duty of Candour regulations and all staff described an open and honest culture. Staff told us about the policy and procedures they followed including writing letters to patients offering an apology and information regarding incidents and complaints.

Diagnostic imaging:

- There had been three radiological incidents reported under ionising radiation medical exposure regulations IR(ME)R across the trust for the six-month period between January and June 2015. Managers told us that these were classified by their medical physics expert as low or no harm and were attributed to plain film and CT procedures and all were due to wrong exposure settings by the operator with larger than intended doses of radiation to the patients. The radiation protection adviser (RPA) report included guidance on prevention of recurrences. The department informed patients when unnecessary exposure to radiation had taken place and gave equivalent everyday examples where possible of how much radiation they had received. They ensured that Duty of Candour requirements were met and offered patients the chance to discuss incidents further if they wished.

Outpatients and diagnostic imaging

- Radiology discrepancy incidents were discussed by case review with radiologists and reporting radiographers. Sonographers discussed discrepancies formally in their own meetings. Medical staff took the opportunity to learn and work as a multidisciplinary team with referrers and clinical teams. Outsourcing reporting companies carried out discrepancy and quality assurance reviews as part of their service level agreements (SLA) with the trust.
- Staff told us that safety and security did not cause concerns for staff. Staff in the breast screening department occasionally worked alone but they could access support from the main x–ray department if they had concerns after vetting referrals.

Cleanliness, infection control and hygiene

- We observed staff in all departments visited adhered to 'bare below the elbow' guidance.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Staff understood and carried out their own responsibilities regarding cleanliness of the environment, hand hygiene. We checked compliance with practice, checklists and signatures and all were completed and correct.
- Hand Hygiene results between February 2016 and June 2016 showed positive results for all outpatient areas. Furness General Hospital hand hygiene audits showed 100% compliance between February 2016 and June 2016 for hand hygiene. The target was 96%.
- The target for mandatory training was 95%. Infection, prevention and control mandatory training completion rates were 89% for level 1 and 100% for level 2. Main outpatients were at 92% compliance for aseptic non touch technique training.
- Personal protective equipment (PPE) such as gloves and aprons was used appropriately in most areas and available for use throughout the departments and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw that treatment rooms and equipment in outpatients were cleaned regularly.
- Staff told us if they had patients with a known infectious disease, they were aware of the process and actions to take. Staff said they would put these patients at the end of the clinic list then deep clean the room.

Diagnostic imaging:

- Staff cleaned and checked diagnostic imaging equipment regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly and safely.

Environment and equipment

- The main outpatients environment at Furness General Hospital was tidy and had adequate seating in the waiting areas for the numbers of patients we observed waiting. In reception there were two electronic check in desks and volunteers were available to assist patients and carers. A reception desk was also available for patients to check in with a member of reception staff. There were over 10 consulting rooms in the outpatient department. Managers showed us a plan, displayed in the reception area which highlighted the plans to increase capacity in the main outpatient area. These plans included a new height and weight room, a new nurses' room and an adult changing facility for patients and carers to help meet their individual needs.
- Main outpatient managers told us they had recently had laminate flooring laid to replace a carpeted area and an estates plan was in place to improve the department, for example the lighting and doors.
- We were told there could be overcrowding in the ophthalmology department waiting areas at Furness General Hospital. However this was not a regular occurrence. Staff told us when this happened they would apologise and bring more seats to the waiting areas for patients.
- Equipment throughout the departments was calibrated, maintained and maintenance contracts were managed by the estates department
- All areas we inspected were clean, and most were well maintained. Most areas were spacious and bright. Consulting, treatment and testing rooms were well stocked and equipment labelled as clean was clean.
- The departments provided multiple single sex and individual toilets. Disabled toilets had alarm calls and rails fitted and there was a baby nappy changing area. All toilets had hand basins, hot and cold water and supplies of hand soap and paper towels.
- Resuscitation trolleys for adults and children, and equipment including suction and oxygen lines were all

checked and cleaned weekly and checklists were signed and found to be up to date. Trolleys were locked and tagged and staff made regular checks of contents and their expiry dates.

- The departments had specially equipped play areas for children with some good quality toys. There was also a small waiting area orientated towards children attending with adults or those attending fracture clinics. The children's outpatient department was located separately on the main hospital site.
- We saw, and staff confirmed that, there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.

Diagnostic imaging:

- During our observations we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging department.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were within the acceptable range.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- Previous checks by the RPA and medical physics expert (MPE) had identified equipment that was reaching the end of its safe and reliable life and therefore required replacement. The trust had met this need and secured a managed contract for the supply and maintenance of diagnostic imaging equipment and had recently refreshed ultrasound kit across all sites.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.

Medicines

- Staff told us, and we observed they followed the medicines and storage policy. A hard copy of this was available in the out patients nurse manager's office. The department received a three monthly pharmacy visit for stock checks and staff told us they checked expiry dates of stock weekly.
- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients department. Small supplies of regularly prescribed medicines were stored in locked cupboards and where appropriate, locked fridges. We saw the record charts for the fridges which showed that the temperature checks were carried out daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date. Prescription pads were stored securely.
- We saw PGDs (patient group directions) for drugs and contrast agents used in the outpatients and diagnostic imaging departments were in place and had been reviewed appropriately.

Diagnostic imaging:

- In the diagnostic imaging department some interventional procedures required sedation and pain relief and these included controlled drugs. These medicines were prescribed and administered by the consultant radiologist carrying out the procedure. All medication used was documented and a controlled drugs book was kept with patients during procedures. Monthly stock checks were made and expiry dates were checked. We saw evidence of dated and signed checklists.

Records

- At previous inspections we told the provider they must ensure the timely availability of case notes and test results in the outpatients department. Outpatient departments had experienced difficulties in obtaining patient records in time for clinic appointments. Previous data provided by the trust was 96% availability for outpatient records and 98% for elective inpatients.

Outpatients and diagnostic imaging

- The trust had almost completed the roll out of its 'Paper Lite' project which ensured that electronic information was available for patients. Staff were very positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.
- Case note availability audits were carried out on a monthly basis. Audit data between October 2015 and June 2016 showed that the trust consistently achieved above their set targets of case note availability in outpatients. Data from May 2016 showed that outpatients across the trust had 99.3% of case notes available and data from June 2016 showed that 99.48% of case notes were available.
- In clinics that had not transferred to electronic notes, they still used paper records. Staff and managers confirmed during the inspection that access to records had improved and there were no current concerns with access to records. Administration staff had been trained to scan documents onto the electronic system, thus reducing more paper records.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- There were no notes left in patient areas. The electronic record system meant that there was no patient information on display and, where recording sheets were used, they were kept face down and away from public view. Patients from A&E carried a small card with their details on. They handed it to staff when they were seen.
- A generic smart card was available for use in the department for staff who did not have one, this was locked in the nurse managers office and staff told us they audited this using the sign in and out sheet for the smart card. This was used when staff did not have access to a card but needed to log information electronically.
- In Ophthalmology, case notes were a mixture of electronic and paper. We were told there could be challenges with case note availability because case notes could be on a different trust site. However, electronic case notes were making access to information better. We were told it was rare that patient's case notes were not available for use.
- We reviewed three paper based and six electronic patient records which were completed with no obvious omissions. Nursing assessments of blood pressure, weight, height and pulse were routinely completed. We observed these checks being undertaken during our inspection.

