North Cumbria University Hospitals NHS Trust

Cumberland Infirmary

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Cumberland Infirmary, Carlisle provides a 24-hour A&E service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics. The hospital has 412 inpatient beds and serves the local people around Carlisle and throughout North Cumbria. The North Cumbria University Hospitals NHS Trust serves a population of 340,000 who live in a largely rural area of Cumbria. We carried out this inspection to follow up on the improvements identified as part of our last inspection of the hospital in May 2014.

Our key findings were as follows: The senior team was visible approachable and demonstrated a deep commitment to improving the quality of the services provided in the hospital. There had been a lot of work undertaken to engage and include staff in the change agenda. There was evidence that a number of significant improvements had been made and the hospital team had sustained its performance in a number of key areas. Four core services, surgery, critical care, outpatients and children and young people services had improved and were now providing good services. However, urgent and emergency care services, medical services, maternity services and end of life care still required improvement. Overall we rated the hospital as requiring improvement in the safe, effective, responsive and well led domains and good in the caring domain. The hospitals mortality rates had remained within expected limits and the processes and systems for reviewing mortality and morbidity were increasingly robust. Patients received care and treatment in a visibly clean and well maintained environment. Staff in the main, adhered to good practice guidance in the prevention and control of infection. Infection rates remained within expected limits. Care and treatment was delivered by committed and caring staff who worked well together for the benefit of patients. However managers were still faced with some substantial challenges with particular reference to the recruitment and retention of medical, nursing and some allied health professional staff. Staff shortages were having a negative impact of patients accessing and receiving treatment in a timely way.

Access and flow

- The Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival was not being met consistently. In 2014/15, Cumberland Infirmary only met the target once in July 2014 with a range over the year between 69.1% to 96.6%. Over the year, 12 patients waited for more than 12 hours from the decision to admit to being admitted. Individual breaches of the four hour target were investigated and the majority were due to patients waiting for a bed in the ward areas. Other reasons for delays included patients waiting for a specialist opinion and waiting for a mental health assessment. A norovirus outbreak in the ward areas during January to March 2015 had impacted negatively on the emergency department as it had caused additional bed shortages and longer waiting times.
- There was insufficient bed capacity in the surgical wards due to beds being occupied by medical patients. This meant that operations were frequently cancelled due to the lack of available beds. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between July 2013 and September 2014.
- Waiting times for outpatient physiotherapy were commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. On 12 December 2014 49 people were waiting over six weeks for a routine physiotherapy outpatient appointment and 42 people were waiting over one week for an urgent referral. The physiotherapy outpatient service was struggling to meet the referral rates due to low staffing numbers. These delays were having a negative effect on rehabilitation times for patients.

Summary of findings

Nurse Staffing

- There continued to be shortages of trained nursing staff on some wards. This was a particular issue in medical services .Nursing staffing levels had been reviewed and assessed using a validated acuity tool with minimum numbers set. Although nurse staffing levels had improved since our last inspection, there were still on average 3 trained nurse vacancies per ward when measured against their agreed establishment.
- In intensive care when bed numbers and/or patient acuity increased it was not always possible to maintain the Intensive Care Societies minimum nursing staffing levels and as no supernumerary clinical hours for senior nurses were built into the staffing rota should patient numbers and acuity demanded the nurse in charge would need to care for a patient compromising their management and clinical supervisory role.
- A rolling recruitment programme to fill nursing posts was on going. Several new initiatives had been implemented. However the outcome of these initiatives was not evident at the time of our inspection.

Medical Staffing

- The levels of substantive medical cover on the medical wards remained insufficient to provide a safe and effective service and in February 2015, four out of ten consultants in on call positions were filled by locums. Three long term locums contributed to the out of hours on-call rota. There were no short term consultant locums on-call out of hours at the time of the visit.
- Fifteen out of 36 resident medical doctors were locums. Registrar, core trainee (CT) and foundation doctor rotas for the front and back of house within Medicine were all populated from substantive staff but occasional gaps had been covered by substantive clinical fellows.
- There were 7.6 whole time equivalent surgical consultant vacancies. Staff rotas were maintained through the use of locum and agency consultants. Where locum doctors were used, they were subject to recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The clinical business unit director for surgery and anaesthetics confirmed that the majority of locum and agency doctors had worked at the hospital on extended contracts so they were very familiar with the hospital's policies and procedures and applied them appropriately.
- The intensive care service had access to a consultant and middle grade anaesthetist at all times although out of hours the middle grade anaesthetist had on call responsibilities for other specialties such as theatres and maternity. This meant that potentially a patient could find themselves waiting in an emergency for appropriate medical attention. This was discussed with the medical director at the time of the inspection who took remedial action to increase anaesthetist cover and mitigate this risk.

Meeting Patients Needs

- As a result of targeted work by managers the availability of case notes being available for a patient's consultation in outpatient clinics had significantly improved from 75% to 95%.
- Referral to treatment times for diagnostic tests had improved and were close to meeting national targets but up to December 2014 the percentage of patients waiting longer than 6 weeks for diagnostic tests was almost 12% against a target of less than 1%.
- The waiting time for outpatient physiotherapy was commonly longer than four months for a routine referral and over three weeks for urgent referral against a desired target of one week. The physiotherapy outpatient service was struggling to manage referrals in a timely way due to low staffing numbers. These delays were having a negative effect on rehabilitation times for patients.
- The surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014.
- In 2014/15, Cumberland Infirmary only met the Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival, once in July 2014 with a range over the year between 69.1% to 96.6%. Over the year, 12 patients waited for more than 12 hours from the decision to admit to being admitted. Individual breaches of the four hour target were investigated and the majority were as a result of patients waiting for a bed in the ward areas.

Summary of findings

- There had been only one further 'never event' reported relating to radiology services at the hospital in April 2014.

Effective Care

- Outcomes for stroke patients between April to September 2014 had improved with the Sentinel Stroke National Audit Programme (SSNAP) showing the trust's stroke services moved from an 'E' rating to a 'D' on a scale of A to E, with A being the best.
- The latest National Diabetes Inpatient Audit (NADIA) 2013 showed that the hospital was performing below the England average in 10 of the 21 indicators and was unchanged from the previous inspection.
- Submission of data to the Intensive Care National Audit and Research Centre (ICNARC) was now consistent.

Competent staff

- Staff carried out skills training in the management of maternity emergencies. Not all midwives or doctors were up to date with this training which meant they not be able to respond as necessary in an emergency. The last practice drill for evacuating a patient from the birthing pool could not be given. A new safety net for this purpose had been purchased but staff had not practised using this equipment in an emergency.
- Concerns raised at the last inspection relating to the mortuary had been addressed and porters had received training in the transfer and care of deceased patients. Equipment in the mortuary had been replaced, a manual to explain about last offices had been developed by the Bereavement and End of Life Group and the mortuary now adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.
- We saw 12 "do not attempt cardio-pulmonary resuscitation" (DNACPR) forms some of which were inconsistently completed. This was supported by the Trusts annual audit figures for DNACPR which showed 170 forms out of 542 forms were not fully completed. This could result in inappropriate resuscitation taking place and the hospital was addressing this through training and further audit.

We saw areas of outstanding practice including:

- The medical Oncology / Chemotherapy / Radiotherapy unit where we saw a cohesive team delivering best practice to this vulnerable group of patients. There were no delays in access to treatment. National guidelines were readily available and utilised. Patients spoke very highly of the standard of care they received.
- The midwife to birth ratio was 1 to 25. This was better than the England average which was 1 to 28. All patients had one to one care during labour. The midwifery staffing numbers were above the National recommendations.

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

Urgent and Emergency care

- Improve performance against the DH target for emergency departments to admit, transfer or discharge patients within four hours of arrival
- Improve the rates for consultant led trauma teams being ready for patients with an injury severity score greater than 15 on arrival (currently 41%).
- In relation to NICE clinical guideline CG16 (Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) increase the number of patients who receive a clear risk assessment (currently 22%).

Medical Care

- Improve the number of substantive medical posts.
- Improve nurse staffing levels
- Improve safety thermometer results particularly on Elm B ward.
- Improve performance in relation to the care and treatment of patients with diabetes.

Summary of findings

- Reduce the pressures on the availability of medical beds which resulted in patients regularly being cared for on wards outside of their speciality.
- Stop moving patients during the night without a medical reason for doing so.
- Provide effective leadership for the newly created team of nurse practitioners.

Surgery

- Improve the recruitment of medical and nursing staff.
- Improve compliance against 18 week referral to treatment standards for admitted patients.
- Improve number of patients whose operations were cancelled and were not treated within the 28 days.
- Develop a strategic plan specifically for surgical services.

Critical care

- Ensure there is access to a consultant and middle grade anaesthetist out of hours who do not have on call responsibilities for other specialities such as theatres and maternity.

Maternity and Gynaecology

- Ensure the epidural service is available though plans in place to introduce this in September 2015.
- Ensure staff are trained in the management of maternity emergencies.

Services for Children

- Improve the staffing position regarding the continued shortage of junior medical staff and the provision of 24-hour paediatric consultant presence on the hospital site which remained a concern as the service still offered a 24 hour emergency service for Children and young people.
- Conclude the children's and young people's service review in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources.

End of Life care

- The Trust needs to liaise with CPFT to ensure that the substantive consultant post for Specialist Palliative Care is recruited to.
- Address the Trusts annual audit figures for DNACPR which showed 170 forms out of 542 forms were not fully completed.

Outpatients and diagnostic imaging

- Improve the percentage of patients waiting longer than 6 weeks for diagnostic tests which is currently almost 12% against a target of less than 1%.
- Improve waiting times for outpatient physiotherapy which are commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week.

In addition the trust should:

Medical

- Continue to improve the quality of care and treatment provided to patients who have suffered a stroke.

Critical Care

- Review the nurse staffing ratios at times of high acuity of patients.

Maternity and Gynaecology

- Mitigate against the security and privacy issues in the maternity ward due to the layout of the environment.

End of Life care

- Provide a bereavement office on site.

Summary of findings

Outpatients and diagnostic imaging

- Continue to improve referral to treatment times.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Our previous inspection in April 2014 found that access to the service and patient flow through the department continued to be challenging. The Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival was not being met consistently. There had been occasions when patients had to be accommodated in A&E overnight, and there were no standard operating procedures in place for staff to follow. In the course of this inspection we found that the Department of Health target was still not being met consistently. A norovirus outbreak in the ward areas from January to March 2015 had also impacted negatively on the emergency department and patients spent longer times in the department due to the reduced bed base. There was a risk-aware culture and evidence of learning from incidents. Patients received care in a clean and suitably maintained environment with the appropriate equipment. Medicines and records were managed effectively and safely. Staff were aware of the safeguarding policy and reported concerns appropriately. Staffing levels were sufficient to meet patients' needs. An initiative to recruit paramedics into band 5 nursing equivalent roles was proving successful. The department participated in national and local audits. Patients spoke positively about the care and treatment they had received and staff treated patients with dignity, compassion and respect. Senior staff in the department provided visible leadership, particularly at times when the department was stretched.
Medical care	Requires improvement 	At our previous inspection in April 2014 we found shortages of both nursing and medical staff throughout the medical directorate combined with high nursing sickness and absence rates was having a negative impact on patient care and experience. In the course of this inspection the levels of medical cover at the hospital remained insufficient to provide a timely and effective service to patients.

Summary of findings

In addition, it was not possible for junior medical staff to access consistent and effective leadership and support as a result of shortages of senior medical staff within the specialties.
There continued to be shortages of trained nursing staff on some medical wards. Nursing staffing levels had been reviewed and assessed using a validated acuity tool with minimum numbers set. Although nurse staffing levels had improved since our last inspection, there were still on average 3 trained nurse vacancies per ward when measured against the agreed establishment. In practice, there were frequently times where ward managers escalated staff shortages and the senior nursing team was unable to respond appropriately and this meant there were times when the wards were not appropriately staffed.
We also found there were shortages of some essential equipment and the way medicines were stored required improvement.
Wards were visibly clean, infection rates for Clostridium difficile and MRSA were within expected ranges.
Services were delivered by caring and compassionate staff. Pressures on the availability of medical beds resulted in patients regularly being cared for on wards outside of their speciality. Systems in place for the routine review of these patients varied and required improvement. There was delay in the relocation of patients who had been transferred out of the area for specialist treatment. Patients continued to be moved during the night without a medical reason for doing so.
Referral to treatment times were meeting standards in all medical specialties except dermatology and rheumatology, Performance was particularly poor with no patients seen within 18 weeks. There had been a deteriorating trend in the referral to treatment times across the medical specialities throughout the last year.

Surgery

Good

During our previous inspection in April 2014, we found the surgical services at this hospital required improvement. In the course of this inspection we found that there had been a number of improvements in the service and that overall rating for the service was good.

Summary of findings

The staffing levels and skills mix was sufficient to meet patients' needs. Although there were nursing and medical staff vacancies across the surgical services at the hospital, there were plans in place to address these. Funding had been secured for the recruitment of nurses and there were plans to recruit additional overseas nurses during July 2015. The staffing levels in the wards and theatres were suitably maintained through the use of bank and agency staff, as well as existing staff working additional hours

Patients received care in safe, clean and suitably maintained premises. There were systems in place for the escalation of patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Patient safety was monitored and incidents were investigated to assist learning and improve care.

The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. The audit records for indicated a high level of compliance. The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits and performance was in line with similar sized hospitals and the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements. The majority of patients had a positive outcome following their care and treatment. Patients were treated with dignity and respect by caring and committed staff.

However, the surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014. There was insufficient bed capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled due to the lack of available beds. . Tis meant care and treatment were not

Summary of findings

always provided in a timely way. There was effective teamwork and visible leadership within the surgical services. The majority of staff were positive about the culture and support available.

Critical care

Good

The previous inspection in April 2014 identified improvements required in the submission of data to the Intensive Care National Audit and Research Centre (ICNARC).We found at this inspection the unit consistently collected and submitted ICNARC data for validation,. The data confirmed that patient outcomes were within the expected ranges when compared with similar units nationally. However, we did identify some concerns regarding nursing and medical staffing that required some improvement. In the course of the inspection we found that there were sufficient numbers of suitably skilled nursing staff to care for the patients. We saw that when bed numbers and/or patient acuity increased it was not always possible to maintain the Intensive Care Societies minimum nursing staffing levels. In addition, there were no supernumerary clinical hours for senior nurses built into the staffing rota. In effect this meant that if patient numbers and acuity demanded then the nurse in charge would need to care for a patient and their ability to fulfil the management and clinical supervisory role in the unit was compromised.
There was access to a consultant and middle grade anaesthetist at all times although out of hours the middle grade anaesthetist had on call responsibilities for other specialities such as theatres and maternity. This meant that potentially a patient could find themselves waiting in an emergency for appropriate medical attention. We raised this with the trust at the time of our inspection who took immediate action to improve anaesthetic cover. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was shared and evaluated. Care was delivered by caring, compassionate and committed staff and patients, their relatives and friends were treated with dignity and respect. Patients and those close to them were positive about the care and treatment provided by the Critical Care Team.

Summary of findings

Maternity and gynaecology

Requires improvement

At the previous inspection in April 2015 we found that the maternity service was delivered by committed and compassionate staff that treated patients with dignity and respect. The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. However, we found that the risks identified were still in place and sufficient actions to mitigate them had not yet been implemented.

In the course of this inspection we found that an epidural service remained unavailable although plans were in place to introduce this in September 2015. There were still inadequate medical staff numbers to provide sufficient out of hours cover.

The midwife to birth ratio was 1 to 25. This was better than the England average which was 1 to 28.

All patients received one to one care during labour

One never event had occurred in the service in April 2014. Learning from this incident had been shared, however, managers were unable to provide information that the use of the five steps to safer surgery, which would help mitigate the risk of recurrence of this event.

There were concerns regarding medicines management and how learning from errors was managed and applied.

Staff carried out skills training in the management of maternity emergencies. However, not all midwives or doctors were up to date with this training which meant they not be able to respond as necessary in an emergency.

Care and treatment was delivered in accordance with National Evidence based guidance. There had been an increase in the clinical and quality audits completed however in the maternity service actions for improvement and change were not always evident.

Although consultation about the future of the service with the local population had increased since the last inspection Staff reported a lack of visibility of the senior management team at this hospital site and a lack of clarity regarding future plans.

Summary of findings

Services for children and young people

Good

The service for Children and young people had improved since our last inspection. There had been improvements to reduce the risk of avoidable patient harm. Resuscitation equipment had been improved and was regularly checked and available for use. Incident reporting was better managed and learning from incidents shared and applied. Child Safeguarding was well managed and supported by staff training. Interagency working in this regard was well established.

Nurse staffing levels had improved and all the wards were adequately staffed, although there was still a shortage of junior medical staff that meant consultants were filling in some aspects of the junior doctor's role. Consultant paediatric cover was provided from 9am until 10pm at night with a consultant on call. Consultants often remained on site out of hours to support the care and treatment of sick children.

Care and treatment was delivered in accordance with NICE guidance. Readmission rates were now within national averages. There was a visible, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive.

Performance against an agreed set of indicators was monitored monthly and actions taken to secure performance improvement where appropriate.

The service was under review and a number of service models were being considered and evaluated in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. A decision about the future of children's care across North Cumbria including the acute paediatric elements had not been reached by commissioners at the time of our inspection.

End of life care

Requires improvement

As part of our previous inspection in April 2014 we found a lack of a trust wide vision and strategy for end of life care including governance and assurance mechanisms. There was a lack of executive leadership, substantive consultant leadership and DNACPR records lacked consistency and accuracy. There was no bereavement office and infection control and equipment concerns were identified. At this inspection we found that the concerns raised at

Summary of findings

the last inspection relating to the mortuary had been addressed and porters had received training in the transfer and care of deceased patients. Equipment in the mortuary had been replaced, a manual to explain about last offices had been developed by the Bereavement and End of Life Group and the mortuary now adhered to infection control procedures. A risk assessment was undertaken on all patients who had died from blood borne diseases.