Diagnostic imaging:

- Diagnostic imaging records and reports were digitised, stored electronically and available to clinicians across the trust via CRIS (Computerised Radiology Information System) and PACS (Picture Archiving and Communications System).
- Senior staff had undertaken a documentation audit to show radiographer compliance in completion of checks. There was good compliance of ID checks. However, the way this was done by individuals varied so some staff were completing written checks and others were completing electronic checks. It was agreed that all staff must complete an electronic check and staff were found to be 100% compliant. Other points audited were patient pregnancy status, which showed 100% compliance, and image markers which also varied according to the method used but staff were 100% compliant across all methods.

Safeguarding

- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query.
- The trust provided information on mandatory safeguarding training compliance rates against a target 0f 95%. Safeguarding adults core skills level 2 was 75% compliance in main outpatients and safeguarding children and young people core skills level 2 was 100% in main outpatients. Safeguarding adults and children core skills level 1 was 89% compliant. In diagnostic imaging; trust records showed that 96% of staff had completed level 1 safeguarding adults and children training , 98% had completed level 2 and 100% had completed level 3.
- Staff could describe the action they would take if patients 'Did not attend' on a number of occasions.
- The Ophthalmology outpatient clinics had a safeguarding noticeboard in the manager's office that had safeguarding guidance documents attached for all staff to follow should they have a safeguarding concern.

Mandatory training

Outpatients and diagnostic imaging

- The trust's mandatory training target was 95%.
- The trust provided information on mandatory training compliance rates.
- In outpatients; Equality, diversity and inclusion mandatory training compliance was 93%. Health, safety and welfare was 96% compliant and information governance was 93% compliant.
- Fire departmental safety awareness compliance was 93%. Managers told us this would have shown to be above the trust 95% target. However new starters to the trust were already on the system but they had not actually started or attended the mandatory training sessions yet. Resuscitation and basic life support training compliance was 89% and resuscitation and paediatric life support training was 100% compliant. Conflict resolution was 89% compliant.
- Staff we spoke with confirmed they had attended mandatory training. Managers had access to an online system to identify staff mandatory training completion rates and would use this system to ensure staff had completed or were booked on mandatory training.
- At our last inspection some staff told us accessing e-learning had practical difficulties as it was located on the intranet. Staff needed to access it through computers in the department, which was not always possible. We also found that staff in the orthopaedic clinic had not completed any recent updates due to pressure of workload and staffing levels. However, at this inspection staff reported no difficulties in accessing computers for e-learning or the time to complete modules at this inspection.

Diagnostic imaging:

- Compliance with manual handling training modules ranged from 70% to 76%. Managers told us 3 key staff had been trained as manual handling facilitators to train staff within the department and improve practice and compliance. Two more staff had volunteered to be trained as facilitators and the team expected compliance for all manual handling training to be 100% by the end of December 2016.
- Equality, diversity and inclusion mandatory training compliance was 100%. Health, safety and welfare was 98% compliant and information governance was 87% compliant.
- Fire departmental safety awareness compliance was 100%. Resuscitation and basic life support training compliance was 91%.

Assessing and responding to patient risk

- Staff were able to describe the action they would take if a patient deteriorated in their care in the department. Dependant on the deteriorating patient situation, staff would do observations, contact the doctor and call the crash team for an urgent response if required. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments.
- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff incorporated assessment tools into patient pathways, following NICE guidance. An example of this was for chronic inflammatory skin disease.
- A one-stop surgical clinic ran on a twelve week time table, mirroring the general surgical clinic timetable. Patients were added to these clinics following a consultation appointment with a surgeon, with the timescale for this dependent upon clinical need, as advised by that surgeon.
- There were no outreach clinics provided from main outpatients, however managers told us they had trialled a video clinic in rheumatology and that the trial had been generally positive. This trial had been offered by the outpatient rheumatology team.
- Daily urgent appointments were available in the main ophthalmology department and staff would put on extra clinics if required.

Diagnostic imaging:

- Diagnostic imaging policies and procedures in the diagnostic imaging department were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) and medical physics expert (MPE) were contracted from an NHS Trust in Manchester to support all trust sites. The RPA visited twice a year and the medical physics expert visited each site once each month.
- There were named certified Radiation Protection Supervisors (RPS) on each site to give advice when needed and to ensure patient safety at all times.

Outpatients and diagnostic imaging

- Two senior consultant radiologists were Administration of Radioactive Substances Advisory Committee **(**ARSAC) certificate holders for diagnostic imaging. One was based at Royal Lancaster Infirmary and the other at Furness General Hospital.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000). Local rules for each piece of radiological equipment were held within the immediate vicinity of the equipment.
- Staff asked patients if they were, or may be, pregnant in the privacy of the x-ray room. Therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and for those who were not. For example patients who were pregnant underwent extra checks.
- Diagnostic imaging used the WHO safer surgical checklist for all interventional procedures.

Allied Health Professional Staffing

- At previous inspections we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce was developed to meet the growing demand for services. The trust had been successful in recruiting occupational therapists. This ensured that patients had access to specialist occupational therapy staff on the acute and short stay wards.
- Physiotherapy outpatients had a planned staffing establishment of 4 whole time equivalent (WTE) staff (three qualified and one non-qualified) and an actual staffing establishment of 24.3 WTE staff (16 qualified, 7.3 non-qualified, and one admin).
- Occupational therapy outpatients had a planned staffing establishment of 0.9 WTE staff and an actual staffing establishment of 0.9WTE staff.
- Dietetics outpatients had a planned staffing establishment of 1.0 WTE staff and an actual staffing establishment of 1.0 WTE staff.

Diagnostic imaging :

- At the time of our inspection, within the diagnostic imaging departments, there were sufficient radiographers, clinical support workers, and nursing staff to ensure that patients were treated safely. There were current vacancies and these were being recruited to.
- There had been difficulties in recruitment of qualified radiographers in the past and managers told us these were improving slowly. They told us that they often received several applications but after offering posts, candidates withdrew after finding posts elsewhere.
- The department did not have full staff establishment and staff told us they felt stretched in terms of increases in shifts allocated and on-call requirements but they were meeting the needs of the service. Managers told us they were supportive of staff and most staff we spoke with were able to corroborate this.
- The trust had trained three reporting radiographers, with another two trainees undertaking training to report axial and appendicular trauma imaging. Two radiographer reporters were extending their skill sets to report GP axial and appendicular imaging; one had begun training and the other was to begin in Sept 2017. Managers were aware that radiographer training was helping to reduce the burden on radiologists, but it affected radiographer numbers, and further staff were required to backfill as staff qualified in advanced roles.
- Sonographers reported their own ultrasound scans. The trust had recently appointed a lead sonographer and refreshed ultrasound kit across all sites.
- Advanced practitioners undertook fluoroscopy including hysterosalpingograms, barium swallows and video fluoroscopy in corroboration with speech and language therapists (SALT) to identify swallowing problems for stroke patients. CT radiographers undertook CT colon imaging.
- Radiology managers told us they outsourced some radiographer reporting. An external company provided a radiographer who worked on a sessional basis on site to report a wider range of examinations. As with outsourced radiologist reporting, there was a service level agreement and contract including quality assurance measures.
- Current staff were undergoing training to specialise in modalities including CT and ultrasound.
- Data provided by the trust showed the radiology staff absence rate at Furness General Hospital was 1.78%.

Outpatients and diagnostic imaging

Nursing staffing

- At previous inspections we told the provider that they must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided. At this inspection department managers told us they regularly reviewed staffing and used an electronic tool to manage staffing throughout the clinics and services. There was no fixed staffing establishment for each day in main outpatients. However we were told staffing was flexible in order to meet the clinic needs.
- Outpatients did not use agency staff and rarely used bank staff to fulfil staffing requirements. There were few vacancies in main outpatients and where there were vacant hours, managers increased other staff hours if requested to backfill the position. There were 20 hours of a clinical support worker role vacant and around 46 hours of a registered nurse role vacant. However, the department was actively recruiting to these positions. Managers told us there were no current nurse staffing concerns.
- The trust provided a staffing report from August 2016 showing that the establishment was 26.5 whole time equivalent staff and there were actually 24.5 whole time equivalent staff at Furness General Hospital and Ulverston Hospital.
- Managers in the ophthalmology outpatient department told us there were no current nurse staffing level concerns and currently no vacancies.
- New posts in dermatology included a skin cancer nurse specialist and two phototherapy nurses.

Diagnostic imaging :

- There were no specialist nurses to support interventional radiology procedures. However, a nurse sometimes travelled from Royal Lancaster Infirmary to FGH support clinical skills training.
- Clinical support workers moved between modalities to provide help and support to staff and patients where required.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades; however we saw that there were consultants available to support lower grade staff when clinics were running.
- Outpatients did not use locum staff.

Diagnostic imaging:

- At our last inspection we told the trust they should consider its investment into the diagnostic and imaging services to respond to increased demand. Radiologist vacancies were identified on the divisional risk register as a high risk and there were ongoing vacancies within the radiology service. There was a continuing national shortage of radiologists and managers told us by the time of this inspection the trust had an establishment target of 19 WTE consultant radiologists to cover all sites. The trust had been able to fill three consultant vacancies so there were now 13 consultants in substantive posts. However, another 5.5 WTE vacancies remained. The trust had appointed an associate specialist and there were four part time locums.
- At the time of our inspection there were sufficient staff to provide a safe and effective service. However there were only two WTE substantive radiologists at FGH, with two WTE vacancies.
- Consultant radiologists told us that they felt isolated and they felt the burden of interventional radiology work was not shared evenly across the trust because consultants were reluctant to travel to Barrow. At the time of our inspection a consultant radiologist from RLI had begun working in the department for one day a week and provided additional support.
- There were no specialist radiology trainees. The trust had lost accreditation with the North West Deanery but managers told us they had won this back.
- A trust-wide duty radiologist role had been introduced and all clinicians across the trust were encouraged to contact the person identified on the rota for advice and guidance rather than approaching individuals. This was a relatively new initiative and not all clinicians were compliant. However staff told us it was reducing interruptions and improving the service to trust clinicians and patients.
- Radiology managers told us they used consultants with honorary contracts to provide reporting cover for nuclear medicine, head and neck and general radiology images. They also described a 'stable locum radiologist cohort' who supported the departments on a regular basis.
- Diagnostic imaging plain film reporting was outsourced from 22:00 to 08:00. The trust sent elective work to four companies on the NHS Framework for elective/routine

outsourcing. Around 26% of plain film, 15% of CT, and 26% of MR was outsourced. Additionally, 51% of nuclear medicine was reported by an external radiologist who provided reporting sessions to the trust.

Major incident awareness and training

- Managers in main outpatients told us the action they would take if there was a major incident. There was a designated allocation board in the department and outpatients would take minor injuries.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

CQC does not currently rate effectiveness for hospital outpatient and diagnostic imaging services. We found that:

- Clinics in main outpatients were well managed and organised and staff were able to plan resources effectively.
- Staff understood about consent and followed trust procedures and practice.
- Outpatient clinics ran every weekday and some specialist clinics were held each Saturday. However most activity happened between Monday and Friday 9am-5pm. Care and treatment was evidence-based and targets were met consistently. Staff were competent and there was evidence of multidisciplinary working across teams and local networks in some specialities. Doctors, nurses and allied health professionals worked well together.
- Diagnostic imaging services for inpatients were available seven days a week.
- Staff felt supported by their line managers, who encouraged them to develop and improve their practice. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.
- Radiology staff were able to explain their safety protocols and the local rules for use of equipment and practice within the area were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy.
- Competency assessments were in place for staff working in the radiology department. Staff we spoke with confirmed that they received one-to-one meetings with their managers, which they found beneficial.

Evidence-based care and treatment

- A clinical audit 2016/2017 programme was in place and documented diagnostic imaging planned audits and other speciality audit plans such as pathology and audiology.
- The Trust's Audiology Service had achieved IQIP accreditation for the last 2 years and had submitted the web based upload for year 3 assessment. The Trust is one of only 43 services throughout the UK to have attained this accreditation status. The trust told us this was the result of a significant amount of work, demonstrating that practices are embedded and services are high quality.
- Clinicians used multidisciplinary team (MDT) meetings to share experiences and bring specialty teams' attention to themes arising within the trust, regionally and nationally, national audit projects and best practice guidelines.
- Clinicians and nurses followed NICE guidelines, examples included those in dermatology for pigmented lesions and vascular clinics for varicose veins.

Diagnostic imaging:

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to Lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice.

Outpatients and diagnostic imaging

- Procedures were in place to ensure the diagnostic imaging department were following appropriate NICE guidance regarding the prevention of contrast induced acute kidney injury.
- Consultant radiologists told us and management staff confirmed they used a WHO checklist for every interventional radiology procedure. Staff had carried out an audit to check compliance with the checklist and found that all procedures underwent a check. However not all checklists were fully completed. A repeat audit was planned to be carried out in the following months.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Simple pain relief medication was administered by staff in the outpatients department if required for minor operations such as removal of skin lesions in dermatology. Records were maintained to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Nutrition and hydration

- Water fountains were provided for patients' use and there was a café staffed by volunteers where people could purchase drinks and snacks.
- We observed staff offering and providing patients with drinks and snacks when they waited for extended times within the department.

Patient outcomes

- Between April 2015 and March 2016, the follow up to new rate and Furness General Hospital has been consistently lower (better) than the England average.
- The average length of time patients waited in the department was measured by the trust as 37 minutes.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process .

Diagnostic imaging:

- All diagnostic images were quality checked by radiographers before the patient left the department. National quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part and these showed appropriate exposure levels. We saw reports to show radiation protection supervisors collated results and reported them to all staff through team meetings.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal. Appraisal rates for the main outpatient department were high and 100% of staff had completed an appraisal. Staff told us appraisals were held each year and provided an opportunity to discuss learning needs.
- The appraisal rate in the ophthalmology outpatient department was 71%. Managers told us remaining staff were booked in to have their appraisal. Competency packs were in place in the ophthalmology outpatient department, for example staff had visual acuity open learning workbooks to complete.
- Staff completed trust and local induction specific to their roles.
- There were two manual handling trainers in the outpatients department and these would be used if a manual handling risk assessment was required.
- Staff we spoke with had undertaken additional training where required and felt managers would be supportive if training was requested.
- There were link roles available in the department, for example there was a link nurse for aseptic non touch technique and a dementia champion in the outpatients department.
- Nursing staff were invited to attend chief nurse development days twice a year. Topics for the latest sessions included patient speakers on their experiences and key speakers on specialist subjects eg sepsis.