Space had been identified to develop a bereavement office on the site. A bereavement Information booklet was not yet completed though this would be available in the near future.

In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plan had been developed. This was in a draft format. A pilot study of this had taken place in two wards at the Cumberland Infirmary but this had not yet been implemented fully.

The substantive consultant post for specialist palliative care post had yet to be filled as the trust was experiencing difficulties in recruiting and Do not attempt cardio-pulmonary resuscitation" (DNACPR) forms were still inconsistently completed.

The Trust had reviewed how it was going to provide and enhance care provision for patients at the end of their life. A draft End of Life Strategy which had recently been disseminated.

Arrangements were being developed so the Trust Board received an annual report outlining progress against key priorities articulated within the strategy.

An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration staff, porters and other external providers of care. The Director of Nursing had taken the executive lead role for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and addressed at board level.

Outpatients and diagnostic imaging **Requires improvement**

At our previous inspection we found elements of this service to be inadequate, notably the availability of patient records when attending for a consultation. In the course of this inspection we

found that as a result of targeted work there had been a significant improvement in this regard. 95% of patient records were now available for their appointment.

The introduction of a team to support and the hub had provided the infrastructure to deliver this important element of the service. Staff were very positive regarding this major improvement and the impact it was having on performance and patient experience. The introduction of the contact centre was beginning to address the appointment delays. This had only been in place for five weeks however this was already having a significant impact on the service. Referral to treatment times were close to meeting national targets but up to December 2014 the percentage of patients waiting longer than 6 weeks for diagnostic tests was of concern. Waiting times for outpatient physiotherapy were commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. The physiotherapy outpatient service was struggling to meet the referral rates due to low staffing numbers. These delays were having a negative effect on rehabilitation times for patients. Patients still frequently overran and patients could wait for extended periods of time to see their doctor. Staff interactions with patients were observed to be professional, compassionate and caring.

Staff provided patients with privacy despite the lack of available space in some areas. We noted "Laurens Room" as an area of good practice which provided privacy and dignity for patients receiving difficult messages.

The vision and plans for the service was clearer, there was an OPD Improvement strategy and a comprehensive improvement plan in place. Staff reported feeling involved in the changes and supported by their line managers.

Cumberland Infirmary

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 Cumberland Infirmary

The Cumberland Infirmary is a general hospital based in Carlisle. Along with the West Cumberland Hospital in Whitehaven, the hospital delivers acute care services as part of North Cumbria University Hospitals NHS Trust. The Cumberland Infirmary, Carlisle provides a 24-hour A&E service with Trauma Unit status, a consultant-led maternity service and special care baby unit, a wide range of clinical services, including delivering complex vascular and general specialist services, and outpatient clinics.

We carried out this comprehensive inspection as a follow up to a previous inspection of North Cumbria University Hospitals NHS Trust in April 2014 which at that time had been identified as a high risk trust on the Care Quality Commission's (CQC) Intelligent Monitoring system. The trust was also one of 11 trusts placed into special measures in July 2013 following Sir Bruce Keogh's review into hospitals with higher than average mortality (death) rates.

We looked at how the trust had responded to the inspection report findings as part of this inspection.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, North Region, Care Quality Commission

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two Inspection Managers, nine CQC inspectors and a variety of specialists including Clinical governance experts; a safeguarding expert; Clinical Manager NHS 111 / Advanced Care Paramedic; Consultant in Palliative Care; Honorary Consultant Physician; Professor of Surgery; Consultant Obstetrician & Gynaecologist; Speciality Doctor Anaesthetics; Consultant Paediatrician & Honorary Senior Lecturer; Specialist Registrar Vascular Surgery ST5; Nurse; End of Life Nurse; Lead Surgery/Post Anaesthetics Nurse; Leadership Consultant and Physiotherapist; A&E Emergency Nurse Practitioner; Head of Midwifery; Senior Nurse, Chief Nurse; Advanced Paediatric Nurse Practitioner; Fellow of the RCP and a sexual health consultant and two Experts by Experience.

Detailed findings

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?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), NHS Trust Development Authority, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the royal colleges and the local Healthwatch.

The inspection team inspected the following eight core services at North Cumbria University Hospitals NHS Trust:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

We carried out an announced inspection visit of the hospitals between 31 March and 2 April 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We did not carried out an unannounced inspection at this hospital.

Facts and data about Cumberland Infirmary

The Cumberland Infirmary has 412 inpatient beds and serves the local people around Carlisle and throughout North Cumbria. The North Cumbria University Hospitals NHS Trust serves a population of 340,000 who live in a largely rural area of Cumbria.

Between January 2014 and December 2014 there were 91,678 inpatient admissions ; 456,665 total outpatient attendances and 78,769 Accident & Emergency attendances.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites as part of North Cumbria University Hospitals NHS Trust. The consultant-led emergency department at Cumberland Infirmary consists of an accident and emergency department (A&E) that is open 24 hours a day, seven days a week, providing urgent and emergency care and treatment for children and adults.

The A&E department at Cumberland Infirmary saw just over 44,000 patients between April 2014 and March 2015.

There were separate walk-in and ambulance entrances with a main reception which was staffed 24 hours a day. The department had a separate children's waiting area and one dedicated room for paediatrics. The department is designated as a major trauma unit and contained 20 clinical assessment spaces: a three-bed resuscitation area and three-bed monitored step down/majors treatment area; 11 trolley cubicles; one psychiatric, one eye/ENT, one triage assessment rooms; and one dedicated decontamination room.

As part of our inspection we visited the emergency department during our announced inspection on 1 April 2015. We spoke with patients and relatives, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the matron for A&E, the clinical lead, consultants, associate specialists, nurses of various grades, the paediatric lead nurse, operational service managers, student nurses as well as ambulance staff. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

Our previous inspection in April 2014 found that access to the service and patient flow through the department continued to be challenging. The Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival was not being met consistently. There had been occasions when patients had to be accommodated in A&E overnight, and there were no standard operating procedures in place for staff to follow.

In the course of this inspection we found that the Department of Health target was still not being met consistently. A norovirus outbreak in the ward areas from January to March 2015 had also impacted negatively on the emergency department and patients spent longer times in the department due to the reduced bed base. There was a risk-aware culture and evidence of learning from incidents. Patients received care in a clean and suitably maintained environment with the appropriate equipment. Medicines and records were managed effectively and safely. Staff were aware of the safeguarding policy and reported concerns appropriately. Staffing levels were sufficient to meet patients' needs. An initiative to recruit paramedics into band 5 nursing equivalent roles was proving successful.

The department participated in national and local audits. Patients spoke positively about the care and treatment they had received and staff treated patients with dignity, compassion and respect. Senior staff in the department provided visible leadership, particularly at times when the department was stretched.

Are urgent and emergency services safe?

Good

Summary

At the previous inspection in April 2014 we reported there was a continued reliance on locum doctors to cover medical vacancies. There were also nursing vacancies, which were affecting roles undertaken by nurses within the department and adversely affecting patient safety. We noted that the draft version 1 of the 'Accident and Emergency Department Operational Policy' did not include reference to the MAJAX and CBRN and the protocol for massive haemorrhage required immediate up dating to bring it in line with current standards.

At this inspection medical staffing in the emergency department consisted of four consultants with vacancies for another two. One post was covered by a locum consultant who had been in the department for over a year and also held the lead for governance in the department. The department had found it difficult to recruit to these posts.

The department didn't have a recognised nurse staffing acuity tool in place but in-house data had been reviewed and analysed to account for peaks and troughs in attendances and used to inform staffing numbers. Patient acuity wasn't taken into account. Current staffing levels met the set criteria but not when the department was busy. The trust was reviewing the draft NICE guidance at the time of the inspection and confirmed professional judgement was currently applied in relation to safe staffing levels.

Guidance for staff in the event of a major incident was available in the business continuity plan and the emergency department operational policy which listed key risks that could affect the provision of care and treatment.

Systems were in place for reporting and managing incidents. There was a risk-aware culture in the department and evidence of learning from incidents to avoid reoccurrence. Patients received care in a clean and suitably maintained environment with the appropriate equipment. Medicines and records were managed effectively and safely across the areas we inspected. Staff were aware of the safeguarding policy and reported concerns appropriately.

Urgent and emergency services

Staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. Staffing levels were sufficient to meet patients' needs but staff were behind with their mandatory training and below the trust target of achieving 80%. There were efficient and well managed processes in place for handovers. The trust had an up-to-date major incident plan and simulation training to deal with major incidents was run by a multi-disciplinary team.

Incidents

- Incidents were raised via the electronic incident reporting system. A policy was in place to support this. Staff were confident about reporting incidents, near misses and poor practice.
- The most frequently occurring incidents reported at Carlisle were security of persons such as safeguarding concerns raised, treatment and patient care, lack of resources and Staffing Levels.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of incident investigations to prevent reoccurrence.
- Learning from incidents was shared across the department via noticeboards, newsletters and at handovers.

Cleanliness, infection control and hygiene

- All areas were clean, well maintained and in a good state of repair. Staff knew about current infection prevention and control guidelines and we observed good practices such as hand washing facilities and hand gel being available throughout the departments.
- Staff followed hand hygiene and 'bare below the elbow' guidance and staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- Data showed that healthcare-associated infections MRSA and Clostridium difficile (C.diff) rates for the trust were within expected limits. There were no cases of C.diff attributed to the A&E department for the previous year.
- The policy was to screen all patients admitted to a ward area from A&E for MRSA. The electronic patient administration system made a note and tracked all patients with any infectious conditions so staff could be alerted.

Environment and equipment

- The admission route was set up so patients who self-presented and those conveyed by ambulance had their own entrances. Patients at risk of deteriorating or those with high acuity were placed in cubicles visible from the nursing stations for quick intervention.
- There was clear segregation for adults and children that attended the department.
- The x-ray service could be easily accessed from the department.
- There was a secure room that was used to assess patients with mental health needs. This met the Section 136 room guidelines (a designated place of safety) under the Mental Health Act (1983).
- The resuscitation area had three cubicles with one designated for children. The cubicles were all well-equipped for adult and paediatric patients. We saw equipment in place for specific procedures that may only be carried out several times a year.
- Sterile single use equipment was available throughout all areas. We found the items to be within their expiry date.
- Electrical and mechanical equipment was appropriately checked and decontaminated. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced efficiently.
- Checklists were completed for daily, weekly and monthly checks of equipment within the cubicles including the resuscitation trolleys.
- Staff received updates and warnings of issues raised by the National Patient Safety Agency (NPSA) such as potential equipment sabotage.

Medicines

- Pharmacy staff were responsible for maintaining minimum stock levels and checking medication expiry dates.
- When issuing medication for patients to take home, the prescriptions and drugs dispensed were checked by two nurses.
- We checked the storage and balance of controlled drugs in the emergency department and found the stock balances were correct and the registers had been signed by two members of staff upon dispensation. The volume of any wasted drugs was recorded accurately where necessary.

- Medicines were generally stored correctly and safely in locked cupboards or fridges and temperatures were recorded where necessary throughout the emergency department.

Records

- The emergency department had developed its own patient clinical assessment records for adults and children. Information was completed around personal details, previous admissions, alerts for allergies and observation charts. All records were kept securely and confidentially.
- The integrated electronic care record tracked the patient through the department. We reviewed five patient records and saw the patients' care and treatment was carried out in accordance with their needs. One patient had been reviewed by a stroke nurse and had the associated observation charts in place and another patient had an allergy to penicillin which was clearly identified at triage and highlighted in the notes.

Safeguarding

- Policies outlined processes for safeguarding vulnerable adults and children. Data showed all staff were currently up to date with training in vulnerable adults and children.
- Staff confirmed they could contact the safeguarding team, social services or a health visitor if a patient was suspected of being at increased risk of neglect or abuse. A nurse with the lead for safeguarding would also come to the A&E from the children's ward to see any vulnerable children.
- It was mandatory for staff to complete a safeguarding trigger in the clinical assessment record for all children who attended A&E. The electronic patient record system alerted staff to any previous safeguarding issues. Records contained the appropriate triggers and a safeguarding referral file was also available in the department.
- Safeguarding records were well completed.

Mandatory training

- Staff had received an induction specific to their role when they had begun work in the department.
- Induction checklists included departmental safety instructions, orientation and policies and procedures and had been signed by staff and their supervisors.
- Staff received mandatory training in areas such as infection prevention and control, moving and handling and safeguarding children and vulnerable adults.
- Staff within the emergency department also received role specific mandatory training such as medicines management, Basic and Advanced Life Support covering adults and paediatrics (BLS, ALS, APLS), Advanced and Immediate and Paediatric Immediate Life Support (ALS, ILS and PILS).
- There was a nursing lead for education within the department but staff were responsible for maintaining their own training, which meant that training could be missed. The trust target was to have 80% of staff having received mandatory training. The performance dashboards showed this target wan not met. For example only 53% of nursing staff had undertaken adult advanced life support training and only 67% were up to date with their basic life support. Figures for medical staff for the same training were lower.
- Only 69% of nursing and medical staff had completed medicines management training. Training in infection prevention and control was at 59% for the nursing staff and only 28% compliance for the medical staff.
- Mandatory training was delivered on a rolling programme and the matron and clinical lead told us all non-compliant staff had been identified and lists had been sent to their line managers for remedial action to be taken.

Assessing and responding to patient risk

- Patients' with minor injuries were booked in via the receptionist and triaged following the Manchester Triage System to determine the nature of the ailment. This involved looking at the pain score, conducting observations and providing pain relief if applicable.
- Patients conveyed by ambulance were seen immediately on arrival via a separate entrance.
- Patients were assigned an acuity status and were seen in order of acuity rather than the order they attended.
- Children in A&E were classed as being under the age of 18 but the definition on the wards was under 16. This sometimes caused confusion and wasn't standardised. Children had their own dedicated waiting room and treatment areas.
- An appropriately qualified nurse performed the screening of patients and depending on the severity of their ailment streamed patients to the appropriate area such as the minor or major injuries.

- The department's operations policy provided staff with guidance on how to escalate patient pathway delays in order to meet the needs of the patients.
- Patients at high risk were placed on care pathways to ensure they received the right level of care.
- An early warning score (EWS) tool was part of the patient record with clear directions for escalation (EWS is a system that scores vital signs and is used for identifying patients who are deteriorating clinically).
- Nurses in triage could request initial blood tests and x-rays so patients were not delayed. This meant results were available when consultants reviewed patients and allowed efficient diagnosis.
- The electronic admissions system automatically alerted staff if any patients had attended the hospital and the A&E department previously and whether they were assigned to any specialist team in the hospital, for example the oncology team, so staff in A&E could seek appropriate care for the patient.
- An escalation policy was in place and bed management meetings took place regularly to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- Emergency resuscitation equipment was available throughout the areas including "grab bags" which contained equipment such as defibrillators for adults and children.
- Risk assessments were in place where necessary in all departments.
- The A&E department had a folder for patients who regularly attended the department with ongoing conditions such as asthma. This was for adults and children and included information of patients at high risk in the community.
- Procedures identified pathways such as trauma, head and chest injuries in both children and adults. These clearly outlines the treatment each location was able to carry out to the patient and when a transfer should take pace, either from Whitehaven to Carlisle or to other hospitals if it was severe trauma. These documents contained checklists of how patients would be sent to other sites and how each site could prepare to receive a patient such as having team responsibilities set out, a team brief and also equipment at the ready.
- A major trauma bypass protocol was in place as part of the Northern Trauma System with the local ambulance provider to ensure patients were directed to the correct site within and outside of NCUH.

Nursing staffing

- Nursing staff of differing grades were assigned to each of the patient areas within the department.
- The department didn't have a recognised staffing acuity tool in place to determine the nursing establishment. In-house data had been reviewed and analysed to account for peaks and troughs in attendances and used to inform staffing numbers. Patient acuity wasn't taken into account. Current staffing levels met the set criteria but not when the department was busy. The trust was reviewing the draft NICE guidance at the time of the inspection and confirmed professional judgement was currently applied in relation to safe staffing levels.
- Staffing consisted of five nurses and one healthcare assistant (HCA) from 7am to 3pm, seven nurses and one HCA from 1:30pm to 9:30pm and four qualified nurses and one HCA covering the night shift. This was flexible and additional nurses or HCA's would be requested if the department was stretched.
- We observed the numbers of nursing staff to be adequate during the inspection.
- A paediatric specialist (band 7) nurse was available 37.5 hours a week and covered a range of shifts including weekends. Assistance would be sought from the ward areas. To mitigate the risk, all staff had Advanced Paediatrics Life Support training to ensure children could be seen by all staff.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. The organisation carried out checks on all agency staff to ensure they had the right level of training in delivering emergency care.

Medical staffing

- All staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends. Consultant cover during the week was available from 8am to 10pm weekdays. Weekend consultant cover was sourced from consultants working at nearby hospitals in the North East who would cover locum shifts. This was a long term arrangement and it was the same consultants who knew how the department functioned.
- Middle grade and specialist doctors, together with junior doctors, were on duty 24 hours a day, seven days a week for 365 days a year.

Urgent and emergency services

- Medical staffing in the emergency department consisted of four consultants with vacancies for another two. One post was covered by a locum consultant who had been in the department for over a year and also held the lead for governance in the department. The department had found it difficult to recruit to these posts.
- There was no specific paediatric consultant but one was available on-call from the children's ward who would attend. The consultant would perform the assessment and admit directly onto the ward if required.
- The clinical lead told us there was a stable workforce but that maintaining steady staffing was a challenge and the aim was to develop new staffing models that would be sustainable.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff underwent a local induction before they were allowed to work in the trust.

Handovers

- Medical and nursing staff had separate handovers during shift changes involving information on the risks, treatment and care for each patient, staffing requirements and patient flow through the department.
- All staff safety huddles were also taking place and had been effective in providing cross information between the medical and nursing teams to better treat the patients.
- Information was logged to ensure those staff not present could also be made aware of any risks.
- Handovers of patients between ambulance and hospital staff were discreet, dignified and efficient.

Major incident awareness and training

- Security guards patrolled the car park; corridors and public areas such as A&E. Staff in the emergency department could call security for immediate support and would also dial 999 for police assistance if required.
- Guidance for staff in the event of a major incident was available in the business continuity plan and the emergency department operational policy which listed key risks that could affect the provision of care and treatment.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- Simulation training was run by a multi-disciplinary team and included major incidents, chemical, biological, radiological and nuclear (CBRN) incident management with table top exercises and operational training. The department had simulated a fire in a plastics factory in May 2014 and had involved the ambulance service as a simulation.
- Staff had received training in Ebola management, flu mask training and decontamination train-the-trainers sessions.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Summary

Effective was unrated at the time of the previous inspection in April 2014 as our methodology did not support there being sufficient evidence available to support a judgement.

At this inspection appraisal rates varied between staff types and data showed 67% of nursing and 50% of medical staff in the Emergency Care and Medicine Business Unit had received appraisals for the year 2014 to 2015 against a set target of 85%. The department participated in national and local audits. A College of Emergency Medicine (CEM) audit was conducted for treatment and risk stratification of feverish children under five with positive outcomes and appropriate actions were assigned as a result. Local audits included an assessment of risk for people who self-harmed and a study on the Ottawa Rules of Ankle Injury compliance in A&E. We saw presentations the doctors had compiled and discussed with their peers which included areas for improvements to increase the quality of the service provided.

A Trauma Audit and Research Network (TARN) audit had been carried out in relation to admissions between January 2014 and December 2014. Data showed six out of the eligible seven patients had met the NICE head injury guidelines for receiving a CT scan within 60 minutes of arrival. However, consultant led trauma teams had only been ready for patients with an injury severity score greater than 15 on arrival for 17 patients out of 42 (41%).

Urgent and emergency services

An audit in relation to NICE clinical guideline CG16 (Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) looked at 52 patients in the emergency department. Results showed only 22% had a clear risk assessment and 92% were seen by the mental health team within an hour. Recommendations and action included adding a sticker to the notes for clearer pathway tracking and providing training to staff.

Treatment and care was provided in line with national guidance and evidence based practice. Patients were assessed for pain relief as they entered the emergency department. Suitable processes were in place to obtain patient consent.

Evidence-based care and treatment

- Care and treatment was evidence-based and followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines.
- Clinical guidelines such as trauma, stroke, pneumonia and fractured neck of femur were developed and referenced with associated nationally recognised standards. Paediatric pain assessments, prescription charts, head injury proforma with observation charts that followed the Paediatric Early Warning Score (PEWS) guidelines were available and accessible to staff electronically.
- Guidance was regularly discussed at governance meetings, disseminated and the impact that it would have on staff practice was discussed.
- Staff undertook clinical audits to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care. A local audit in relation to antibiotic use in the emergency department had been conducted and actions had been clearly identified and acted upon such as all junior staff had to have their practice checked by senior staff.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A screening process identified any patients who may need pain relief which was given immediately.
- A review of patient records and patients we spoke with confirmed that they had been offered appropriate pain relief in a timely way.

Nutrition and hydration

- The department had facilities to make drinks and snacks such as toast and cereal. Staff had access to a fridge with sandwiches for patients.
- All staff offered drinks and small snacks to patients waiting in the department. We saw patients being offered refreshments during our visit. Staff checked if patients could have refreshments before offering them due to the nature of their medical conditions.
- If patients ended up staying overnight then systems were in place for patients to choose meals as they would in ward areas.

Patient outcomes

- A consultant lead was assigned for audit in the emergency department. The department participated in national College of Emergency Medicine (CEM) audits so they could benchmark their practice and performance against best practice and other emergency departments. Audits included consultant sign off, renal colic, pain relief and fractured neck of femur.
- An audit for CEM treatment and risk stratification of feverish children was conducted between November 2014 and December 2014 for patients less than 5 years of age. The standard was children presenting to ED with medical conditions should have observations and be see within 20 minutes. Results showed only 42**%** of observations were identified as being performed in the first 20mins of arrival with most being unable to tell whether they were or not (38% of patients). This follows a downward trend from 2010 (83%) and 2012 (53%). Only 88**%** of patients had sufficient information recorded in order to risk stratify them a risk rating was recorded for 84**%** of patients showing a gradual improvement from 2010 (73%) and 2012 (66%). The recording of observations was generally high around 88% against a target of 100% and showing improvement from the previous years. There has been deterioration in the recording of observations within 20mins of arrival with the total number identified at an all-time low of 42%. Actions to improve this included the introduction of an area for staff to record the time with the initial observations in the record.

- Local audits were conducted in areas such as assessment of risk for people who self-harm, study on Ottawa Rules of Ankle Injury compliance in A&E and assessment of suspected cardiac chest pain in the emergency department.
- The Ottawa Ankle Rule audit looked at whether x-rays were appropriately done to implement savings in the trust. Doctors looked at 50 ankle/foot injuries over a 10 day period and found 10% of x-rays were inappropriately conducted in December 2014 as opposed to 4% in December 2013. Recommendations and actions included teaching Ottawa ankle and foot guidelines to doctors and triage nurses in the department.
- A Trauma Audit and Research Network (TARN) audit had been carried out in relation to admissions between January 2014 and December 2014. Data showed six out of the eligible seven patients had met the NICE head injury guidelines for receiving a CT scan within 60 minutes of arrival. Consultant led trauma teams had only been ready for patients with an injury severity score greater than 15 on arrival for 17 patients out of 42 (40.5%).
- An audit in relation to NICE clinical guideline CG16 (Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) looked at 52 patients in the emergency department. Results showed only 22% had a clear risk assessment and 92% were seen by the mental health team within an hour. Recommendations and action included adding a sticker to the notes for clearer pathway tracking and providing training to staff.

Competent staff

- Departmental records showed appraisal rates varied between staff types. As of March 2015 only 67% of nursing and 50% of medical staff in the Emergency Care and Medicine Business Unit had received appraisals for the year 2014 to 2015 against a set target of 85%. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Staff told us they had received an appraisal or were due to have one. Information provided by the trust identified that the process for 2014 to 2015 had started and was still ongoing.
- The nursing and medical staff were positive about on-the-job learning and development opportunities.
- Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- We observed collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of care. Medical and nursing staff discussed patient needs with the ward staff to ensure an effective handover took place.
- Collaborative working with the medical and surgical departments meant each ward area knew the number and type of patient that would be transferred to them.
- Daily meetings, involving the nursing staff, therapists and medical staff were conducted to ensure there were sufficient staffing levels and the ambulance staff also attended the bed management meetings when required.
- Specialist support teams such as the CRISIS team for people with mental health problems worked with staff in the emergency department. The team had specific pathways, management plans and confidential systems in place.

Seven-day services

- The emergency department operated 24 hours a day throughout the year. Auxiliary services such as the X-ray department, specifically to assist A&E, was open 24 hours a day, 7 days a week.
- Consultants, middle grades, specialist and junior doctors covered the rotas 24 hours a day, 365 days a year.
- Pharmacy services were not available 7 days a week, but a pharmacist was available on call out of hours. The department held a stock of frequently used medicines such as antibiotics and painkillers, which staff could access out of hours.

Access to information

- Patient records were easily accessible with information being updated regularly.
- The documentation was either electronic, such as the booking information and some patient notes or was available in paper format such as the consent forms.
- Data such as waiting times, ailments and patient acuity was available electronically via a specialist system so all staff knew which patients needed to be seen in order of acuity and which tests were outstanding.

- Information about the patient such as test results, x-rays or medical information taken during booking in, triage or in the A&E department was readily available across the receiving wards so the relevant receiving wards could co-ordinate their services and be prepared.
- The department had an electronic booking in system which tracked all the patients in the department and those who needed to be moved to the ward areas. This screen with all the patient details such as names, date of birth and presenting ailment could be seen in the receiving ward areas. Staff raised concerns this caused confidentiality issues especially when staff had previously been admitted to A&E.
- Nurses ensured all the information was collated and checked before the patient was transferred to a ward area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to ask patients fore consent and explained how they sought verbal and implied informed consent due to the nature of the patients attending the emergency department. Written consent was sought before providing care or treatment such as anaesthetics. Patient records showed that verbal or written consent had been obtained from patients or their representatives.
- Staff received training in and understood the requirements of the Mental Capacity Act 2005, safeguarding vulnerable adults and children and Deprivation of Liberties Safeguards (DoLs).
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient.

Are urgent and emergency services caring?

Good

Summary

At the previous inspection we reported patients were involved in their care and treatment, staff spent time explaining treatment options to allow patients and relatives to make an informed choice. Patients and relatives overall were complimentary of the staff and of the treatment they had received.

At this inspection patients spoke positively about the care and treatment they had received and staff treated patients with dignity, compassion and respect at all times. Staff provided patients and their families with emotional support and comforted patients who were anxious. Staff could access management support or counselling services if they required.

Compassionate care

- Patients, relatives and representatives were positive about the care and treatment provided.
- We observed many examples of compassionate care including an occasion where staff gave extra assistance to an elderly and confused patient in the major's area.
- The NHS Friends and Family Test had a response rate which was above the national average between November 2014 and February 2015. The results showed that the majority of patients would recommend the department to their family and friends.
- We saw patients' cubicle curtains were closed during consultation and staff spoke with patients in private to maintain confidentiality. Patients felt they were afforded sufficient privacy and dignity.
- Staff gave children teddy bears donated to the department from the Teddy Loving Care (TLC) appeal to help them remain calm.

Understanding and involvement of patients and those close to them

- Patients received information about their care and treatment in a manner they understood.
- Upon admission, patients were allocated a designated nurse to ensure continuity of care.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed their consent had been sought before care and treatment was delivered.
- Patients and those close to them were also involved in the planning for discharge from the department.
- Patient records contained appropriate signatures, and where the patient was under 18, we saw appropriate signatures from their parents or guardians.

Emotional support

- We observed many positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.

Urgent and emergency services

- Staff confirmed they could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.

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

Requires improvement

Summary

At the previous inspection we reported access and flow to be challenging. Patients were accommodated in A&E overnight due to bed pressures in the hospital, but there were no standard operating procedures in place for staff to follow on how the accommodation should be provided. There were delays in triage as triage staff were expected to cover other areas due to staff vacancies. Children were not being consistently triaged as there was only one paediatric nurse available for the entire department.

At this inspection the Department of Health target for emergency departments to admit, transfer or discharge patients within four hours of arrival was only met for quarter two of 2014/15, with 95.9% compliance. Cumberland Infirmary only met the target once in July 2014 with a range between 69.1% to 96.6%. Over the year, 12 patients waited for more than 12 hours from the decision to admit to being admitted. Individual breaches of the four hour target were investigated and the majority were due to patients waiting for a bed in the ward areas. Other reasons for delays included patients waiting for a specialist opinion and waiting for a mental health assessment. A norovirus outbreak in the ward areas during January to March 2015 had impacted negatively on the emergency department as it had caused additional bed blockages and longer waiting times.

During routine operating hours, the department could cope with the patient flow. An escalation policy and daily bed management meetings were in place to deal with pressures on capacity. Staff had access to interpreter services, specialist support teams for people with mental health problems and for patients living with dementia.

Service planning and delivery to meet the needs of local people

- The trust wide escalation policy described how the emergency department would be involved in dealing with foreseen and unforeseen circumstances and when demand caused pressure on capacity.
- Papers had been presented at the emergency preparedness committee to ensure any significant demand for services over winter was accounted for such as lack of staffing or capacity.
- Daily bed management meetings were taking place where core data was reviewed such as ambulance wait times, patient discharge data and length of stay of patients across the hospital as well as staffing and capacity to treat patients in a timely way.
- There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.
- There were set clinics daily with slots for patients to be checked following injuries such as fractures. This meant patients could be seen in a timely manner rather than wait for an outpatient appointment.
- A procedure outlined the actions staff in A&E should take if any patients were to remain overnight in A&E. This included obtaining a bed, lockers and ensuring meals were ordered.

Meeting people's individual needs

- Staff had access to a telephone interpreter service for non-English speaking patients. Patient information leaflets were available mostly in English. Staff would ask relatives or family members to assist in interpretation in the first instance. Consent would only be gained through professional interpreting to maintain patient confidentiality and choice.
- Specialist support teams for people with mental health problems were available between 8am to 8pm with the community out-of-hours crisis team providing cover at other times.
- Patients living with dementia were assessed and treated in cubicles opposite the main nursing station to protect them and so staff could maintain visibility.
- Staff asked patients with learning disabilities if they had a completed "passport document" with them. The

passport is a document completed by the patient or their representative which includes key information such as the patient's medical history and their likes or dislikes.
- Where a patient was identified as living with dementia or having learning disabilities, staff could contact a trust-wide specialist link nurse for advice and support.
- A relatives' room was available for people who had witnessed traumatic incidents such as a road traffic accident or bereavement. Information around bereavements was available which gave step by step instructions on the services available and how they could be accessed. There wasn't a specific viewing room for deceased patients, but if a patient passed away a room would be used to allow family to spend extra time with their loved ones. If this occurred, a picture of a nightingale bird was placed on the door and in the ward to make all staff aware.
- Information relating to patient safety was displayed on notice boards and provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents.

Access and flow

- During routine operating hours, the department had enough capacity to manage patient flow. However, when patients requiring admission or additional services external to the emergency department could not be discharged this caused a backlog.
- The Department of Health target for emergency departments is to admit, transfer or discharge at least 95% of all patients within four hours of arrival.
- In 2014/15, the trust as a whole, only met the target for quarter two with 95.9% compliance. The trust achieved a compliance of 93.9% in quarter one, 88.3% in quarter three and only 81% compliance with the four hour target in quarter four.
- In real terms, this meant that a total of 7903 patients waited more than four hours to be admitted, transferred or discharged from the emergency department from a total of 79013 patients who attended over both sites.
- Trust data classed patients being aged 18 and under as a paediatric attendance. Between April 2014 and March 2015 16.5 thousand patients aged 18 and under attended with the second highest age group being 19-29 with 13 thousand attendances.
- Overall a total of 12 patients waited for more than 12 hours from the decision to admit to being admitted in quarter four only.
- The Department of Health data is a trust wide combination for Cumberland Infirmary at Carlisle and West Cumberland Hospital at Whitehaven.
- Data for Cumberland Infirmary showed the A&E department had only met the target once in July 2014 between April 2014 and March 2015 with a range of 69.1% to 96.6% compliance with the four hour target.
- All individual breaches of the four hour target were investigated and categorised into why they occurred. The week prior to our inspection Cumberland Infirmary achieved 87.1% compliance with 913 attendances and 119 breaches. The breach report showed the majority (90) were due to patients waiting for a bed in the ward areas. This was a similar pattern for other weeks, for example, week commencing 16 March there were 853 attendances with 165 breaches and 79.2% compliance with the four hour target due to 165 patients waiting for a bed in the ward areas. Between April 2014 and March 2015 77% of all patients who waited more than 4 hours were admitted into the hospital and only 23% were discharged.
- Other reasons for delays included patients waiting for a specialist opinion and waiting for a mental health assessment. A norovirus outbreak in the ward areas during January to March 2015 had impacted negatively on the emergency department as it had caused additional bed blockages and longer waiting times.
- The trust had done extensive work to investigate why the 4-hour waiting target was sometimes exceeded. Factors contributing to poor performance included bed occupancy within the hospital, which had been above the England average of 85% between April 2013 and September 2014 for general and acute beds.
- The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit and being admitted was comparable to the England average between April 2014 and March 2015.

Learning from complaints and concerns

- A trust wide policy included information on how people could raise concerns, complaints, comments and compliments with contact details for the Patient Advice and Liaison Service (PALS).
- Information was displayed in the department about how patients and their representatives could complain.

Urgent and emergency services

- Complaints were recorded on a centralised trust-wide system and monitored as part of the ward quality indicators. We saw a number of "you said, we did" boards identifying changes that had been made from complaints and other patient feedback.
- Staff understood the process and told us information about complaints was discussed during routine team meetings.

Are urgent and emergency services well-led?

Good

Summary

At the previous inspection we reported there were clear lines of accountability within the team structure. The team worked well together and there was good oversight for the department, including a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager).

Both medical and nursing staff expressed their views about the service openly and constructively. The staff were caring and passionate about the department and about the care they provided to patients.

At this inspection the trust's vision, objectives and improvement priorities were clearly displayed throughout the department. Senior staff in the department provided visible leadership, particularly at times when the department was stretched. The divisional risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and at executive level.

An initiative to recruit paramedics into band 5 nursing equivalent roles was proving to be successful as the department received trained and qualified staff. Team away days were held to look at improvements as well as bringing the team together. Ideas had been brought into the department to increase the quality of the service.

Vision and strategy for this service

- The vision was "To provide person centred best in class quality healthcare services" and had five elements to deliver this which were "Patients come first, to provide safe and high quality care, to have responsibility and accountability, everyone's contribution counts and to have respect".
- The trust's priorities, outlined in the "Quality Strategy for 2014-18", incorporated this vision and included specific strategic objectives applicable to the emergency department such as meeting national standards and developing plans to achieve 7 day working for emergency care.
- The trust's vision, objectives and improvement priorities were clearly displayed throughout the department and staff had a clear understanding of what they meant for their practice.