Outpatients and diagnostic imaging

- There were no established models of regular nursing clinical supervision in use in outpatients. Clinical supervision sessions provide an opportunity for reflection in all aspects of nursing practice. However, managers confirmed they were aware of this and could describe the future plans of embedding the proposed trust clinical supervision policy into the outpatient department.

Diagnostic imaging:

- Appraisal rates provided by the trust for diagnostic imaging were 67%. The use of appraisals is important to ensure staff have the opportunity to discuss their work load and any development needs or support required to help them carry out their role. Managers told us staff not yet completing an appraisal had been identified and this would be completed before the end of the financial year.
- New radiology staff were assessed against radiology preceptorship competencies and medical devices training was provided for new and existing staff. Staff were supported to complete mandatory training, appraisal and specific modality training and were timetabled as supernumerary for the first two weeks in post.
- Students were welcomed in all departments. Radiography students came for elective placements and managers told us they regularly recruited new graduates from their student cohorts.
- The department provided local rules and MRI safety training trust-wide for medical and non-medical referrers.
- Radiographers were trained to use each piece of new equipment by applications specialists from suppliers.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients and diagnostic imaging departments. Staff were observed working in partnership with a range of staff from other teams and disciplines, including volunteers, radiographers, therapists, nurses, booking staff, and consultant surgeons. Examples of this included 'one-stop' clinics for Cardiology, Respiratory, Thyroid and Urology.
- The trust provided rapid access clinics for a number of services such as Cardiology, Maxillo-facial and ear, nose and throat.
- Joint clinics were organised to care for patients with conditions that crossed specialties. An example of this was a psoriatic arthritis clinic provided by dermatology and rheumatology.
- Outpatients offered a number of minor surgery clinics across specialities and managers told us that they could refer to external services such as electronic district nursing notes as necessary.
- Dermatology outpatients provided a nurse prescribing clinic running alongside a consultant clinic at Ulverston.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- District nurses used outpatient department dressings rooms six days a week and provided postoperative dressings, minor operations nursing support, and dressings for non-housebound patients. This helped teams work more closely together and reduced community travel costs.
- Staff were seen to be working across specialties, directorates and trust sites towards common goals. They asked questions and supported each other to provide the best care and experience for the patient.
- Specialty multidisciplinary team (MDT) meetings were attended by staff from the specialist clinical areas and outpatients department including nurses, consultant leads and radiologists. These meetings were held weekly and the teams discussed management plans as well as case reviews and sharing of best practice. Examples of specialties involved in MDT meetings were cancer, paediatrics. Consultants told us these were well attended and had an educational value for everyone.

Seven-day services

- Clinics were offered between 8:30 am and 5:30 pm Monday to Friday and until 9pm on a Monday evening. There was a once a month Saturday clinic at Furness General Hospital and a once a month Saturday clinic at Ulverston community health centre.
- Daily urgent appointments were available in the main ophthalmology department and staff would put on extra clinics if required to meet demand.
- Managers displayed volunteer sheets for extra capacity clinic staffing with skill mix requirements noted. Staff could volunteer for extra shifts and were paid bank staff rates.

Diagnostic imaging:

Outpatients and diagnostic imaging

- The diagnostic imaging department provided general radiography, CT, ultrasound scanning and fluoroscopy services for outpatients, inpatients and GP patients every day. There was a rota to cover evenings and weekends so that patients could access diagnostic imaging services when they needed to.
- Magnetic resonance imaging (MRI) was provided by the trust and supplemented by a mobile scanner through a private organisation to provide a service seven days a week.
- Diagnostic imaging provided a GP walk in service for patients from 7.30am to 7.30pm every week day.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- A generic smart card was available for use in the department for staff who did not have one, this was locked in the nurse managers office and staff told us they audited this using the sign in and out sheet for the smart card. This was used when staff did not have access to a card but needed to log information electronically.
- Diagnostic results were available through the electronic system used in main outpatients and staff with login access could view results as required.

Diagnostic imaging:

- Diagnostic imaging departments used picture archive communication system (PACS) and computerised radiology information system(CRIS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- Diagnostic results, including pathology results, were available through the electronic system used in the department. These could be accessed through the system available in clinics.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make. During our inspection a radiographer raised query about an unknown referrer and the manager worked with them to establish that the referral could be accepted. They added the doctor to the list of referrers.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing, diagnostic imaging, therapy and Medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Consent forms were in use in main outpatients, for example for dermatology minor procedures or tonsillectomies. Written consent forms were scanned onto the electronic system.
- Staff in outpatients and diagnostic imaging services had undertaken Mental Capacity Act and Deprivation of Liberty Safeguards training. Staff we spoke to told us they had a basic understanding and if any queries arose in the outpatient setting they would contact the named leads within the trust for advice.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as 'good' because:

- During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions.

Outpatients and diagnostic imaging

- People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.
- Patients we spoke with were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.
- There were services to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment and were able to make informed decisions about the treatment they received.
- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk to about their condition. There was access to volunteers and local advisory groups to offer practical advice and emotional support to patients and carers.

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- Clinic names were not displayed in order to maintain privacy and confidentiality.
- Patients' privacy and dignity was respected by staff. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff were observed to knock on doors before entering and doors closed when patients were in treatment areas. However, we did notice that some rooms did not have a curtain to draw around the examination couch so it was not clear how a patient might prepare themselves in privacy for an examination.
- We spoke with nine patients and three people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department.
- Comments from the friends and family test survey were shared with staff at staff meetings and results showed 86.4% of patients were likely to recommend friends and family to the outpatient service in September 2016. This was worse than the England average of 92%)
- The departments had set aside quiet rooms where staff, including specialist nurses, could discuss results or share bad news face to face. This ensured patients could access emotional support in a timely manner.
- Managers told us a hearing loop was available in the main outpatient department and could be used if required. Staff had access to interpreter services and staff would usually organise a deaf interpreter before an appointment if possible. Chaperones were available to patients.
- Staff told us they would check that patients understood what had been said in the clinics and would support patients, families and carers during clinics.
- Outpatient services had developed 'next step' cards and these were provided to patients in clinics and provided further contact information on who to contact if they had further questions or enquiries.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and medical staff. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment.
- We observed examples in outpatients and diagnostic imaging where staff gave patients and families time and opportunities to ask questions.
- Clinical support workers frequently checked the entrance areas of clinics and checked radiology reception to greet people and assist them when necessary. Staff we spoke with described examples where they would provide further support to patients if required.

Emotional support

- We observed volunteers greeting most visitors to the department to ask if they needed help or directions.
- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, staff offered explanations or signposted them to services for advice and information.

Outpatients and diagnostic imaging

- Staff made sure that people understood any information given to them before they left the departments. Emotional support for patients was available. For example, specialist nurses worked with the clinical teams in the breast services department and were present for extra support when patients received bad news.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as 'good' because:

- The trust provided a range of specialist clinics for patients in the North West including Lancashire and Cumbria.
- We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and imaging sessions were added to meet demand and waiting times for diagnostic imaging appointments were within acceptable timescales. Patients were able to be seen quickly for urgent appointments if required.
- Clinics and related services were organised for some specialties so that patients were only required to make one visit for investigations and their consultation. Clinic and imaging appointments were rarely cancelled .
- The Trust met most referral to treatment targets (RTT) in most specialties.
- Reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for inpatients and outpatients.
- There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.
- During our last inspection we noted that there was no information available in the departments for patients who have a learning disability. At this inspection staff told us, and gave examples of how they made sure services could meet patients' individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English.
- The outpatient and diagnostic imaging departments were able to access telephone translation services, interpreters via the booking service in the contact centre and sign language specialists for patients.
- The departments recorded concerns and complaints, which they reviewed and acted on to improve patient experience.