Governance, risk management and quality measurement

- Emergency care was affiliated with the Medicine Business Unit. Risks and quality management were managed by the Emergency Care and Medicine Operational Board.
- Senior staff were aware of the departmental risks, performance activity, recent serious untoward incidents and other quality indicators.
- The local risk register was available to all staff and included a sign off sheet once they had read them. The top risks were poor patient flow, paediatric support and ensuring an efficient triage. These appeared to be reviewed monthly and any actions that had been undertaken to decrease the risks had been shared with the departmental staff.
- Day-to-day issues, information around complaints, incidents and audit results were shared on notice boards around the department and also via meetings.
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles in department. The departments were well led locally by the senior staff who provided visible leadership, particularly at times when the department was stretched.
- The teams appeared to be motivated and worked well together.

- The clinical lead had overall responsibility for daily management and was an emergency consultant. The nursing team was led by a matron who was visible within the department and supported by a number of senior nurses.

Culture within the service

- The culture was positive and this reflected on staff portraying positive attitudes. Staff felt the overall ethos was centred on the quality of care patients received over trying to meet targets.
- Staff told us the morale within the department was mostly good and the teams worked well together. However, at times, when the department reached high patient capacity, staff felt that the morale dropped.
- Staff felt their efforts were acknowledged and felt if they raised any concerns or issues in relation to patient care or any adverse incidents, these would be acted upon.

Public and staff engagement

- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and departmental meetings.
- The department included 'What are you saying' information on notice boards, which listed improvements made by the trust in response to queries raised by staff and patients.
- In 2014 57% of all eligible staff took part in the NHS staff survey. The results for the trust showed 71% of staff felt satisfied with the quality of work and patient care they were able to deliver and 88% agreed their role made a difference to patients. Negative responses included only 30% of staff felt they had a well-structured appraisal in the last 12 months, 39% suffered work related stress in the last 12 months and 21% experienced physical violence from patients, relatives or the public in last 12 months.
- Staff accessed information such as audit results, lessons learned from incidents, performance indicators, clinical pathways and policies and procedures via the intranet site.

Innovation, improvement and sustainability

- The trust received additional financial resource to enable them to manage the winter pressures as outlined in the winter plan 2014 -2015 presented at the emergency preparedness committee in September 2014. The plan took into account any significant demand for services and pressures such as lack of staffing, increased A&E attendances, admissions and transport problems.
- The A&E department had difficulties in recruiting nurses due to a number of issues including the location of the hospital. Recently, an initiative had been brought out to recruit band 5 paramedics to train into the nursing roles. This was proving to be successful as the paramedics were already trained in many aspects of the role.
- Team away days had been held in April 2014 and January 2015 for the team to discuss the positive and negative issues as well as looking at ways to improve the service. Quality improvements included making the reception area more friendly, increasing storage and rotating staff from the wards into the A&E to increase skills and awareness.
- Increasing patient flow had been prioritised and the trust was working with external partners to improve community services to keep patients in their homes and to ensure community beds were used appropriately. Work in the hospital included raising awareness around discharge by ensuring the expected date of discharge was available and to aim to discharge by lunchtime where possible.

Medical care (including older people's care)

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

Information about the service

The medical care services at Carlisle Infirmary are managed by the medical and urgent care business unit and provide care and treatment for a wide range of medical specialities including acute and respiratory medicine, cardiology, elderly care, gastroenterology, renal medicine and stroke care. There were 30,000 admissions to medical care services at Carlisle Infirmary in 2013/14, of which 40% were emergency admissions.

We visited wards Willow A, B, C/D, Elm A, B, Elm C, Larch A/B, Beech A, the Heart Centre and the Discharge Lounge. We were unable to visit Maple A and Larch C wards due to access being restricted to prevent the spread of infection.

We observed care, looked at records for ten people and spoke with 19 patients, seven relatives and 34 staff across all disciplines, including doctors, nurses and health care professionals. We also spoke with members of the divisional management team.

Summary of findings

At our previous inspection in April 2014 we found shortages of both nursing and medical staff throughout the medical directorate combined with high nursing sickness and absence rates was having a negative impact on patient care and experience.

In the course of this inspection the levels of substantive medical cover at the hospital remained insufficient. In addition, it was not possible for junior medical staff to access consistent and effective leadership and support as a result of shortages of senior medical staff within the specialties.

There continued to be shortages of trained nursing staff on some medical wards. Nursing staffing levels had been reviewed and assessed using a validated acuity tool with minimum numbers set. Although nurse staffing levels had improved since our last inspection, there were still on average 3 trained nurse vacancies per ward when measured against the agreed establishment. In practice, there were frequently times where ward managers escalated staff shortages and the senior nursing team was unable to respond appropriately and this meant there were times when the wards were not appropriately staffed.

We also found there were shortages of some essential equipment and the way medicines were stored required improvement.

Wards were visibly clean, infection rates for Clostridium difficile and MRSA were within expected ranges.

Medical care (including older people's care)

Services were delivered by caring and compassionate staff. Pressures on the availability of medical beds resulted in patients regularly being cared for on wards outside of their speciality. Systems in place for the routine review of these patients varied and required improvement. There was delay in the relocation of patients who had been transferred out of the area for specialist treatment. Patients continued to be moved during the night without a medical reason for doing so.

Referral to treatment times were meeting standards in all medical specialties. There had been a sustained improvement over the past 8 months in the referral to treatment times across the medical specialities.

Are medical care services safe?

Requires improvement

Summary

At the previous inspection there were robust systems for the reporting of incidents and the management of risk within the hospital. However, there were chronic shortages of both nursing and medical staff throughout the medical directorate in the form of vacant posts. These shortages, when combined with high nursing sickness absence rates, heavy dependence on nursing bank and agency staff, high usage of locum doctors, plus an ongoing inability to staff wards within the medical directorate to the agreed safe levels at all times, meant that care and treatment was not being provided safely.

At this inspection the levels of medical cover at the hospital remained insufficient to provide a safe and effective service to patients and in February 2015, four out of ten consultants in on call positions were filled by locums and fifteen out of 36 resident medical doctors were locums. At the time of our inspection there were consultant vacancies in specialist posts such as gastroenterology, respiratory, care of the elderly and general cardiology.

There continued to be shortages of trained nursing staff on some wards. Nursing staffing levels had been reviewed and assessed using a validated acuity tool with minimum numbers set. Although nurse staffing levels had improved since our last inspection, there were still on average 3 trained nurse vacancies per ward when measured against their agreed establishment.

A rolling recruitment programme to fill these posts was ongoing. Several new initiatives had been implemented, including an increase in the student nurse intake to two per year and the trust was in the process of recruiting 50 nurses from the Philippines.

An escalation process was in place. This was only effective if senior staff could access nurses via the nurse bank or redeploy them from wards which were better staffed. In practice, there were frequently times where ward managers escalated staff shortages and the senior nursing team were unable to respond their nurse staffing requirements.

We also found there were shortages of some essential equipment and the way in which some medicines were

stored required improvement. The safety thermometer showed variable results between January 2014 and January 2015, fluctuating between highs of 100% harm free care on some wards to lows of 50% on Elm B ward in January 2015.

The wards were seen to be clean, infection rates for Clostridium difficile and MRSA were low, records were of a good standard, NEWS scores were consistent and accurate, response provided by medical staff to a patient whose condition was deteriorating was timely and effective and plans were in place to deal with the additional pressures on beds and staffing within the hospital during the winter and at other times of peak demand on services.

Incidents

- There were robust systems in place for reporting incidents and 'near misses' within the medical business unit. Staff had received training and were confident in the use of the incident reporting system.
- There had been a significant improvement in the system for providing staff with feedback from incidents since our last inspection. Weekly governance meetings were held at ward level where outcomes of incidents were discussed. Staff told us that feedback from incidents was generally good.
- There was a system in place for reviewing mortality and morbidity. We saw examples of how learning from these reviews was shared throughout the trust, in the form of case studies, in order to improve the quality of patient care. This method of sharing learning was popular with staff.
- Senior clinical staff were aware of their responsibilities regarding the Duty of Candour legislation, but junior staff had little awareness of the legislation.

Safety thermometer

- The medical business unit was managing patient risks such as falls, pressure ulcers, bloods clots, and catheter urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month.
- The trust monitored these indicators and displayed information on the ward performance boards, although the information was out of date on two of the wards we visited. Staff told us that individual ward performance was discussed regularly at staff meetings. Minutes of staff meetings we reviewed confirmed this.
- The results were variable between January 2014 and January 2015, fluctuating between highs of 100% harm free care on some wards to lows of 50% on Elm B ward in January 2015.

Cleanliness, infection control and hygiene

- The wards we inspected were clean. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels.
- The hospital infection rates for Clostridium difficile (C.diff), including the wards within the medical unit, had been below the England average, with only one case reported between April 2013 to November 2014. Methicillin Resistant Staphylococcus Aureus (MRSA) infection rates, had been around the England average since May 2013.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the wards we visited.
- There were suitable arrangements for the safe disposal of waste. We saw that used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed appropriately, however staff on most wards told us the waste was not collected often enough and frequently built up, particularly in the Heart Centre, where staff told us that waste "was not collected for days". Sharps such as needles and blades were disposed of in approved receptacles.
- The changing room for the catheterisation laboratory was across a thoroughfare from the laboratory used by patients undergoing procedures. This meant that staff had to cross the corridor wearing their surgical clothing designed to be worn in the restricted surgical areas only. This represented an increased risk of infection to patients.

Environment and equipment

- Staff on every ward we visited told us there was a shortage of infusion pumps within the hospital. Pumps

were either unavailable or had parts, such as electrical leads, missing. This made them unusable. Infusion pumps were needed on a daily basis to deliver essential drug treatment to patients and shortages meant that treatment was delayed while staff sourced a working infusion pump. Two reported medication errors between October and December 2014 were attributed to infusion pump failure.

- There was insufficient storage for essential equipment on all the medical wards. This meant that corridors, bays and bathrooms within the wards were cluttered with equipment, making it difficult for staff and patients to move freely around the wards.
- We found several items of out of date single use equipment on Willow D ward which was disposed of by staff during our inspection.
- We checked the resuscitation equipment on all of the wards we visited and found this had been checked daily by a designated nurse.

Medicines

- Medical care services had access to a ward-based pharmacy service, with dedicated support from pharmacists and technicians. Pharmacy staff visited the wards to check the appropriateness of prescribing and to ensure adequate supplies of medicines were available.
- We looked at the prescription and medicine administration records for four patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Controlled drugs were stored and managed appropriately.
- Storage of medicines on the medical wards we visited was poor. We found medicines stored on the floor in three wards where there was the potential for contamination.
- The temperatures of rooms and corridors where drugs were stored was not monitored on any of the medical wards. Manufacturers recommend that most of these drugs should not be stored above 250C, but there was no way of knowing what temperature the drugs had been stored at. Drugs stored outside of the recommended temperatures may not be fit for use.
- We found out of date medicines in one drug fridge and medicines belonging to a previous patient which had expired in December 2014. We highlighted this to staff and the medicines were disposed of.

Records

- During our inspection we reviewed ten sets of patient records. Nursing care records were comprehensive, current and easy to navigate and contained all the information required to support the delivery of safe care.
- Nursing documentation contained a range of risk assessments covering the major risks for patients. The standardised risk assessments covered risks such as tissue damage, risks of falls and use of bed rails. These had usually been updated when required
- We reviewed eight sets of medical and allied health professional records on four wards and found them to be accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults.

Mandatory training

- Levels of compliance with mandatory training had improved considerably since our last inspection. Compliance rates for clinical staff on all the wards within the medical business unit were above 90%.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) was used for acutely ill patients. NEWS is a scoring system that identifies patients at risk of deterioration or needing urgent review. We found that NEWS scores were consistently and accurately completed.
- We found that the response provided by medical staff to a patient whose condition was deteriorating was timely and effective.

- Medical staff were supported, at night, by a team of nurse practitioners, some of whom were still in training. Medical and nursing staff spoke positively about the new nurse practitioner role and the response provided by these nurses.
- We spoke with four of these nurse practitioners during our inspection. They told us that they were frequently deployed to wards where there were shortages of trained nurses, which meant the completion of their training had been delayed. They also told us that the responsibilities of their role were unclear as they had no job description.
- Wards within the medical business unit had on-site access to the services of a critical care unit when required.

Nursing staffing

- Nursing staffing numbers were reviewed throughout the medical business unit twice each year. Staffing levels had been assessed using a validated patient acuity tool. There were minimum staffing levels set for medical wards throughout the hospital. Required and actual staffing numbers were displayed on every ward we visited.
- Since April 2014 the number of contracted qualified nursing staff in the trust had risen by 1.33% and unqualified by 4.25%
- As of January 2015 agency usage in the trust represented 3.4% of the whole time equivalent(WTE) worked. The usage had decreased from just over 23% in April 2014.
- Although nurse staffing levels had improved since our last inspection, there were still, on average, 3 trained nurse vacancies on most of the medical wards measured against their agreed establishment. A rolling recruitment programme to fill these posts was on going. Several new initiatives had been implemented, including an increase in the student nurse intake to two per year, with a view to retaining them once qualified, and partnership working with other trusts. The trust was in the process of recruiting 50 nurses from the Philippines after recruitment of nurses from Europe had not proved very successful.
- An escalation process was in place to highlight staff shortages to the senior nursing management team. This was only effective if senior staff could access nurses via the nurse bank or redeploy them from wards which were better staffed. In practice, there were frequently times where ward managers escalated staff shortages and the senior nursing team were unable to respond their nurse staffing requirements.
- We also found that where there were no trained nurses available that healthcare assistants would be sent to fill gaps in the rotas. This placed additional pressure on the existing trained staff.
- Staff on medical wards where there were higher numbers of trained staff within their establishment, due to the complexity of severity of the condition of patients within their care, told us they were frequently the first to be moved to cover staff shortages in other areas of the hospital. They told us they were concerned that leaving their designated ward short of a trained nurse while they provided cover on another ward left the ward unsafe for patients.
- The skills and experience of temporary staff differed and it was not always possible to provide care from the same staff. This had an impact on the continuity of care provided.
- Nursing handovers took place at the start of each shift on all the medical wards. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were well structured and detailed which meant that staff on duty were familiar with the needs of patients under their care.

Medical staffing

- Historically the trust have struggled to recruit into consultant medical posts at the Cumberland Infirmary. In February 2015, four out of ten consultants in on call positions were filled by locums and fifteen out of 36 resident medical doctors were locums. At the time of our inspection there were consultant vacancies in specialist posts such as gastroenterology, respiratory, care of the elderly and general cardiology.
- Following the visit in April 2014, a front and back of house model was adopted within the Cumberland Infirmary together with hospital at night. Additional foundation level doctors/a new core trainee level rota were implemented to support this.
- There had been three senior medical appointments contributing to care in respiratory medicine, acute medicine and gastroenterology.

Medical care (including older people's care)

- The hospital had cardiologist of the week, respiratory physician of the week, gastroenterologist of the week, renal physician of the week, stroke physician of the week and an out of hours gastro-intestinal bleed service in place.
- Locums underwent full induction to the trust prior to commencing work.
- There was a consultant presence on site between 8am and 10pm, 7 days a week.
- The consultant on site covered all patients from all specialities, except renal and cardiology. A ward round was undertaken Saturday and Sunday morning by a Consultant Cardiologist, a board round and review of sick patients on Willow C was also undertaken.
- Renal, cardiology, endoscopy and stroke specialities had 24/7 and 7/7 on-call consultant cover; stroke on-call cover was provided by telestroke. The renal consultant reviewed Willow B patients routinely at weekends. There were two consultants with overlapping cover to review all wards.

Major incident awareness and training

- Plans were in place to deal with the additional pressures on beds and staffing within the hospital during the winter and at other times of peak demand on services. The effectiveness of these plans was reviewed regularly in line with changing demands on the service provided.
- Several table top and live play exercises had been undertaken during 2014 and early 2015.

Are medical care services effective?

Requires improvement

Summary

At the previous inspection the medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance. However, analysis of Sentinel Stroke National Audit Programme (SSNAP) and NADIA data demonstrated that improvements are needed in the management of patients with diabetes and those who had had a stroke.

At this inspection outcomes for patients were mixed, with outcomes for stroke patients being in the next to worst category nationally. Analysis of data for Cumberland Infirmary submitted by the trust for April to September 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) showed that the trust's stroke services attained an overall score of 'D' on a scale of A to E, with A being the best. This was an improvement on the previous quarter when the hospital had been rated as 'E'. A review had been undertaken of some of the high risk clinical pathways within the trust, which included the stroke pathway. Following discussions with the clinical senate and respected stroke physicians from other trusts, a business case was in the final stages of development to seek board approval to form a hyper acute stroke unit at Cumberland Infirmary from the autumn of 2015.

The latest National Diabetes Inpatient Audit (NADIA) 2013 showed that the hospital was performing below the England average in 10 of the 21 indicators and was unchanged from the previous inspection.

However, doctors were not issued with access to the hospital information systems in a timely manner.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and had been updated periodically, as required.
- Clinical guidelines for most conditions were available and accessible via the trust intranet.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with sepsis and care of people living with dementia.
- Specific local audits were undertaken within each of the medical specialities, relevant to the care and treatment provided within the speciality. In addition, more general audits were undertaken across the medical business unit. These included infection control and documentation audits
- Patients on the medical assessment unit were reviewed by a consultant once daily, with a board round later in the day. Handovers were a mixture of verbal and written, but were comprehensive and all the medical staff interviewed spoke positively about the quality of the handovers.
- The endoscopy unit has a Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal

recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale standards.
- Sentinel Stroke National Audit Programme (SSNAP) data from October to December 2014 showed overall they remained at a "D" with improvement in physiotherapy and discharge processes but worse in admittance to a stroke unit, thrombolysis and MDT. Only 16% of patients had received a six month assessment.
- The National Diabetes Inpatient Audit (NADIA) data has not been updated since the last inspection.