However:

- There were some specialties where the 18 week referral to treatment targets (RTT) were not always achieved and some backlogs for follow up waiting times.
- The diagnostic imaging service had breached six week wait targets for outpatients in specialist MRI services. The target was breached from December 2015 to March 2016 and then met for the following five months. In September 2016 there was a breach by 0.04%.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department. At the time of this inspection information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic and 19.6% of clinics started later than planned.

Service planning and delivery to meet the needs of local people

- The trust served a mixed rural and urban geographical area of 1000 square miles. The trust's outpatient and diagnostic imaging services were located throughout the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Services were planned in line with regional commissioning plans and the service senior managers produced an annual business plan from the trust 5 year plan.
- Clinics were booked 52 weeks a year and the outpatient department had access to a room booking service which allowed them to monitor which rooms were available and book extra rooms for extra clinics if required.
- Outpatients offered some clinics via video conferencing and staff told us, following a positive trial, they were proposing to introduce this further.
- Clinical nurse specialists were available in some clinics.

Outpatients and diagnostic imaging

- Between April 2015 and March 2016, the trusts 'Did not attend rate' for Furness General Hospital was lower (better) than the England average.
- One stop minor surgery outpatient clinics were available at the service; the benefit of these clinics was that patients who required minor surgery would have their appointment time reduced by attending these clinics.
- The Ophthalmology outpatient clinic was expanding its service to evenings and weekends to address demand. The service had also developed five new pathways where patients could be seen in the community. The benefit for patients of this service was that they were able to seek the required service closer to home. The service had worked with a number of external community services to develop these pathways. The department were able to refer patients to the external community clinics and refer back to the hospital service if required.
- The outpatients department flexed capacity and staffing to meet demand. Extra clinics were added to ensure provision met demand.
- Clinics were organised to meet patients' needs. Some specialist one-stop clinics were organised so that all investigations and consultations happened on the same day. Clinicians, nurses and therapists carried out joint assessments and treatment and regular Saturday morning clinics were scheduled.
- Staff meetings were held first thing in the morning to plan for the day ahead. They discussed each clinic taking place and highlighted concerns such as patient numbers or cancellations.
- Managers told us that the trust were exploring moving more outpatient sessions from the hospital to community to bring care closer to the patient's home. Staff were aware that this system would involve working with a wider range of commissioners and community services because it would involve treating patients from across trust borders.
- Outpatients and diagnostic imaging departments were responsive to requests from clinicians to accommodate patients on 2 week waits and short notice additional clinics.

Diagnostic imaging:

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- The radiology department had dedicated porters who supported patients and staff to ensure patients were in the right place at the right time for their procedure. They transported inpatients to and from wards and we saw no backlogs of patients on beds or trolleys during our inspection.
- Digital dictation was used in diagnostic imaging to enable a swift turnaround for reports and letters. Urgent reports were flagged for prioritisation Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements.
- Consultant radiologists worked across divisions to identify examinations that did not require radiologist reporting such as routine orthopaedic films an chest x-rays for respiratory clinics. Specialty teams had agreed that when they did require specific images to be reported they would request them specifically.
- The trust had reconfigured its interventional radiology (IR) service. In the month prior to our inspection there had been a regional agreement that another local trust would provide for nephrostomy and trauma patients. This had been provided on weekdays only but was due to be available 7 days a week. Radiologists were unable to provide IR for patients with suspected gastrointestinal haemorrhage. The trust had agreed that the pathway for these patients would be for endoscopy as the first investigation.

Access and flow

- Between August 2015 and July 2016, the trusts referral to treatment time (RTT) for non-admitted pathways for outpatient services was better than the England overall performance. The latest figures for July 2016 showed 92% of this group of patients were treated within 18 weeks.
- Between August 2015 and December 2015 the trust's referral to treatment (RTT) time for incomplete pathways achieved the national standard of 92%. It had then been below the national standard since January 2016.
- Between January 2016 and July 2016 there were 64299 appointments from referral to first attended appointment in outpatients. Of these, 71% of patients were seen within 5 weeks of referral, 18.52% of patients were seen between 6 and 11 weeks, 6% were seen between 12 and 17 weeks and 4% were seen over 18 weeks.

Outpatients and diagnostic imaging

- The 2 week wait from GP urgent referral to first consultant appointment figures varied between quarter 2 2015/2016 and quarter 1 2016/2017. 91% of patients were seen within 2 weeks in quarter 2 2015/2016 and 93% of patients were seen within 2 weeks in quarter 3 of 2015/2016. The trust achieved the 2 week standard in quarter 4 of 2015/2016 with 95% of patients seen within 2 weeks and the trust achieved the 2 week standard in quarter 1 of 2016/2017 with 97% of patients seen within 2 weeks.
- The trust achieved the standard of 96% for the percentage of people waiting less than 31 days from diagnosis to first definitive treatment between quarter 2 2015/2016 and quarter 1 2016/2016. The trust were at 99% or above between these periods.
- The trust achieved the operational standard of 85% of percentage of people waiting 62 days from urgent GP referral to first definitive treatment between quarter 2 of 2015/2016 and quarter 1 of 2016/2017. The trust achieved 86% or above during these periods.
- Information provided by the trust showed that 12% of patients waited longer than 30 minutes to see a clinician once in clinic and 20% of clinics started later than planned. We observed patients waiting for three outpatient clinics for over 40 minutes. Nursing staff informed patients of the waiting times verbally and displayed information on boards in the waiting areas.
- Two patients told us that they had received a telephone call the day before their appointment to ask if they could attend clinic earlier in the afternoon. Both patients were pleased they could come earlier in the afternoon, even with a wait of about 40 minutes to be seen.
- The most commons reasons for clinic cancellations were annual leave, clinic slot cancellations and care provider unavailable.
- Ophthalmology outpatients did not always meet referral to treat (RTT) targets, for example RTT data for August 2016 provided by the trust showed ophthalmology RTT performance at 85.8% across the trust. Follow up appointment waiting times were not always met. This data reflected trust wide referral to treat information
- Extra clinics had been introduced to clinics such as ophthalmology to address appointment waiting times.
- Staff described ophthalmology outpatient capacity as “a challenge”. We were told the clinics did not generally exceed the referral to treat 18 week targets. However some specialist clinics did exceed them . Data provided by the trust showed that there were a number of patients waiting over the 18 week referral to treat target for appointments and follow up appointment capacity was’ a challenge’. Extra clinics were added to address appointment waiting times. The trust provided information which detailed the reasons for the failure to meet RTT targets which were medical staff vacancies and capacity and demand and some of the action being taken to address the RTT position such as a business case for more staff.
- There were surgical and medicines clinics that were breaching RTT targets, However these were managed by the individual speciality directorates.