Pain relief

- We spoke with five patients in detail about their pain relief. Everyone told us they had received timely and effective pain relief.
- Medication records demonstrated that patients were prescribed suitable pain relieving medicines and that they had been administered as needed.

Nutrition and hydration

- Appropriate nutritional assessments had been undertaken and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.
- Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assistance was given to those patients who needed help. We observed many examples of patients being assisted with meals and drinks in a sensitive and compassionate way.

Patient outcomes

- An analysis of data for Cumberland Infirmary submitted by the trust for April to September 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) showed that the trust's stroke services attained an overall score of 'D' on a scale of A to E, with A being the best. This was an improvement on the previous quarter when the hospital had been rated as 'E'.
- A review had been undertaken of some of the high risk clinical pathways within the trust, which included the stroke pathway. Following discussions with the clinical senate and respected stroke physicians from other trusts, a business case was in the final stages of development to seek board approval to form a hyper acute stroke unit at Cumberland Infirmary from the autumn of 2015. There was evidence to suggest that this would improve outcomes for the largest number of patients.
- An analysis of the data submitted by the trust as part of the Myocardial Ischaemia National Audit Project (MINAP) showed that Cumberland Infirmary was worse than the England average for two of the three nSTEMI indicators.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was performing below the England average in 10 of the 21 indicators.
- Readmission rates within the medical business unit were below the England average in all specialities except gastroenterology.

Competent staff

- Medical locums were long term and had undergone appropriate checks, inductions and have also supported training in a supervisory role.
- There was a system in place within the trust to ensure that staff within the medical business unit were registered with the General Medical Council and the Nursing and Midwifery Council and maintained active registration entitling them to practice.
- Nursing and medical appraisal rates across the medical division business unit were good, and were considerably improved since our last inspection.
- Nursing appraisal rates on all of the medical wards we visited were over 90%.
- All the medical staff we spoke with who were directly employed by the trust had received an appraisal during the last year.
- The 2014 NHS staff survey showed that there was a statistically significant positive change in staff reporting that their appraisal was well structured.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.

Medical care (including older people's care)

- We saw that teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. MDT decisions were recorded and care and treatment plans amended to include changes.
- Access to psychiatric input, provided by a local mental health trust, was reported by both nursing and medical staff as slow, particularly out of normal working hours. Patient referrals or requests for review of existing patients made on a Friday would frequently not be actioned until after the weekend, despite patients being otherwise fit for discharge.
- There were few specialist nurses within the hospital to support patients, although a stroke specialist nurse had been appointed since our last inspection.

Seven-day services

- Routine ward rounds did not take place at weekends; the acute physician undertook a Board round on each medical ward alongside the matron between 12pm and 2pm. Only patients requiring an urgent review were seen. Urgent reviews were undertaken by the on call doctors who were usually from another specialism with the medical unit.
- Medical wards did not have routine input from allied health professionals out of hours however, there was routine occupational therapy and physiotherapy input to the Emergency Assessment Unit at weekends.
- Basic emergency imaging services were available out of hours, such as ultra sound scans.

Access to information

- The information technology department within the trust were slow to issue access to the trust information systems. All the doctors we spoke with told us it was not unusual for colleagues to wait over a week for this type of access.
- In order to be able to work effectively, these doctors had used other doctors' passwords in order to access the electronic system. This represents a breach of confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. We saw staff obtaining verbal consent when helping patients with personal care
- .The requirements of the Mental Capacity Act 2005 were not understood by staff with regard to the application of Deprivation of Liberty Safeguards (DoLS). None of the staff we spoke with, including the ward managers, could describe when a DoLS would be required for patients receiving care and treatment at the hospital.

Are medical care services caring?

Good

Summary

At the previous inspection the medical services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.

At this inspection the findings were the same. We observed staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients. Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. All the people we spoke with were positive about their care and treatment.
- The average response rate for the Friends and Family test on medical wards at Cumberland Infirmary between Dec 2013 and August 2014 was 39%, which was better than the England average of 30%. Wards within the medical division scored better than the England average, with an average of over 90 % of patients reporting they would be likely or extremely likely to recommend these wards to friends and family.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care.

Medical care (including older people's care)

- They told us they had sufficient opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Emotional support

- There were very few specialist nurses employed at the hospital

Are medical care services responsive?

Requires improvement

Summary

At the previous inspection medical patients admitted to wards outside of the medical directorate were well managed and were seen regularly by medical staff. However, some patients were moved several times before being admitted to the most appropriate ward to treat their medical condition. Other patients were moved after 11pm in order to avoid breaches of waiting times in the Accident and Emergency department.

There were no clearly defined pathways of care in place for the care, treatment or support of patients once an initial diagnosis of living with dementia had been made.

At this inspection pressures on the availability of medical beds resulted in patients regularly being cared for on wards outside of their speciality. Systems in place for the routine review of these patients varied and required improvement. there was a delay in the repatriation of patients who had been transferred out of the area for specialist treatment. One ward we visited had three patients who had been awaiting repatriation for more than a week from areas over one hour's driving time away from Carlisle Infirmary. For families, this made visiting these people time consuming, expensive and in some cases impossible.

Patients and staff told us people were frequently moved during the night without a medical reason for doing so, which was against the trust policy. One patient we spoke with had been moved to three wards in one night and another four people had been moved between midnight and 5am.

Some patients who were otherwise fit for discharge were waiting over a week for angiograms.

Since the last inspection all the wards we visited had introduced the Butterfly scheme for patients with a diagnosis of living with dementia, but the scheme was not yet well embedded in the medical wards within the hospital. An adults 'hospital passport' is now used for patients with a learning disability and provided vital information to ward and department staff regarding the individual, their support requirements and any adjustments that may be required. The Trust has also recently developed and introduced a comments/ complaints leaflet in an accessible format.

Referral to treatment times were meeting standards in all medical specialties. There had been a sustained improvement over the past 8 months in the referral to treatment times across the medical specialities.

Service planning and delivery to meet the needs of local people

- There were good links with commissioners and other providers, including the ambulance service, during the planning and delivery of services.
- The average length of stay for patients at Carlisle Infirmary was similar to the England national average for all medical specialities except geriatric medicine and rehabilitation services which were significantly worse than the England average

Access and flow

- Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels for medical patients frequently in excess of 100%. This meant there were usually more medical patients than available beds within the hospital. Records showed that between September 2014 and December 2014 there were a total of 1,277 instances where surgical beds were occupied overnight by medical patients (medical outliers) between September 2014 and December 2014.
- Bed management meetings were held throughout the day. We found these to be generally well structured and organised, however the way in which the number of

medical patients being cared for on wards outside of their speciality was not reported accurately at these meetings. An example of this was the cardiology ward, where one patient was stated to be outside their speciality when we found an additional seven medical patients were also being cared for on this ward. The bed management team did not consider these patients were being cared for outside their speciality, despite the fact that most were respiratory patients and one was a gastroenterology patient. Reporting in this way gives an inaccurate picture of the state of the hospital to the senior team and makes it less likely that patients will be transferred to the most appropriate ward for their speciality prior to discharge.

- Medical review of medical patients being cared for on wards outside of their speciality varied, depending on the individual doctors providing their care. Some doctors would visit the ward regularly to review patients, while nursing staff told us they constantly had to remind other doctors that patients needed a review of their care and treatment.
- We reviewed eight sets of records of medical patients who were receiving care and treatment on surgical wards and found that none of them received a daily review during the week, with four receiving a review only twice weekly. We spoke with three of these patients who confirmed this and told us they were unhappy about the frequency of medical reviews.
- Beds were frequently occupied by patients, otherwise fit for discharge, who were awaiting angiograms. An angiogram is an X-ray test that uses a special dye and camera to take pictures of the blood flow in an artery or a vein and would usually be performed in a catheterisation laboratory. There was only one catheterisation laboratory at Cumberland Infirmary. There were nine in patients waiting for angiograms between 29 March 2015 and 2 April 2015. The next available list was on 7 April 2015, which meant that the longest wait was 9 days.
- Referral to treatment times were meeting standards in all medical specialties. There had been a sustained improvement over the past 8 months in the referral to treatment times across the medical specialities.
- Due to the shortage of medical beds, there was a delay in the relocation of patients who had been transferred out of the area for specialist treatment. One ward we visited had three patients who had been awaiting relocation for more than a week from areas over one hour's driving time away from Carlisle Infirmary. For families, this made visiting these people time consuming, expensive and in some cases impossible.
- Patients and staff told us people were frequently moved during the night without a medical reason for doing so, which was against the trust policy. One patient we spoke with had been moved to three wards in one night and another four people had been moved between midnight and 5am.

Meeting people's individual needs

- Progress had been made in the implementation of the trust action plan regarding the care of patients with a diagnosis of lining with dementia since our last inspection, which included the introduction of the Butterfly scheme within the hospital. The Butterfly scheme is a national project which identifies those living with dementia to staff and describes a range of approaches to help staff meet their needs. A lead nurse for patients living with dementia had been allocated on each of the wards we visited and several nurses had attended the training provided as part of the implementation of the Butterfly scheme. All of the wards we visited had received a box of Butterfly scheme information and materials for use.
- All wards, particularly the care of the elderly wards, had implemented, or had begun to implement the scheme. The leads had not been allocated any protected time to undertake these additional duties or oversee the roll out of the scheme on the wards. As there was no designated person or team to provide leadership and drive the initiative forward, it was not yet well embedded in the medical wards within the hospital. However, during our inspection we observed some examples of good interactions and care being delivered by staff at all levels to people with a diagnosis of living with dementia.
- For patients whose first language was not English, staff could access a language interpreter if required.
- An adults 'hospital passport' is used for patients with a learning disability and provides vital information to ward and department staff regarding the individual, their support requirements and any adjustments that may be required. The Trust has also recently developed and introduced a comments/complaints leaflet in an accessible format.

Medical care (including older people's care)

- Staff on Willow B ran an outpatient treatment service for patients. There was not suitable waiting area and patients waited for treatment on chairs in the corridor. We spoke with two patients during our inspection who had been waiting in the corridor for two hours.
- The discharge lounge within Carlisle Infirmary was underutilised. There was a highly skilled and experienced team in the discharge lounge but staff on the medical wards were sometimes reluctant to send patients to the discharge lounge. We discussed this with staff on the medical wards who told us that releasing a patient to the discharge lounge meant a new patient would be allocated to the ward.
- Access to information was good for patients and their families. We saw examples of comprehensive information for patients regarding the management of their health conditions.
- The requirements of the Mental Capacity Act 2005 were not being met with regard to the application of Deprivation of Liberty Safeguards.
- The trust commissioned the services of a diabetes specialist nurse for 20 hours a week, which was insufficient to deal with the demand. As the specialist nurses had to prioritise their time on the basis of patient need, there were patients they were unable to see who would have benefitted from the service they provide each time they visited the hospital.

Learning from complaints and concerns

- Staff could describe trust complaints system and tell us how they would advise patients and relatives to make a complaint, should they wish to do so.
- Large prominently displayed posters and leaflets informing people about how to make a complaint were visible on each medical ward and in corridors throughout the hospital.
- Staff told us that learning from complaints was shared at the weekly governance meetings, where relevant. We saw minutes of governance meetings which confirmed this.

Are medical care services well-led?

Good

Summary

At the last inspection the trust vision and values for the organisation had been cascaded across the medical directorate. There were examples of good leadership by individual members of medical and nursing staff throughout the medical directorate. Generally, the wards/ departments were well-led, although there was a disconnect between the staff providing hands-on care and the executive team.

At this inspection most staff had a clear understanding of the trust vision, values and objectives and the system in place to communicate risks and changes in practice to nursing staff had improved considerably. The nursing and midwifery strategy had been launched in December 2014. All the nursing staff were aware of the strategy and could tell us about the impact this might have on them in the future

Information relating to core objectives and performance targets were visibly displayed in all of the areas we visited. Junior nursing and ancillary staff understood the newly created performance boards during our last inspection and had not been engaged in the setting of the key objectives specific to their wards. During this inspection we found that staff at all levels now understood the purpose of the performance boards and felt they could directly contribute to setting of specific ward based objectives.

The system in place to communicate risks and changes in practice to nursing staff had improved considerably since our last inspection.

Matrons within the medical business unit had attended a leadership development training programme. Ward managers had either attended leadership training or were scheduled to attend in the near future.

The leadership for the newly created team of nurse practitioners required strengthening.

The medical and emergency care business unit was failing to deliver the agreed cost improvements of £3.6 million, with a forecast shortfall in excess of £ 2 million.

Vision and strategy for this service

Medical care (including older people's care)

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust vision, values and objectives had been cascaded across the medical wards and most staff had a clear understanding of what these involved, although there was less awareness amongst the medical staff than the nursing and allied health professional staff.
- The nursing and midwifery strategy launched December 2014. All the nursing staff were aware of the strategy and could tell us about the impact this might have on them in the future.

Governance, risk management and quality measurement

- Information relating to core objectives and performance targets were visibly displayed in all of the areas we visited. Junior nursing and ancillary staff understood the newly created performance boards during our last inspection and had not been engaged in the setting of the key objectives specific to their wards. During this inspection we found that staff at all levels now understood the purpose of the performance boards and felt they could directly contribute to setting of specific ward based objectives.
- The system in place to communicate risks and changes in practice to nursing staff had improved considerably since our last inspection. Information was given verbally at staff meetings and reinforced with written minutes of the meetings which were accessed by staff who were unable to attend. Staff we spoke with and minutes of meetings we reviewed confirmed this.
- A medical dashboard had been developed and was being used to monitor performance and quality against a range of targets.

Leadership of service

- We saw some examples of good leadership by individual members of medical and nursing staff throughout the medical business unit that were positive role models for staff however the disconnect between staff was still evident and had not moved on as much as expected.
- Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable.
- Matrons within the medical business unit had attended a leadership development training programme. Ward managers had either attended leadership training or were scheduled to attend in the near future.
- The team of nurse practitioners were not receiving effective leadership at the time of our inspection. They were unsure of the parameters of their roles as they did not have clear job descriptions and felt the expectations on them were sometimes greater than they felt able to deliver.

Culture within the service

- Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust.
- Staff spoke of low morale within the hospital which they attributed to the pressure of work and constantly being either short staffed or being moved to other wards which were short staffed.

Public and staff engagement

- Staff spoke very positively about the levels of nursing staff engagement in the recent nursing and midwifery strategy which had involved staff at all levels.
- The trust, including the medical business unit, scored in the worst 20% on an overall indicator of staff engagement used within the NHS staff survey in 2014, although the score is improved from 2013.

Innovation, improvement and sustainability

- The medical and emergency care business unit was failing to deliver the agreed cost improvements of £3.6 million, with a forecast shortfall in excess of £ 2 million. Weekly meetings to discuss the cost improvement programme (CIP) did not always take place.

Surgery

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

Information about the service

The hospital carried out a range of surgical services, including urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). There were six surgical wards and ten theatres that carried out emergency trauma and general surgery as well as some day case and elective surgery procedures.

As part of the inspection, we inspected the theatres, the day case unit, the endoscopy unit, the Maple B/C/D wards (elective and trauma orthopaedic wards), Beech B (the orthopaedic ward), Beech C (the emergency surgical ward) and Beech D (the elective surgery ward).

We spoke with 12 patients and the relative of another patient. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, theatres staff, the matron for general surgery, the matron for theatres, the matron for orthopaedics, the chief matron for surgery. The clinical director for general surgery, the clinical director for orthopaedics and trauma and the clinical business unit director for surgery and anaesthetics.

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

Summary of findings

During our previous inspection in April 2014, we found the surgical services at this hospital required improvement. In the course of this inspection we found that there had been a number of improvements in the service and that overall rating for the service was good.

The staffing levels and skills mix was sufficient to meet patients' needs. Although there were nursing and medical staff vacancies across the surgical services at the hospital, there were plans in place to address these. Funding had been secured for the recruitment of nurses and there were plans to recruit additional overseas nurses during July 2015. The staffing levels in the wards and theatres were suitably maintained through the use of bank and agency staff, as well as existing staff working additional hours

Patients received care in safe, clean and suitably maintained premises. There were systems in place for the escalation of patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Patient safety was monitored and incidents were investigated to assist learning and improve care.

The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist. The audit records for indicated a high level of compliance. The surgical services provided effective care and treatment that

Surgery

followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits and performance was in line with similar sized hospitals and the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements. The majority of patients had a positive outcome following their care and treatment. Patients were treated with dignity and respect by caring and committed staff.

However, the surgical services had failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014. There was insufficient bed capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled due to the lack of available beds. This meant care and treatment were not always provided in a timely way. There was effective teamwork and visible leadership within the surgical services. The majority of staff were positive about the culture and support available.

Are surgery services safe?

Good

Summary

During our previous inspection in April 2014, we highlighted that there had been six surgical 'never events' across the trust between November 2012 and January 2014. . A 'never event' is a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

There were 7.6 whole time equivalent consultant vacancies. Staff rotas were maintained through the use of locum and agency consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The clinical business unit director for surgery and anaesthetics told us that the majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.

We highlighted that there had been six surgical 'never events' between November 2012 and January 2014. There had been no 'never events' reported by the trust relating to the surgical services at the hospital since January 2014. A 'never event' is a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

At this inspection there had been no 'never events' reported by the trust relating to the surgical services at the hospital since January 2014. The staffing levels and skills mix was sufficient to meet patients' needs. Although there were nursing and medical staff vacancies across the surgical services at the hospital, there were plans in place to address these. Funding had been secured for the recruitment of nurses and there were plans to recruit additional overseas nurses during July 2015. The staffing levels in the wards and theatres were suitably maintained through the use of bank and agency staff, as well as existing staff working additional hours.

The theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist and staff adherence to WHO guidelines was monitored through monthly audits. The

audit records between October 2014 and February 2015 showed there was a high level of compliance by staff (97% to 100%) in key measures such as team brief participation and staff conduct during the sign in / sign out phases.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place for the escalation of patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Incidents

- There had been no 'never events' reported by the trust relating to the surgical services at the hospital since January 2014. There had previously been six surgical 'never events' during the period November 2012 to January 2014. A 'never event' is a serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
- The strategic executive information system data showed there were 28 serious incidents reported in relation to surgical services across the trust between February 2014 and January 2015. This included seven grade 4 pressure ulcers, five grade 3 pressure ulcers, three incidents relating to healthcare acquired infections and four incidents relating to delayed diagnosis of patients. We saw evidence that these incidents were investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. Learning from incidents was shared at weekly staff meetings and on staff notice boards in resource areas on the wards.
- Patient deaths were reviewed by individual consultants within their surgical specialty area. These were also presented and reviewed at monthly governance meetings within the surgical business unit.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections).
- Safety Thermometer information between December 2013 and December 2014 showed that the trust performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers. The data showed that the number of incidents reported each month was consistent with no was an overall increasing or decreasing trends.
- Information relating to this was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and four Clostridium difficile (C. diff) infections relating to surgery at the hospital between April 2014 and March 2015. The number of infections was within the expected limits for the hospital.
- We looked at the investigation report and action plan for a C. diff incident on Beech D (elective surgery ward) in December 2014. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- There had been no surgical site infections following hip replacement surgery reported by the hospital between July 2014 and December 2014. The hospital reported five incidents of patents acquiring surgical site infections following knee replacement surgery and two incidents of infections following fractured neck of femur (hip) surgery during this period.
- The trust had employed two surgical site infection specialist nurses, with one working at each hospital site. Their role was to provide training and to liaise with general practitioners (GP's) so patients that acquired infections following surgery could be identified and treated promptly.
- The wards and theatres we inspected were clean and safe. Staff were aware of current infection prevention

and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was appropriately checked and cleaned regularly and the equipment we saw had service stickers displayed and these were within date. Single-use, sterile instruments were stored appropriately and were within their expiry dates.
- Equipment needed for surgery was readily available and any faulty equipment could be replaced from the hospital's equipment store
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff raised requests with the maintenance team by phone and told us they received good and timely support.
- Reusable surgical instruments were sterilised on site in a dedicated sterilisation unit and theatre staff told us they did not have any concerns relating to the sterilisation or availability of surgical instruments used for surgery.
- Reusable endoscopes (used to look inside a body cavity or organ) were cleaned and decontaminated in a dedicated decontamination room. We saw that scopes were decontaminated in accordance with best practice guidelines with a segregated clean and dirty area and use of a coding system for traceability. The facility was accredited by the joint advisory group for gastrointestinal endoscopy (JAG).
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. Medical staff were aware of the policy for prescribing antimicrobial medicines.
- We saw that medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff we spoke with confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for three patients and found these to be complete, up to date and reviewed on a regular basis.
- The medication charts also showed that oxygen given to patients was prescribed and documented correctly.

Records

- The trust used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for four patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. The staff we spoke with were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was clearly displayed in the areas we inspected. Each area we inspected also had safeguarding link nurses in place.
- Safeguarding incidents were reviewed by the departmental managers and the trust safeguarding board reviews the number and trends of reported safeguarding incidents every three months.

Mandatory training

- Staff received mandatory training in areas such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and conflict resolution.
- The surgical business unit quality and safety report from February 2015 showed that overall mandatory training compliance for staff across the emergency surgery and elective care business unit was 81% up to the end of December 2014.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis. We saw that information on mandatory training performance was displayed on notice boards in each area we inspected.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- Patient records showed that saw that staff had escalated correctly, and repeat observations were taken within necessary time frames to support patient safety.
- We observed one theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- Staff carried out an audit to monitor adherence to the WHO checklist by observing theatre teams and reviewing the completed checklist records. The audit records between October 2014 and February 2015 showed there was a high level of compliance by staff (97% to 100%) in key measures such as team brief participation and staff conduct during the sign in / sign out phases.

Nursing staffing

- Nurse staffing levels were reviewed against minimum compliance standards, based on national NHS safe staffing guidelines every six months. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. Staffing levels were maintained through the use of overtime for existing staff, as well as through the use of bank or agency staff.
- The matrons told us staffing levels were based on the dependency of patients and this was reviewed daily. We saw that a patient showing confusion symptoms following surgery was provided with 1:1 nursing care.
- The theatres had sufficient numbers of staff with an appropriate skills mix to ensure surgical operations and procedures could be carried out safely. Records showed the nursing staff vacancy rate within theatres was 0.34% during December 2014 and there had been consistently low usage of bank or agency staff (less than 1%) during 2014.

- We found that Beech B (orthopaedic ward), Beech C (emergency surgical ward) and Beech D (elective surgery ward) had sufficient numbers of trained nursing and support staff.
- The vacancy rate for nursing staff was 8.34% on Beech B ward and 4.79% on Beech C / D wards during December 2014. The overall use of bank or agency staff on these wards was less than 1% between January 2014 and December 2014.
- The Maple B/C/D wards (elective and trauma orthopaedic wards) had sufficient staff numbers during the inspection. The chief matron for surgery told us the hospital had agreed funding to increase the nursing establishment from 50.84 to 72.63 whole time equivalent staff and recruitment for these positions had commenced. The hospital also planned to increase the number of patient beds on these wards from 44 to 57 beds.
- The chief matron for surgery told us the majority of existing staff vacancies would be filled by the increase in staffing on the orthopaedic wards (Maple B/ C /D) and there was also a plan to travel to the Philippines in June 2015 to source approximately 50 new nurses across the trust. In addition, the surgical wards had recruited 13 nursing cadets to provide additional support for ward staff and had also identified three healthcare assistants that will be sponsored for nurse training.
- The matrons for general surgery and orthopaedics and the chief matron for surgery told us there had been improvements in staffing levels since our last inspection in July 2014; however they also confirmed that further recruitment was planned in order to fully meet patient needs.
- Ward staff told us they felt busy at all times and told us their workload increased where high dependency patients were admitted to the wards. However, they told us they were able to provide safe and effective care to patients. Patients spoke positively about the staff and did not highlight any concerns relating to staffing numbers.

Surgical staffing

- The wards and theatres we inspected had a sufficient number of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The proportion of consultants, middle grade doctors and junior doctors was greater than the England average. The proportion of registrars was below the England average (24% compared with the England average of 37%).
- Records showed that during February 2015, the consultant establishment within surgical services at the hospital was for 44.50 whole time equivalent posts, of which 36.9 whole time equivalent consultants were permanently employed. There were 7.6 whole time equivalent consultant vacancies. Staff rotas were maintained through the use of three locum consultants and four agency consultants during this month.
- Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The clinical business unit director for surgery and anaesthetics told us that the majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.
- The clinical business unit director told us they had appointed a urology consultant that was due to start in July 2015 and would replace the existing locum consultant in place. There were two locums in place within the ear, nose and throat (ENT) specialty and a vacancy for one ENT consultant was currently advertised.
- The clinical business unit director told us they had also identified a consultant within general surgery that would replace a locum consultant within that specialty. There were three consultant vacancies advertised within ophthalmology and one vacancy advertised for a trauma and orthopaedic consultant.
- The clinical business unit director and clinical directors for general surgery and trauma and orthopaedics told us they had historical difficulties in recruiting suitable staff due to the geography and location of the trust. However, they were confident that the skills mix was sufficient to ensure all surgical specialties provided by the hospital were covered by appropriately skilled consultant surgeons and anaesthetists.
- There were 8.13 whole time consultant anaesthetists at the hospital during February 2015 with one vacant post. The hospital used a locum consultant anaesthetist to

provide additional cover during the month. The clinical business unit director told us they had recently appointed four anaesthetists during March 2015 to address the shortfall across both hospitals.

- We found there was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed except ophthalmology on call consultants who had clinics and/or theatre lists whilst on call.
- The ward and theatre staff told us they received good support from the consultants and ward-based doctors.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the surgical services, and this listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected and staff were aware of how to access this information when needed.

Are surgery services effective?

Good

Summary

At the previous inspection we reported that surgery was managed in accordance with recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Royal College of Surgeons standards for emergency surgery. We looked at audit data for general surgical, orthopaedic and ophthalmology at a trust wide level and found evidence that this information was available in the areas we visited. Patient reported outcome measures, although available, were not used or discussed.

At this inspection the surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements in compliance with the national hip fracture audit and performance reported outcomes measures.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE). Emergency surgery was managed in accordance with the National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).
- Enhanced recovery pathways were used in a number of surgical specialities. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- During 2013/14 the emergency surgery and elective care business unit completed 95 local clinical audits and participated in 11 National audits. The business unit identified 12 national audits for which the trust was eligible and participation in 128 local audits during 2014/15.
- Audit findings were reviewed at monthly business unit governance board meetings. Progress against the clinical audit plan 2014/15 and compliance with NICE guidelines was also reported to the trust-wide safety and quality committee every three months. The quarter 3 clinical audit report stated 340 NICE guidelines were relevant to the trust and 231 of 340 (68%) were found to be compliant however only 57 (17%) had been audited. 109 were awaiting compliance status.

- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at five policies and procedures on the hospital's intranet and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. Patients told us staff gave them pain relief medication when needed.
- Staff in the surgical wards and theatres were supported by a clinical nurse specialist and two acute pain specialist nurses that worked at each hospital. Some of the staff in the acute pain team had moved to other posts or retired. The trust had identified that the pain management services provided did not adequately meet the pain management needs of all its patients.
- A business case to consolidate acute pain services across the Trust was under development.

Nutrition and hydration

- The patient records included assessments of patients' nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients did not eat enough, this was addressed by the medical staff to ensure patient safety. Patient records also showed that there was regular dietician involvement with patients who were identified as being at risk. Patients with difficulties eating and drinking were placed on special diets.
- Wards had protected mealtimes in place when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- Pre-prepared meal bags were offered to patients following surgery so they could eat and drink as soon as possible following surgery.

Patient outcomes

- The national hip fracture audit 2014, reporting on all of 2013, showed that the hospital performed better than the England average for five out of the nine indicators, including the percentage of patients admitted to orthopaedic care within four hours, the number of patients developing pressure ulcers and for total the length of patient stay at the hospital.
- The hip fracture report highlighted that the hospital performed worse than the England average for patients having a pre-operative assessment by an orthopaedic geriatrician, bone health medication assessments, falls assessments and the number of patients having surgery on the day of or after day of admission.
- The clinical business unit director for surgery and anaesthetics told us they had made improvements in compliance since the 2014 audit and had also recruited two consultant orthopaedic geriatricians with one based at each of the trust's two hospitals.
- Trust data showed that the number of patients assessed by an orthopaedic geriatrician, bone health medication assessments completed, falls assessments completed and the number of patients having surgery on the day of or after day of admission had improved and the hospital had performed better than the England average between July 2014 and February 2015.
- The lung cancer audit 2014, reporting on all of 2013, showed the trust performed better than the England and Wales average for the number of cases discussed at multidisciplinary meetings and the percentage of patients having a CT scan before bronchoscopy. The trust performed worse than the England and Wales average for the percentage of patients receiving surgery in all cases (9.8% compared with the average of 15.1%).
- The national bowel cancer audit of 2014 showed that the trust was performing better than the England average for the number of patients that had a CT scan, the number of patients for whom laparoscopic surgery was attempted, length of stay above five days,
- The trust performed similar to the England average for the number of cases discussed at multidisciplinary team meetings (98% compared with average of 99.1%) and the number of patients seen by a clinical nurse specialist (87.4% compared with average of 87.8%).
- The national bowel cancer audit also showed that the trust was worse than the England average for case

ascertainment rate (86% compared with average of 94%), data completeness (79% compared with average of 87%) and the number of patients that underwent major surgery (53.7% compared with average of 63.7%).

- The national emergency laparotomy audit (NELA) report from May 2014 showed that 11 out of the 28 standards were met by the hospital. This included having a fully staffed emergency theatre available at all times, a care pathway for the management of patients with sepsis and policies for consultant surgeons and consultant anaesthetists to formally hand over in person.
- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or better than the England average.
- The number of patients that had elective and non-elective surgery and were readmitted to hospital following discharge was similar to or better than the England average for all specialties.
- The average length of stay for elective and non-elective patients across all specialties was better the England average.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Records showed 70% of nursing staff and 54% of medical staff across the surgical services at the hospital had completed their annual appraisals up to the end of December 2014.
- Appraisals were on-going and the staff we spoke with told us they routinely received supervision and annual appraisals.
- Records showed that 100% of surgical medical staff had been positively recommended to the General Medical Council for revalidation.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- The ward staff we spoke with told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed that there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff we spoke with told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- Consultant were available between 8am and 10pm, with a consultant on call during out-of-hours service. At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- The hospital used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant that staff could access all the information needed about the patient at any time.
- Notice boards detailed information relating to staffing levels and identified patients with specific needs, such as patients at risk of falls. Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected.

- Staff told us the information about patients they cared for was easily accessible. Staff could access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to explain how they sought informed verbal and written consent from patients before providing care or treatment. Patient records showed that consent had been obtained appropriately from patients or their representatives and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from the appropriate person (advocate, carer or relative) that could legally make decisions on the patient's behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Are surgery services caring?

Good

Summary

At the previous inspection we reported that surgical services were delivered by a hardworking, caring and compassionate staff. We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took patients' wishes into account.

At this inspection patients spoke positively about their care and treatment. They were treated with dignity and compassion.

Data for patient satisfaction surveys showed that most patients were positive about recommending the hospital's wards to friends and family. Staff kept patients and their relatives involved in their care and supported their emotional needs.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- We spoke with 12 patients and the relative of another patient. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between December 2013 and January 2015 showed that the surgical wards consistently scored above the England average, indicating that most patients were positive about recommending the hospital's wards to friends and family.
- The percentage of patients that completed the survey out of all eligible patients (average response rate) was 20%, which was worse than the England average of 32%. Ward staff told us they routinely encourage more patients to complete the test when they were discharged from the hospital.
- A review of the data from the CQC's adult inpatient survey 2013 showed that the trust was about the same compared with other trusts for all 10 sections, based on 414 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient records included pre-admission and pre-operative assessments that took into account individual patient preferences.

Surgery

- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. One patient commented that "excellent communications with consultant, procedures were well described".

Emotional support

- Patients told us they were supported with their emotional needs. Information leaflets were available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that they were able to voice any concerns or anxieties.
- Staff could also access psychological support for the families of patients who were seriously ill.

Are surgery services responsive?

Requires improvement

Summary

At the previous inspection we reported that senior managers are aware of the current issues within surgery services and are considering changes in the way the service is delivered. Referral to treatment time (RTT) was not being met for admitted patients. Staff were able to learn from complaints as weekly team meeting minutes showed that the discussion of complaints was a regular agenda item and there was also a box containing all complaints relevant to the ward located at the nurse's station.

As in the previous inspection the surgical services failed to meet 18 week referral to treatment standards across all specialties between July 2013 and September 2014. There was insufficient bed capacity in the wards due to surgical beds being occupied by medical patients. This meant that operations were frequently cancelled due to the lack of available beds. The number of patients whose operations were cancelled and were not treated within the 28 days was worse than the England average between July 2013 and September 2014.

There were systems in place to support vulnerable patients. The majority of complaints relating to surgical services at the hospital were resolved within expected time frames during 2014/15. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The hospital provided a range of elective and unplanned surgical services for the communities it served. This included trauma and orthopaedics, ophthalmology, oral surgery, urology and general surgery (such as colorectal surgery).
- Hospital episode statistics 2013/14 data showed that 25,477 patients were admitted for surgery at the trust between July 2013 and June 2014. The data showed that 48% of patients had day case procedures, 19% had elective surgery and 33% were emergency surgical patients.
- There were arrangements in place with neighbouring trusts to allow the transfer of appropriate patients for surgical specialties not provided by the hospital, such as oncology, spinal surgery and plastic surgery.
- The hospital had ten operating theatres for surgery, including two day surgery theatres.
- There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week with a separate theatres for trauma 8am to 5pm seven days a week so that patients requiring emergency surgery during out of hours and weekends could be operated on promptly.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas

such as medication and communication to the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patients stay at the hospital.

- The overall trust-wide bed occupancy rate between April 2013 and September 2014 ranged between 84.4% and 89.7%. The high level of bed occupancy was reflected in the surgical wards we visited as we found that all available beds were occupied. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- We did not see significant numbers of medical patients admitted to the surgical wards (medical outliers) during the inspection. However, staff told us medical patients were regularly admitted to the surgical wards over the past few months due to a lack of available beds within medical wards.
- Records showed that between September 2014 and December 2014 there were a total of 1,277 instances where surgical beds were occupied overnight by medical patients (medical outliers) between September 2014 and December 2014.
- Trust data for operations cancelled on the day of surgery at the hospital showed that there had been a total of 1143 operations cancelled on the day of surgery between July 2014 and March 2015 and these accounted for 9.8% of all operations carried out at the hospital. Approximately 50% of the cancellations were due to clinical reasons or patient choice. However, 528 of the 1143 (47%) operations cancelled on the day of surgery were due to non-clinical reasons.
- Trust data for all operations cancelled across the trust (including prior to admission and on day of surgery) showed that there had been a total of 695 operations cancelled for non-clinical reasons between January and March 2015, and 419 (62%) of these cancellations were due to ward beds unavailable and bed shortages.
- NHS England data showed that between July 2013 and September 2014 the trust performed worse than the England average for the number of patients whose operations were cancelled and were not treated within the 28 days. A total of 88 patients were not treated within 28 days during this period.
- The trust measured operating theatre session times (minus time lost through late starts and early finishes). The data between April 2014 and March 2015 showed that the percentage of sessions that were completed within scheduled times across the hospital's operating theatres ranged from 78% to 83%. This meant there were occasions where theatre lists started and finished later than scheduled.
- NHS England data showed national targets for 18 week referral to treatment (RTT) standards for admitted patients were not achieved between April 2013 and November 2014 only 79.4% of patients were seen within 18 weeks. The data showed that the trust did not meet the waiting time target of 90% for any of the surgical specialties provided.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia care. The areas we inspected also had dementia link nurses in place. Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff also used an 'adult passport' document for patients admitted to the hospital with a learning disability or dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could access appropriate equipment, such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the trust.