Diagnostic imaging:

- Radiology managers told us diagnostic imaging waiting times, measured over all sites, from all urgent and non-urgent referrals met national targets except for some CT and MRI scan appointments. Average wait times across all modalities for 2 week wait patients ranged between 3.9 days and 12 days. For inpatients, the average wait for a scan ranged between 0.2 days for general radiology to 1.5 days for MRI. Average wait times for emergency patients ranged between 0 days for general radiology, CT, fluoroscopy and obstetrics to 8 days for nuclear medicine.
- Managers told us that they had received very positive comments from other departments and specialties on their performance in providing a good and prompt service to meet targets. These included Accident and Emergency imaging and reporting as well as timely imaging for specialties to support referral to treatment targets.
- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and 7-day working arrangements. They organised additional CT sessions to accommodate urgent diagnostic imaging requests as necessary.
- In the diagnostic imaging department, reporting times for urgent and non-urgent procedures consistently met national and trust targets for all scans and x-rays for inpatients and outpatients.
- On the day of our inspection the breast screening clinic was a busy, single handed service but good appointment planning and vetting of referrals by the radiographer ensured good flow and limited waiting times for patients.

Outpatients and diagnostic imaging

Meeting people's individual needs

- There were a number of information leaflets provided in the outpatient waiting areas. Staff told us they could request and print easy to read leaflets if required.
- Staff told us the butterfly scheme for dementia patients was in use and the department had a link nurse for dementia. Staff did not always have to rely on referrers or those accompanying patients to inform them if a patient required extra support; the butterfly label was attached to patient notes and nursing homes often sent a dementia passport.
- The department had access to yes and no cards, pain scale cards and body charts for patients' use. There were health education leaflets and dietary leaflets in place. Signs for toilets and x-ray were in dementia-friendly colours (yellow and black).
- Patients were offered a choice of appointments where possible and could attend a different trust site if requested.
- Staff could access private areas to hold confidential conversations with patients if necessary and receptionists informed staff quickly if patients had communication difficulties.
- Staff told us they would regularly show anxious patients around the minor operations areas in the department. They told us that a visit and a chat with staff prior to their appointment was usually enough to reduce a great amount of anxiety on the day. This reduced stress for the patient, potential last minute cancellations, and the amount of time taken for the procedure and, therefore, shorter waits for other patients.
- Breast screening service offered a one-stop-shop approach to appointments where all investigations and consultations were carried out on the same day and patients left with a diagnosis and treatment plan.
- We saw that colorectal nurse specialists offered a stand-alone drop in stoma clinic. Following colorectal surgery, patients were provided with a leaflet giving them information about accessing the clinic, locations and contact numbers. Staff told us, on average, seven or eight patients attended a two-hour drop in session for advice and care with skin concerns, problems with stoma bags, referrals to other agencies, psychological issues and appliances. Staff told us this clinic was more time effective than trying to visit the same number of patients at home within two hours. Patients could access care quickly without having to wait for an appointment and staff had time available to visit patients who could not travel to the hospital.
- Staff offered food or a snack and regular drinks to patients who were required to be at the hospital for long periods of time, for example those with multiple appointments or waiting for ambulances.
- We observed a prisoner with escorts using separate areas of the department for their dignity and to respect the anxieties of others.
- Bariatric and high rise furniture and equipment was available and accessible.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets.
- Patients could access free internet via WIFI throughout the departments.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. However booking staff had to rely on GPs and hospital referrers ensuring that the trust were aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality.

Diagnostic imaging:

- Patients with complex individual needs such as those with learning difficulties were given the opportunity to look around the department prior to their appointment. Staff could provide a longer appointment or reschedule an appointment to the beginning or end of the clinic.
- There were separate toilets and waiting areas for patients who had received radioactive injections. This reduced the risk of radioactive exposure to visitors and ensured correct waste procedures were adhered to.

Learning from complaints and concerns

- Outpatient services at Furness General Hospital had received 16 complaints and diagnostic imaging had received 4 formal complaints between April 2015 and March 2016. Furness General Hospital took an average of

27.63 days to investigate and close complaints. This complied with the trust policy, which states that complaints should be signed off within 35 days from receipt of complaint, unless a different timescale has been agreed with the complainant.

- The main themes highlighted on complaints were centred on patient care, and delays to treatment.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at local team meetings, actions agreed and any learning was shared.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint.
- Patient advice and liaison information regarding complaints was on display throughout the outpatient departments.
- Outpatient services had developed 'next step' cards and these were provided to patients in clinics and provided further contact information on who to contact if they had further questions or enquiries.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as 'good' because:

- The management structure was clear and all outpatient main services were managed by one division with one common goal. Managers and staff talked of the trust's recent difficulties and their vision for the future of the departments. They were aware of the risks and challenges. Staff we spoke with felt supported by their local team leaders and managers, who encouraged them to develop and improve their practice. Staff worked well together as a productive team and had a positive and motivated attitude. Teams were involved in planning improvements for departments and services.
- There was good communication between specialties and directorates and staff. Staff felt proud to work for the trust and felt they provided a good service to patients. They were frustrated about past problems and the continuing poor public perception of the trust.
- There was an open and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.
- There were systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments.
- Local managers were active, available and approachable to staff. Business continuity plans had been developed to manage incidents, accidents and risks. Individual departments had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.
- Regular daily meetings took place in all departments where anticipated problems were discussed. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were mainly supportive of staff who wanted to work more efficiently and were able to develop to improve their practice, be innovative and try new services and treatments.
- We found that risks identified during our inspection were on the risk register. At previous inspections we had not seen evidence of clear plans to mitigate the identified risks. However, at this inspection there were clear plans for positive change.

However:

- Some staff told us that because of prolonged shortages in staffing they felt stretched with no room for additional work or stresses to the departments.

Vision and strategy for this service

- The core clinical services division had a vision which was 'providing the best services in the right time and place'. A core clinical services business plan was in place for 2016/2017 and included outpatients and diagnostic imaging. The plan set out service development plans for outpatients and radiology services. Most staff we spoke with were aware of the values and vision of the trust and the 'better care together' strategy.

- Staff told us that senior managers were approachable to ask questions or discuss their concerns.
- Staff told us that they had a flexible and effective room utilisation plan and full control to make decisions on how to use the rooms. Clinical specialty staff worked with outpatients department managers to inform them when rooms were not required thus freeing up space for other teams.
- The outpatient department were working towards 'choose and book' as part of the development.
- Staff told us they regularly planned for the future with the aim to provide an efficient, safe and cost effective service. The dermatology team were in the process of developing a weekly nurse led surgery clinic and they were reviewing and redesigning surgical instrument packs.

Diagnostic imaging:

- The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.
- The trust had a strategy for the introduction and continued use of more efficient and effective working using information technology such as electronic records and digital dictation systems. A new picture archiving and communication system (PACS) had recently been introduced and training was underway for staff across all trust sites. The system had been upgraded through a regional collaboration with other local trusts. Staff understood that the new system would improve accessibility and remote reporting in the future, although this depended on suitable broadband width especially in rural areas.
- Department managers had produced a business plan to replace the existing but inefficient gamma camera with a PET CT scanner. This would be more effective in meeting the future needs of the service.