- The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified individual managers when complaints were overdue.
- Staff told us that information about complaints was discussed at weekly staff meetings to aid future learning.
- During 2014/15, the trust received a total of 234 complaints relating to the surgical services. This included 175 complaints related to surgical services provided at this hospital. The trust resolved 150 complaints (85%) within the agreed timeframe with six closed beyond the agreed date.
- The most frequent reason for patient complaints (77% of complaints received) related to the treatment and care provided along with the outcomes of the treatment by the clinicians during inpatient and outpatient care.

Are surgery services well-led?

Good

Summary

At the previous inspection we reported the trust had a vision and strategy for the organisation with clear aims and objectives. The trust's vision, values and objectives had been cascaded across the surgical wards and departments and most staff had a clear understanding of what these involved. From the information provided, it is unclear whether information on the surgical dashboard was discussed during governance meetings for all the surgical specialities.

At this inspection the trust vision and values had been cascaded across the surgical wards and departments and staff had a clear understanding of what these involved. Whilst strategic direction for surgical services was included as a key element within the overall trust clinical strategy, there were no standalone detailed strategic plans specifically for these services. Plans for improving the services were incorporated into other trust wide strategies, such as the medical workforce strategy 2014-19, which included specific objectives such as improving 7 days service provision and plans to centralise surgical services at each hospital in order to improve patient care. The trust planned to develop a standalone detailed strategic plan for the emergency surgery and elective care business unit during 2015.

There was effective teamwork and clearly visible leadership within the surgical services. The majority of staff were positive about the culture and support available. Monthly governance meetings reviewed incidents, key risks and monitoring of performance. Risks were documented and escalated by the service appropriately. There was routine public and staff engagement and actions were taken to improve the services.

Vision and strategy for this service

- The trust vision was "to provide person centred world class quality healthcare services" and the values were based on providing safe, caring and responsive services.
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.
- Whilst strategic direction for surgical services was included as a key element within the overall trust clinical strategy, there were no standalone detailed strategic plans specifically for these services. Plans for improving the services were incorporated into other trust wide strategies, such as the medical workforce strategy 2014-19, which included specific objectives such as improving 7 days service provision and plans to centralise surgical services at each hospital in order to improve patient care. The trust planned to develop a standalone detailed strategic plan for the emergency surgery and elective care business unit during 2015..

Governance, risk management and quality measurement

- There were monthly governance meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Risks were documented and escalated by the service appropriately. The risk register for surgery showed that key risks had been identified and assessed. The biggest risk was the lack of progress on cancellation of operations.

- In each area we inspected, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Information relating to patient safety was displayed on notice boards in each of the areas we inspected. This provided up-to-date information on staff training and appraisal, specific issues and audit performance.
- We saw that routine audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to ward and theatre managers through performance dashboards.

Leadership of service

- There were clearly defined and visible leadership roles across the emergency surgery and elective care business unit. The services were divided into clinical directorates based on specific surgical specialties and each speciality had a clinical director and an operational service manager.
- The surgical wards were led by ward managers that reported to the matron for general surgery or the matron for orthopaedics. The matron for theatres oversaw the theatres across both hospitals.
- The theatres and ward based staff we spoke with told us they understood the reporting structures clearly and that they received good support from their managers.

Culture within the service

- The staff we spoke with were proud, motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- The surgical business unit governance report from February 2015 showed that staff sickness levels across the surgical services ranged between 4.66% and 6.15% between January and December 2014. The sickness levels were higher than the overall trust and national averages during that period. The most frequent reasons for staff sickness were anxiety, stress, depression or other psychiatric illnesses and other musculoskeletal problems.
- Staff sickness levels were reviewed daily in the wards and theatres and staffing levels were maintained through the use of overtime for existing staff and bank and agency staff.

Public and staff engagement

- The patient experience team conducted monthly surveys by speaking with patients on the surgical wards. The surveys asked for patient opinions in nine areas, including respect and dignity, involvement, pain control, doctors, nurses, pain control and medicines. Feedback from patient surveys was displayed in the areas was mostly positive with average scores of nine out of 10.
- The trust also carried out a patient survey between April and December 2014. The survey was based on the national NHS patient survey programme and involved questionnaires being mailed to patients at home shortly after discharge.
- The average score for this hospital's inpatient surgical wards was 79%, based on 709 responses. The average score for the hospital's day case services was 87%, based on 403 responses. This showed the majority of patients were satisfied with the care they received.
- The survey highlighted areas for improvement including patient involvement during discharge processes, cleanliness and hand hygiene and information relating to medicines and their side effects.
- The staff we spoke with told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. The trust also engaged with staff via email blogs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The medical staff took part in away days that took place eight times per year and included training and discussions around improvements to clinical processes.
- The surgical business unit had reviewed the findings from the 2013 survey of NHS staff and identified areas for improvement relating to the percentage of staff witnessing errors, near misses and incidents, communication between managers and staff, the health and wellbeing of staff, staff motivation at work and staff experiencing violence from patients and other staff.
- The surgical business unit staff survey action plan 2015 listed actions taken to improve these areas including encouraging staff to report incidents, training on

preventing and handling aggression to staff, improving team briefings and communication and improvements in training, appraisal and development opportunities for staff.

Innovation, improvement and sustainability

- The medical workforce strategy 2014-19 and nursing, midwifery and allied health professionals strategy 2014-17 outlined planned improvements for surgical services with specific objectives relating to staffing and delivery of services.
- The chief matron for surgery and clinical business unit director told us the key risks to the surgical services were staffing and ensuring vacancies were filled and improving compliance against 18 week referral to treatment standards. They told us they were confident the services were sustainable.
- The surgical services had recently developed a ward 'heat map', which included up-to-date information on key indicators such as patient safety information, complaints and staffing. The chief matron for surgery told us they planned to use these across all the surgical departments.
- The surgical services had implemented a ward accreditation scheme, which would assess individual wards and departments based on their performance.
- There was an on-going action plan to improve performance against RTT standards for each specialty. This included key actions such as improved planning to reduce the back log of patients, improving theatre capacity and use of private sector healthcare organisations to treat patients awaiting surgery.

Critical care

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

Information about the service

The critical care unit at Cumberland Infirmary is a nine bedded integrated intensive care and high dependency unit with five level 3 and four level 2 beds commissioned. In reality the beds were flexed according to demand and sometimes this balance changed. For example there had been occasions when the unit had to manage nine level 3 patients. There was also a side room with an atrium or gowning area that was used for patients with specific infection control issues. The side room could provide either positive or negative pressure as required. At the time of our inspection there were five patients on the unit (three level 3 and two level 2).

Although functional, both clinical areas were dated with limited space and natural light and fellshort of the most recent HBN-04-2 specifications. Cumberland Infirmary was the first private finance initiative (PFI) hospital in the country.

For the purposes of governance the unit sits in the emergency care and medicine business unit. During the inspection we spoke with three medical staff, more than ten members of the nursing team, two patients and one set of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

The previous inspection in April 2014 identified improvements required in the submission of data to the Intensive Care National Audit and Research Centre (ICNARC).We found at this inspection the unit consistently collected and submitted ICNARC data for validation,. The data confirmed that patient outcomes were within the expected ranges when compared with similar units nationally.

However, we did identify some concerns regarding nursing and medical staffing that required some improvement. In the course of the inspection we found that there were sufficient numbers of suitably skilled nursing staff to care for the patients. We saw that when bed numbers and/or patient acuity increased it was not always possible to maintain the Intensive Care Societies minimum nursing staffing levels. In addition, there were no supernumerary clinical hours for senior nurses built into the staffing rota. In effect this meant that if patient numbers and acuity demanded then the nurse in charge would need to care for a patient and their ability to fulfil the management and clinical supervisory role in the unit was compromised.

There was access to a consultant and middle grade anaesthetist at all times although out of hours the middle grade anaesthetist had on call responsibilities for other specialities such as theatres and maternity. This meant that potentially a patient could find themselves waiting in an emergency for appropriate medical attention. We raised this with the trust at the

Critical care

time of our inspection who took immediate action to improve anaesthetic cover. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was shared and evaluated. Care was delivered by caring, compassionate and committed staff and patients, their relatives and friends were treated with dignity and respect. Patients and those close to them were positive about the care and treatment provided by the Critical Care Team.

Are critical care services safe?

Requires improvement

Summary

As at the previous inspection in April 2014 there were robust systems embedded for reporting and learning from incidents. There was an awareness of the need to provide a safe and clean environment for patients and performance against safety thermometer indicators was effectively monitored.

However, at this inspection there were elements within the safety domain that required improvement..

There were occasions when the patient occupancy and acuity means that not all the Intensive Care Society nurse staffing standards were met. More specifically it is not always possible to ensure that one nurse looks after one level 3 patient and there were no supernumerary senior nurse hours built into the rota. We were advised that all occasions when the staffing and acuity on the unit outstripped the staffing numbers were reported as incidents. From the medical perspective, out of hours cover for critical care was provided by an anaesthetist who also had to cover obstetric emergencies and theatres.

The monthly incident figures showed that the 'top' incidents in the unit were pressure sores, lack of resources and staffing levels. Further analysis showed that of the 31 pressure sores reported as incidents, 14 were reported as being developed whilst in the North Cumbria trust. In terms of lack of resources the most commonly cited incidents related to a lack of beds and pressure relieving mattresses.

Both clinical areas, although functional, were dated with limited space and natural light and fell short of the most recent HBN-04-2 specifications.

Incidents

- All the staff we spoke with were confident in using the trust's incident reporting system. They also felt that they received adequate feedback mainly via the staff huddles held on both daily on both day and nights shifts.
- Incidents were investigated when indicated and the outcome reports were available for staff to read. There was evidence that learning from incidents and near misses were shared and learning applied. For example,

since May 2014, longer guide wires had been introduced following the investigations into two previously reported never events involving central venous catheter guide wire retention. In addition two man checks had been introduced alongside revised electronic records. We saw 'lessons learned' information in a communication file and the results of incident investigations and associated action plans displayed on the staff room noticeboard.

- There had been no never events reported in critical care since the last inspection.
- The business unit produced monthly incident figures which showed that there had been 160 reported incidents in the Cumberland Infirmary critical care unit between April and December 2014. Of the reported incidents 78 had resulted in no harm to the patient. Forty-seven had resulted in minor harm, 10 in moderate harm and 22 near misses with one incident remaining open and under investigation. This demonstrated a good reporting culture.
- The monthly incident figures showed that the 'top' incidents in the unit were pressure sores, lack of resources and staffing levels. Further analysis showed that of the 31 pressure sores reported as incidents, 14 were reported as being developed whilst in the North Cumbria trust. In terms of lack of resources the most commonly cited incidents related to a lack of beds and pressure relieving mattresses.
- Staff were aware of the recently introduced responsibilities around duty of candour and referred to information leaflets that were available.

Safety thermometer

- The safety thermometer information on display in the unit gave a quick and simple method for surveying patient harm. This information along with the unit's vision and values statements was displayed outside the relatives' room in the entrance lobby to the unit.
- Staff completed documentation on pressure areas each day and completed an incident report should any issues be noted. This and other patient risk assessments were continually updated on the unit's electronic record system.

Cleanliness, infection control and hygiene

- At the time of inspection the unit was clean if somewhat cluttered.
- We saw staff adhering to good practice guidance for the prevention and control of infection. There were adequate numbers of hand washing sinks and hand gel dispensers throughout the unit.
- We saw staff using personal preventative equipment appropriately, such as gloves and aprons, when delivering care and treatment.
- Disposable curtains were being used around the bed areas and they were 'in date'.
- All staff including visiting physicians adopted a bare below the elbow approach.
- The unit had an isolation cubicle available with the ability to adjust the airflow independently to provide either positive or negative pressure depending upon the needs of the patient being isolated.

Environment and equipment

- Although functional, both clinical areas were dated with limited space and natural light and fell short of the most recent HBN-04-2 specifications.
- Each bed space was suitably equipped and able to manage the care and treatment of a level 3 patient.
- There was a lack of storage space for equipment and disposables on the unit. This had been recognised as an issue.
- Resuscitation and difficult airway trolleys were in place and checked daily and/or after use. We did find a laryngeal mask with out of date packaging, which we brought to the attention of the staff at the time who replaced the mask.
- The transfer kit was also checked daily so that it was ready for use when required.

Medicines

- Allergies were clearly documented in the electronic prescription records that we looked at.
- All patients' medicines were stored securely in a locked cupboard.
- The resuscitation trolleys had recently been reviewed and drugs were now only used from emergency drug boxes rather than being also stored on the trolley.
- We saw that the controlled drugs were administered in accordance with the Nursing and Midwifery Council standards for medicines management.
- Controlled drug stocks were reconciled daily.

Records

- The unit utilised a complete electronic medical records system which also assisted clinical decision making. This enabled care and treatment to be planned in a way that promoted continuity with a reduced risk of omissions and errors. It included electronic prescribing and a series of clinical and non-clinical risk assessments all in line with national and local ally developed guidance.
- The electronic record system allowed hard copy records to be printed for the ward teams when patents were discharged from critical care.

Safeguarding

- We saw evidence in the training records that all staff had received both adult and children's' safeguarding training at level one. With sisters and link nurses having completed adult safeguarding to level two and sisters and link nurses having completed children's' safeguarding to level three.
- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.

Mandatory training

- Detailed records were kept of the extensive range of mandatory training undertaken for all nursing staff.
- The records clearly showed who was up to date with what mandatory training subject. Over 85% of staff were up to date with their mandatory training.

Assessing and responding to patient risk

- There were tools in place for the early detection of deterioration and we were informed that appropriate medical assistance could be requested at all times.
- The patient's electronic records contained a range of clinical risk assessments. For example, venous thromboembolism, moving and handling and visual infusion phlebitis (VIP) assessments.
- The wards used a national early warning scoring system (NEWS) to facilitate the early detection of the deteriorating patient. The NEWS documentation clearly stated the escalation pathway for deteriorating patients.
- There was a critical care outreach team who were able to provide a 24/7 service. This included having time to teach and undertake audit. Every attempt was made to ensure that two outreach staff were on duty Monday to Friday and referrals could be made by any members of the ward team that had concerns about a patient.
- Daily activity data sets were completed by the outreach team so that their performance and effectiveness could be measured. Outreach staff also undertook their own audits and contributed to national cardiac arrest audit data.
- The outreach service did not yet provide any follow up clinic opportunities for ex critical care patients. There was no clinical psychology support available.
- We were told that sometimes the ward staff found it difficult to understand the hard copy information printed from critical care's electronic record system however, the outreach team were able to support the ward staff with this if needed.

Nursing staffing

- On the day of inspection there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that people received safe care and treatment.
- There were five patients on the unit (three at level 3 and two at level 2) and there were seven nursing staff on duty although the planned number was for eight. Since the last inspection the team had been augmented by the appointment of two ward clerks working 20 hours each per week.
- However, from talking to staff and reviewing evidence it is clear that there are times when minimum nursing staffing levels, as defined by the intensive care society standards, were not met. For example, in addition to the bedside nurse ratios of one nurse per level 3 patient and one nurse for every two level 2 patient there should be a clinical co-ordinator who is not included in the bedside nurse ratios at either band 6 or 7. This does not occur and no supernumerary or management time is planned into the rota.
- We saw that sub-optimal nurse staffing numbers were mainly supported by unit staff working additional hours. We saw that the escalation plan made reference to the use of bank or agency staff but that no process was apparently available for this to actually happen.
- At times when the unit was not busy staff were moved to help in other in-patient areas. This process was detailed in a staff escalation policy. Understandably staff preferred to stay on the unit and not be moved. Although the escalation procedure stated that they should return to critical care if the patient numbers and acuity demanded.
- We saw that there were two shift handovers per day and in addition a sister to sister handover took place to

include any non-clinical issues. The sisters had recently introduced a daily handover sheet to help ensure that important information was communicated between shifts.
- All new nursing staff were supernumerary until deemed competent to work unsupervised.

Medical staffing

- The unit was led by a clinical director based predominantly at the Cumberland Infirmary site.
- The unit itself had a consultant of the day who worked from 8am until 5pm assisted by a middle grade anaesthetist until 8pm. This arrangement does not lend itself to the same levels of continuity that having a consultant on for five days would provide.
- Out of hours medical cover was provided by a middle grade anaesthetist with consultant availability on call. We were told that often the on call consultant actually stayed on site. It should be noted that the out of hours middle grade medical cover for critical care also provided cover for the obstetric unit, cardiac arrests and theatres. Whilst this level of cover has not been reported as resulting in any actual patient harm, the potential exists for delays in medical attendance if the middle grade medic was attending to patients on obstetrics, theatres or was on a cardiac arrest call.

Major incident awareness and training

- The unit had a major incident plan. There was an up to date version on the intranet.
- Staff received training on managing a major incident.
- We did not see any evidence to demonstrate that the major incident plan had been practised.

Are critical care services effective?

Good

Summary

At the last inspection we found that there had been a gap in the unit's data collection and submissions to ICNARC had been missed. At this inspection we saw that the unit demonstrated continuous patient data contributions to ICNARC.This data showed that patient outcomes were within the expected ranges when compared with similar units nationally. Care was delivered in line with evidence-based, best practice guidance. There was a commitment to clinical audit and evaluation.