Governance, risk management and quality measurement

- At our last inspection we found that the trust's governance and management systems were not fully embedded in all parts of the service and not all services were following trust policies and procedures. At this inspection we found evidence from board level to conversations with support staff that improvements had been made across all areas.
- Managers we spoke with were able to describe the risks and challenges to their services and the action being taken to mitigate risks. Risks described such as staffing were documented on the risk register. Risks were discussed at the monthly division governance assurance group meeting which outpatient and diagnostic service managers attended. The core clinical services risk register was reviewed monthly. Staff reviewed risks, produced action plans and closed risks accordingly.
- Learning from risks was shared across the organisation via newsletters, regular staff team meetings, and staff communication emails.
- There were governance arrangements in place for outpatients and diagnostic imaging. Governance was discussed at the division governance assurance group who would then escalate governance concerns to the weekly patient safety summit, the trust quality committee which in turn was escalated to the trust management board. Staff told us that mortality reviews also fed into this group.
- The core services division had a governance lead and deputy governance lead in place. Managers attended monthly executive meetings to discuss targets, risks and achievements. The deputy director of finance and chief operating officer attended divisional management team meetings.
- The main outpatient department used the 'WESEE' document to record meetings and this included sections to follow such as workforce and staffing, and training issues.
- The service managers led finance and workforce 'check and challenge' meetings and staff voices with staff side representatives. Managers told us the aim was to encourage open dialogue.
- Managers in the main outpatient department were the governance lead for the department. Managers received weekly performance reports which documented mandatory training and other operational reports. Managers from each service within the division attended a monthly divisional governance and assurance group meeting. Information from this meeting would then be feedback to staff in the departments.
- Diagnostic imaging had a separate risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and radiology protection specialists.

Outpatients and diagnostic imaging

- In diagnostic imaging radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the patient safety manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included radiology related stroke thrombolysis and non-thrombolysis imaging times.
- Within the diagnostic imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example. CT urograms had replaced IVUs (intravenous urograms) following a national audit on the prevention of contrast induced acute kidney injury.

Leadership of service

- Department managers and team leaders told us they felt supported by senior managers and that senior members of staff were accessible if required.. Department managers told us they regularly visited the different trust sites and we were told there were no communication challenges between the different hospital sites.
- Managers at Furness General Hospital told us they encouraged staff to develop and encouraged further training in staff. An example was to support registered nurses in the vascular clinic who would be able to assist further, for example in bandaging. Tissue viability staff had been asked to provide support and train nurses in this. Staff were also encouraged to develop if they had a particular area of interest.
- Staff found the local managers of the service to be approachable and supportive.
- Outpatients staff told us their managers had an open door policy and would attend the other site they managed at Ulverston Hospital around once a month. However, staff told us they were always available on the telephone if required.
- Many staff we spoke with told us that they had worked at the hospital for many years. We observed good, positive and friendly interactions between staff and local managers.
- Staff felt that line managers communicated well with them and kept them informed about the day to day running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff told us they were able to access training and development provided by the trust. However, some staff had not been able to access funding from the trust or time to be released for external courses.
- Staff told us that the executive team sent out regular communications to staff.

Diagnostic imaging:

- Staff told us diagnostic imaging department leadership felt stable and was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train more staff.
- Staff told us they saw the divisional management team regularly. The clinical director had a clinical role as well as senior management responsibilities so understood the needs, priorities and pressures on staff within the department.
- Consultant radiologists told us that the communication style of the new clinical director was better than previously and interpersonal relationships had improved.
- Most of the staff we spoke with told us they were content in their role. However, the department, especially CT, had been short staffed all of the previous year and demand had increased. CT staff told us they found it increasingly difficult to work additional shifts.
- Diagnostic imaging department leadership was positive and proactive. Staff told us that they knew what was expected of staff and the department and that every effort was being made to recruit and train more staff.
- Managers told us that IR(ME)R incidents were never looked on as a reason to apportion blame but as an opportunity to learn. Staff involved completed a reflection exercise and learning points were disseminated in team meetings and a 'Learning to Improve' bulletin.

Culture within the service

- Staff were proud to work at the hospital. They were passionate about their patients and felt that they worked in highly skilled teams. Staff told us that they would be proud if members of their family were cared for by staff in the department. However, some staff told

us they felt frustrated that the hospital's reputation was still poor following previous inspections and reviews. They told us this caused additional stress and strain on morale in very busy departments.
- Department managers told us that there were formal team meetings. However, they said it was difficult to have a set team meetings regularly.
- Staff we spoke with told us their teams were good, supportive and they enjoyed their role. Staff felt respected and valued by managers.
- Managers told us they encouraged team work throughout the outpatient departments and that, because of this approach, the culture had improved. Managers felt there was openness and honesty. They said that in general staff embraced change, could see the overall picture for improvements and contributed to a 'can do' culture.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- We were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.

Diagnostic imaging:

- Diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities and suggest changes.
- Department managers told us that there were formal team meetings. Teams would have team meetings on trust audit days.

Public engagement

- Outpatients and diagnostic imaging had used feedback forms to seek patient views and feedback. These were available in the waiting areas of all departments. Staff were able to give us working examples of changes that had been made following patient comments.
- Outpatients departments had received donations from the public including picture frames for photographs and radios in dermatology.
- The hospital League of Friends provided £7,600 for a new theatre couch for the biopsy room.

Staff engagement

- Staff in all departments told us team leaders encouraged staff to share ideas and support staff in implementing new ideas to benefit the service provided.
- Staff told us main outpatients and diagnostic imaging managers shared new information and news with staff through team meetings. Information was attached to the appendix of meeting minutes and staff signed an attendance document so managers knew information and minutes had been read.
- The main outpatient department at Furness General Hospital had undertaken a staff survey to gather staff views on outpatient improvements. This provided a platform for staff to raise improvement ideas.
- Staff told us they held staff huddles each morning. We saw evidence of notes from meetings and information for staff on noticeboards.
- We met several volunteers who were proud to provide additional support for patients. Many volunteers were staff who had retired but wanted to continue to offer their support.
- Staff took part in fundraising for their departments. In dermatology staff had purchased dermatoscopes, weighing scales, free-standing fans, two televisions for waiting rooms, a privacy screen and extra chairs.
- Policies and procedures were available to staff via the trust intranet.
- Managers told us that staff were keen to work with consultants to develop new practices, including the extension of roles and the introduction of new procedures.
- Departmental staff liaised with specialists from other hospitals within the trust and neighbouring trusts to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.

Innovation, improvement and sustainability

- The Ophthalmology outpatient clinic was expanding its service to evenings and weekends to address demand. The service had also developed five new pathways where patients could be seen in the community. The

benefit for patients of this service was that they were able to seek the required service closer to home. The service had worked with a number of external community services to develop these pathways. The department were able to refer patients to the external community clinics and refer back to the hospital service if required.

- The department had been involved in innovative practice, for example the department had introduced 'next steps' cards which were provided to patients and contained contact details of who to contact should they have any questions.
- Anticoagultation therapists worked from the pathology service to improve guidance to clinicians and patients. They had been involved in developing pathways involving re-educating long term patients and accessing inpatients before their discharge. They had been able to demonstrate better patient compliance with anticoagulation therapy over the six to eight months the new pathway had been in place. They had developed good relationships with nursing home and residential care staff to identify vulnerable patients.
- The pathology service had achieved United Kingdom Accreditation Service (UKAS) accreditation in microbiology. They provided testing after deep cleaning had taken place in clinical areas and the biochemistry laboratory carried out Brain Natriuretic Peptide assay to quickly identify markers for heart failure which reduced the number of echocardiograms required, thus reducing waiting lists and cost. A procalcitonin study was established to improve the use of antibiotics, especially for intensive care patients, reduce resistance, costs and side effects.
- Biochemistry staff had carried out a Listening into Action project to reduce the percentage of haemolysed blood samples from patients, particularly in the accident and emergency department (A&E). They had trialled the placement of a dedicated phlebotomist for A&E during busy periods, education of staff and improvement of the process. The project had successfully reduced figures from 10 or 12% to 2%.

Outstanding practice and areas for improvement

Outstanding practice

- There were a number of outstanding examples of compassionate care and emotional support shown by all levels and disciplines of staff who did not hesitate to go the extra mile to made a difference for their patients and their loved ones;
- The medicine division delivered outstanding RTT outcomes across all specialisms despite pressures on the service overall;
- The Listening into Action programme has delivered some simple, effective and significant quality improvements for the organisation and the patients across the hospital.
- There were many examples of public engagement in the development and delivery of maternity services, such as co-designing the new maternity unit, interviews of recruitment of new staff including midwives and matrons and the development of guidelines and strategies.
- The service was one of three trusts who were successful in securing funding to pilot a maternity experience communication project. This was a patient based, communication improvement-training tool for multi-professional groups in maternity services. The project had the potential to be adopted nationally if learning outcomes and measurable improvements were made for women using maternity services.
- The bereavement team, chaplaincy and specialist palliative care team worked together to promote compassionate care at the end of life. A particular innovation relating to this had been the development of death cafes. A death café provided an opportunity for people to talk more openly about death and dying. The trust had held death café's for the public as part of dying matters week and also had used them to support staff to talk more openly about death and to promote better communication with patients and relatives at the end of life.
- There were a number of innovations relating to compassionate care for patients at the end of life. This included the use of canvas property bags with a dragonfly symbol so staff knew that the person had been recently bereaved. In addition bereavement staff sent out forget me not seeds to family members following the death of a loved one. Families were also able to get casts of patient's hands which was a service provided by an external organisation with funding for this provided by the trust.
- The trust had adopted the dragonfly as the dignity in death symbol. This was used as a sign to alert non-clinical staff to the fact that a patient was at the end of life or had died. A card with the symbol could be clipped to the door or curtain where the patient was being cared for. By alerting all staff this meant that patients and family members would not have to face unnecessary interruptions and non-clinical staff knew to speak with clinical staff before entering the room. An information card had been produced for non-clinical staff explaining the difference between the dragonfly symbol (dignity in death) and the butterfly (dementia care).
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- A remembrance service was held by the chaplaincy every three months for those bereaved. We were also told that 'shadow' funeral services had been delivered within the trust when patients had been too unwell to attend funerals of loved ones.
- Relatives were sent a condolence letter by the bereavement service a few weeks after the death of a loved one, support was offered at this time.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

In urgent and emergency care services:

- Monitor performance information to ensure 95% of patients are admitted, transferred, or discharged within four hours of arrival in the emergency department.
- Ensure patients do not wait longer than the standard for assessment and treatment in the emergency department.

Action the hospital SHOULD take to improve

In urgent and emergency care services:

- Ensure observations are recorded appropriately to allow the assessment and early recognition in the deteriorating patient
- Ensure nursing documentation is completed in accordance with the trust policy.
- Continue to ensure that staff complete mandatory training in accordance with trust policy.
- Continue to ensure equipment checks are completed consistently in accordance with trust policy.
- Ensure the regular update of patient group directions in accordance with trust policy

In medical care:

- Ensure all nursing and medical clinical documentation is completed legibly, in full and in accordance with recognised professional standards;
- Ensure multi-factorial falls risk assessments are completed in all cases where risk indicates and the same is evidenced in the electronic patient record or in the medical notes;
- Ensure robust divisional oversight of the respiratory unit at Furness General Hospital (FGH) due to shortfalls in substantive senior medical presence on-site, vulnerability of senior medical staffing and reliance upon senior locum contracts;
- Ensure where medicines are stored in fridges, temperature ranges are recorded in accordance with policy to ensure the safety and efficacy of the medicine is not compromised;
- Ensure all staff complete all elements of their mandatory training requirements and ensure accurate compliance figures are maintained;
- Ensure all staff benefit from the appraisal process and these are completed on an annual basis in accordance with local policy;
- Ensure action plans put in place to address shortfalls in local and national patient outcome audits findings are monitored and reviewed in a timely manner reasonable timeframe to ensure compliance is measured;
- Ensure there is a review of patient comments and PLACE findings regarding food quality and consider measures which may be implemented to improve nutritional care;
- Ensure staff awareness and knowledge of MCA and DoLS theory is underpinned by consideration of procedural competence in making such applications to avoid potential legislative breaches;
- Ensure all patients are aware of alternative treatment options (including risks and benefits) in addition to recommended treatment options;
- Ensure the number of patient bed moves after 10pm are kept to a minimum to avoid patient and family anxiety and distress;
- Ensure the remit of the nurse-led ambulatory care unit is fully understood by all key personnel to ensure its safety and efficiency in delivering patient care;
- Ensure the effectiveness of the new governance framework is measured and adapted accordingly;
- Ensure the effectiveness of current staff engagement themes and consider other formats which will support divisional strategy and appease staff disharmony; and,
- Ensure reasonable measures are put in place to support staff wellbeing and ensure all staff know what is available to them.

In surgery:

- Continue to improve Referral to Treatment Times (RTT) for patients and continue to implement Trustwide initiatives to improve response.
- Prioritise hip fractures (within 48 hours)
- Ensure all procedures were performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue to engage staff and encourage team working to develop and improve the culture within the wards and theatre department.

Outstanding practice and areas for improvement

- Continue with staff recruitment and retention.
- Improve the completion of NEWS.
- Improve environmental cleanliness.
- Improve the monitoring of fridge temperature and take action if temperatures exceed the expected range.

In critical care:

- There was no provision for dedicated critical care pharmacy cover at the FGH site as recommended by GPICS (2015). The critical care unit should take action to create plans that adhere to guidance.
- The unit should takeaction to improve physiotherapy staffing and be clear in how it supports rehabilitation for patients in line with GPICS (2015).
- Patients discharged from critical care should receive a ward follow up visit by critical care nurses within 36 hours of discharge, it was reported that this could not be provided consistently by staff in the unit and was affected by activity and staffing resources. Staff we spoke with were planning improvement as part of the appointment of a supernumerary coordinator. The trust should support this GPICS (2015) standard.
- The unit should continue to monitor discharges out of hours and develop actions with the trust to improve that FGH critical care discharges out of hours were 6.7% which is worse than the national average of 2.3% as reported by ICNARC for 2015/16. Discharges out of hours, between 22.00hrs and 07.00hrs have been proven to have a negative effect on patient outcome and recovery.

In maternity and gynaecology:

- Ensure that outcome measures are developed to monitor the effectiveness of the strategic partnership with Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.
- Ensure that care records (including cadiotocograph CTG's) are legible, complete, timed and dated.
- Continue to monitor the cultural assessment survey for obstetrics and gynaecology and improve values around organisational culture.

In services for children and young people:

- The hospital should ensure there is a review of all children and young people's mortality and morbidity.
- The hospital should ensure that documentation refers to Gillick competency and should ensure that staff are properly trained and confident to assess Gillick competency properly.
- The hospital should continue to ensure that communication takes place with partner agencies about the placement of CAMHS patients.

In outpatients and diagnostic imaging:

- The trust should continue to build relationships and develop closer team working for medical staff in radiology and breast services across all locations to develop a one trust culture.
- The trust should continue to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. This is particularly in relation to radiology, dermatology and allied health professionals.
- The trust should ensure it meets referral to treat targets in outpatient clinics and should ensure they address backlogs in follow up appointment waiting times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulation activity. How the regulation was not being met: The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust breached this standard between October 2015 and September 2016. It had been performing worse than the England average and this standard for all but three months of this 12 month period.