The trust was also part of the North of England Critical Care Network (NoECCN) and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE). For example we saw care bundles for sepsis, ventilator acquired pneumonia, falls and nutrition. From talking to staff we saw that the care bundles in use were now better embedded than at the last inspection. We noted however, that at present the unit had not yet implemented a delirium scoring process although we were told that this was 'work in progress'.
- All policies, procedures and guidance were readily available for staff at the bedside via the trust intranet and the electronic patient record system.
- We saw that care and treatment was non-discriminatory.
- At the last inspection we found that there had been a gap in the unit's data collection and submissions to ICNARC had been missed. At this inspection we saw that the unit demonstrated continuous patient data contributions to ICNARC. There was a member of the nursing team who had dedicated hours assigned for ICNARC data management. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The ICNARC data showed the unit performed within expected parameters on all metrics when compared with similar units nationally.

Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain.

Critical care

- The trust provided an acute pain management service led by a band 7 nurse who was assisted by two band 6 nurses. The team operated across both trust sites and we were told currently had no medical lead.
- The unit at Cumberland Infirmary used a different type of patient controlled analgesia (PCA) delivery system to the one used at the West Cumberland Infirmary in Whitehaven. We saw that currently there was no formal PCA training for nursing staff.
- There was no epidural pain relief service being provided.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration.
- People had a choice of suitable food and drinks with hot and cold drinks being available throughout the day and night.
- We saw strict fluid balance monitoring for patients which included hourly and daily totals of input and output.
- Staff had easy access to a dietician who was able to support patients with their individual dietary requirements.

Patient outcomes

- Information was routinely collected about the outcomes of people's care and treatment.
- Low levels of central venous catheter related infections, pressure sores and a low standardised mortality rate indicate a good approach to clinical care.
- Since the last inspection the unit had introduced the use of patient diaries. They are often used in cases where people have been sedated and subject to mechanical ventilation. There are completed by the nursing staff and relatives and allow the patient to later reflect on their stay in critical care as they try to evaluate and make sense of the time they were unconscious.

Competent staff

- Whilst the unit had a practice educator, the post holder had to work across both trust hospital sites.
- Staff completed an equipment competency evaluation to assess their ability and review the effectiveness of the guidance.
- New nurses went through a supernumerary period and there was a comprehensive and robust mentoring and preceptorship programme.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- We saw that all nursing staff were in receipt of an annual appraisal and staff told us about their personal development opportunities. For example senior nurses had been involved in a leadership programme.
- Greater than 50% of the trained nursing staff had completed a post registration award in critical care nursing.
- All trained nurses had been trained in intermediate life support with many of the senior nurses also having obtained advanced life support qualifications.
- All the staff we spoke with told us they felt supported and that one of the unit's strengths was its peer support.

Multidisciplinary working

- We saw evidence of positive multi-disciplinary team working. For example, ward rounds would often include relevant professionals like nurses, specialist nurses, physiotherapists, dieticians and pharmacist which helped to improve communication and coordinate patient care.
- The critical care outreach team worked closely with the unit staff and visited the unit every day to establish the likelihood of any discharges. The critical care outreach staff had also assisted in the unit when requested to do so.
- During the course of the inspection we saw a patient being admitted to the unit from the wards by the outreach team who had been monitoring the deteriorating patient on the ward and then liaising with the critical care team to facilitate their admission.

Seven-day services

- A consultant led ward round took place every week day. At the weekend and out of hours consultant cover was via an on-call rota. Out of hours and at weekends the unit relied on medical cover from a middle grade anaesthetist who also had on call responsibilities for obstetrics, theatres and if required, patient transfers.
- Out of hours pharmacy, physiotherapy and imaging services were available during the daytime at weekends and then via on call.

Access to information

- All the information needed to deliver effective care and treatment was readily available to staff via the bed side access to the electronic patient record system.

- Formal handover documentation was prepared for ward staff when a patient was discharged from critical care. We were told that at times ward staff found it difficult to interpret the electronic system print outs and that the outreach staff would then help to interpret the records.
- The relative's room contained a variety of useful information for visitors including how to contact the patient advisory and liaison team (PALS). The relatives we spoke with told us that they were given all the information they needed about the care and treatment of their loved one.

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

- The review date had passed for the trust consent policy that we saw.
- The staff we spoke to were able to demonstrate understanding of the issues of consent and capacity for patients in critical care.
- Whilst staff were able to verbalise their understanding of restraint, there were as yet no delirium or restraint pathways in place.
- We saw no evidence of best interest decision making processes.
- There had only been three DOLS applications in the last year across the trust.

Are critical care services caring?

Good

Summary

As at the previous inspection in April 2014 we saw that critical care was being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect and the care being delivered was patient focussed taking their wishes into account.

Compassionate care

- We saw that staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- Staff were encouraging, sensitive and supportive in their attitude. When we arrived on the unit staff were supporting the family of a patient who had very recently passed away. We saw that they managed this situation with professionalism and sensitivity.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people appropriately explanations given prior to care being delivered. We noted that closure clips and do not disturb signs were used to effect.
- Visiting times were flexible to accommodate the varying needs and commitments of people.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with people so that where possible they understood their care and treatment. This was corroborated by the two patients that we were able to speak with during the inspection.
- We spoke with three relatives visiting the critical care unit during the inspection and all spoke highly of the care their relative was receiving. They confirmed that they were kept informed and updated as to 'what was going on'.
- Since the last inspection the unit had introduced patient diaries for those people who were unconscious during part of their stay in critical care. Intensive care patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- All records of care were reported on the unit's electronic patient record and information system which included a record of any communication with relatives and friends. The electronic system also prompted junior doctors to talk to relatives daily. This had been as a response to a patient experience survey which reported that there were not enough opportunities to talk to medical staff. This was an example of the trust's 'you said and we did' scheme in action.
- Language interpreters and sign language interpreters were available on the unit should they be required.

Emotional support

Critical care

- By their actions, staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- We saw that staff offered a bereavement service, which included 'memory boxes', which may include a hand print or lock of hair. An annual memorial service was also organised and we were told was very well attended.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relatives care and treatment plans.
- There was a senior nurse for organ donation in post who worked closely with the critical team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.

Are critical care services responsive?

Good

Summary

At the previous inspection in April 2014 the evidence showed that patients were well supported when, and if, they underwent a transition from the ICU to the ward or in preparation for their discharge. Patients were admitted to or discharged from the unit within four hours of the making of the decision. The unit was very proactive in ensuring appropriate length of stay and patients' rehabilitation needs were assessed within 24 hours of admission to the critical care unit. The unit had the resource of an outreach team to provide follow-up service for patients discharged from ICU.

However, it was recognised that the workload in critical care was steadily increasing in conjunction with the reconfiguration of patient pathways across the trust. Concerned about the likely impact that this would have on service delivery, the unit's leaders had been instrumental in commissioning an independent report published in July 2014 which reviewed and made recommendations for the future capacity and capability of the critical care service at Cumberland Infirmary. For the last validated quarter of ICNARC data (October to December 2014) the number of admissions to the unit was 197. This was the highest number for any quarter since data had been collected back in 2010.

Service planning and delivery to meet the needs of local people

- Delivering a full range of acute and critical care services to a relatively rural community on two geographically distant and separate sites is operationally challenging. The trust's long term strategy for the provision of critical care services across the two sites is still under review.
- Since the last inspection the trust had sanctioned an increase in the capacity of the unit by one bed. This increase in capability included 5.4 whole time equivalent nursing posts though this did not enable a supernumerary senior nurse on the rota.

Meeting people's individual needs

- There were a number of structured bed management meetings throughout the day. These were attended by representatives from all the specialties including critical care. The meetings gave an overview of the bed management situation within the trust.
- The unit was funded for five level 3 patients and four level 2 patients. However, the reality was that the occupancy and acuity flexed according to patient need. So on occasions the unit had managed nine level 3 patients. When this happened, the staffing levels meant that level 3 patients did not always receive care on a 1:1 nurse patient basis.
- The care records that we reviewed demonstrated that peoples' individual needs were taken into consideration before delivering care.
- The team on critical care were able to meet the cultural needs of patient's in terms of religious beliefs and specialist dietary requirements.
- There were facilities for relatives and visitors situated just outside the door to the clinical area. These included the option to make a drink and also a separate area to lie down. Although at the time of inspection this area was being used to store equipment.

Access and flow

- The number of admissions to the unit had steadily increased in line with the re-configuration of services across the trust that included major elective and all emergency surgery being moved to the Cumberland Infirmary site.
- Patients requiring critical care were admitted within four hours of the decision being made that they needed that level of care.

Critical care

- There were low numbers of delayed discharges with most patients being discharged within 4 hours though for the October to December 2014 quarter 8-10% of patients were discharged out of hours.
- A growing number of elective surgical cases had been cancelled. Discussions took place daily between the nurse in charge, anaesthetists and surgeons if bed availability looked like being a problem. Other measures had been instigated to improve patient flows and mitigate against cancellation such as :
  - Re-arranging the order of operating lists.
  - The use of extended recovery.

Learning from complaints and concerns

- We found low levels of complaints about critical care and evidence that the service responded promptly to people's comments and concerns.
- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with trust policy.

Are critical care services well-led?

Good

Summary

At the previous inspection in April 2014 the trust had a vision and values for the organisation, which had been cascaded across the hospital. We found examples of good leadership by individual members of staff. We found the unit to be well-led with good interaction with the executive team.

At this inspection the medical and nursing team on the unit were committed to providing the safest care possible. The unit leaders had been instrumental in driving the 2014 independent review by the North of England Critical Care Network into the current and future capacity of the Cumberland Infirmary unit. It was not yet clear which of the report's recommendations for the longer term capability of the unit were to be implemented.

Vision and strategy for this service

- There was a clear vision and strategy presented by the trust in that it strove to be 'safe, caring and responsive'.
- In 2014 the trust commissioned a critical care capacity review, which was carried out by the North of England Critical Care Network. They duly published their findings in a report dated July 2014. A key recommendation was that the trust should develop a trust wide critical care delivery group to allow for greater co-ordination and longer term planning of the critical care service across the trust. To date this group had not been established.
- In terms of the advanced nurse practitioner service their plan or strategy, once qualified, was unclear in terms of lines of accountability and funding.

Governance, risk management and quality measurement

- Governance processes were in place to monitor and review the quality of the service provided in critical care. These included governance and staff meetings where dashboard reports were considered in respect of incidents, complaints and risk.
- We saw that monthly meetings took place to discuss activity within the unit and reflect upon incidents.
- The keys outcomes from the various staff and governance meetings was shared during a daily 'huddle' within the unit.

Leadership of service

- Senior medical and nurse leaders were committed to providing a safe service for their patients.
- The critical care unit had a designated consultant clinical lead and the nursing team was led by an experienced matron. The matron worked across both trust hospital critical care units.
- The critical care team at Cumberland Infirmary had been instrumental in driving the 2014 independent review into current and future critical care capacity at Cumberland Infirmary. This had been borne out of increased admission rates, increased non-clinical transfers out of the unit and increased cancellation of elective surgical cases. The review was also asked to consider nurse staffing levels in light of the increased occupancy and reconfiguration of trust wide patient pathways.

Culture within the service

- The culture within the unit was one where staff felt supported and they worked as a cohesive team.
- Staff did voice the perception that since moving to the emergency care and medical business unit there was a view in the wider hospital that critical care had too many staff. Staff told us that the unit was approached on a daily basis and asked to assist in covering staffing gaps

on the medical wards. Staff felt that there was perhaps a lack of understanding in the business unit about the nature of critical care, the acuity of critical care patients of why they needed the staffing levels they did? There were times when even the critical care Matron was overruled and staff were moved to assist in other areas.

Public and staff engagement

- Staff struggled to understand the logic of their recent business unit move from surgery to medicine, where it was felt that there was a lack of understanding about critical care and its specific management.

Innovation, improvement and sustainability

- The unit was an active member of the North of England Critical Care Network. Membership of the network enabled the unit through collaborative working with commissioners, providers and users of critical care to focus on making improvements where they were required.
- The 2014 critical care capacity review published a number of recommendations that if implemented would serve to improve the critical care capability at Cumberland Infirmary. These include:
  - The development of a trust wide critical care delivery group.
  - Physical expansion of the critical care facility including staffing and support services is required in the longer term.

Maternity and gynaecology

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

Information about the service

Cumberland Infirmary in Carlisle provided care and treatment for maternity and gynaecology patients in Carlisle and the surrounding rural areas of North Cumbria. The maternity services comprised outpatient clinics, a ward for post natal and ante-natal care and a delivery suite. Community midwifery services were provided by midwives employed by the trust. For gynaecology patients there was a women's outpatients department, and inpatient beds on a surgical ward. There was a termination of pregnancy service which operated as part of the surgical services.

During our visit we spoke with 20 staff and six patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for four patients. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

The service was managed through the North Cumbria University Hospital emergency surgical and elective care business unit and was led by a clinical director with a head of midwifery professional lead.

There had been a review of Cumbria wide provision of maternity services by the Royal College of Obstetricians with the report being published the week before the inspection. Managers and staff were keen to understand how this would affect the service provided at West Cumberland Hospital and this led to uncertainty about the future of the service.

Summary of findings

At the previous inspection in April 2015 we found that the maternity service was delivered by committed and compassionate staff that treated patients with dignity and respect. The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. However, we found that the risks identified were still in place and sufficient actions to mitigate them had not yet been implemented.

In the course of this inspection we found that an epidural service remained unavailable although plans were in place to introduce this in September 2015. There were still inadequate medical staff numbers to provide sufficient out of hours cover.

The midwife to birth ratio was 1 to 25. This was better than the England average which was 1 to 28. All patients received one to one care during labour

One never event had occurred in the service in April 2014. Learning from this incident had been shared, however, managers were unable to provide information that the use of the five steps to safer surgery, which would help mitigate the risk of recurrence of this event.

There were concerns regarding medicines management and how learning from errors was managed and applied.

Maternity and gynaecology

Staff carried out skills training in the management of maternity emergencies. However, not all midwives or doctors were up to date with this training which meant they may not be able to respond as necessary in an emergency.

Care and treatment was delivered in accordance with National Evidence based guidance. There had been an increase in the clinical and quality audits completed however in the maternity service actions for improvement and change were not always evident.

Although consultation about the future of the service with the local population had increased since the last inspection Staff reported a lack of visibility of the senior management team at this hospital site and a lack of clarity regarding future plans.

Are maternity and gynaecology services safe?

Requires improvement

Summary

At the previous inspection safety required improvement There was a lack of medical staff and this remained the same, specifically out of normal working hours, which led to concerns for high risk patients or those requiring surgical intervention.

One never event had occurred at the hospital in April 2014. This had been a swab which was retained following obstetric surgery. Learning from this had been shared. The trust was unable to provide information that the use of the five steps to safer surgery, which would mitigate the risk of recurrence of this event, was audited to ensure compliance.

Patients and staff from the surgical ward moved freely into and out of the delivery suite and this area was accessible to visitors from the surgical ward. This compromised the security of the patients and babies in this area.

Required actions as a result of learning from incidents were inadequately shared throughout the trust. The procedures for the safe management of medicines were not always followed. Medical staff in the maternity service were not all up to date with their mandatory training.

Staff carried out skills training in the management of maternity emergencies. Not all midwives or doctors were up to date with this training which meant they not be able to respond as necessary in an emergency. The last practice drill for evacuating a patient from the birthing pool could not be given. A new safety net for this purpose had been purchased but staff had not practised using this equipment in an emergency.

The midwife to birth ratio was 1 to 25. This was better than the England average which was 1 to 28. We were told 100% of patients had one to one care during labour.

Information from the NHS safety thermometers indicated that the service was performing within expected ranges for these measures. Clinical risks to patients were identified and actions to reduce them were put in place. A mortality

action plan had been developed in response to a Cumbria wide review of perinatal mortality. These actions included the introduction of additional risk assessments, audits and review of care pathways.

The maternity and gynaecology units were clean and tidy however not all practices and procedures met with infection prevention and control guidance. Midwifery staff had received appropriate training. Required records were kept correctly. There were measures in place to protect patients from abuse. Midwifery staffing was adequate to meet the needs of the patients.

Incidents

- Staff told us there was a clear incident reporting system which was easy to use. There was a "trigger list for incident reporting maternity services" which was on display in in the communal staff areas. This was designed to serve as a reminder for staff of what to report as an incident.
- One never event had occurred at the hospital in April 2014. Never events are serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. This had been a swab which was retained following obstetric surgery. Learnings from this had been shared. The trust was unable to provide information that the use of the five steps to safer surgery, which would mitigate the risk of recurrence of this event, was audited to ensure compliance.
- A record of incidents was kept with subsequent investigations, outcomes and further actions if required. Managers said they used this record to identify any patterns emerging and would discuss these at labour ward forums.
- The numbers of incidents reported in the last nine months had remained static, however there were four serious incidents reported in the past 12 months. These incidents had been or were in the process of being investigated. Action plans had resulted where the investigation was completed.
- We saw that whilst there were actions regarding the individual issues identified from a serious incident any wider learning was not evident. Two of the serious incidents were related to errors in the administration of medicines, one at each hospital site within the trust. Whilst the specifics of that medicine had been managed to prevent recurrence the overarching issue of incorrect procedures for checking medicines prior to administration had not been addressed. This meant learning from the incidents was not robust.
- Mortality and morbidity within the maternity services were included in the "maternity services quarterly integrated governance report." In the report of January 2015 there were two neonatal deaths and one intrauterine death included. The status of investigations and any resulting actions were part of the report.
- A mortality action plan had been developed in response to a Cumbria wide review of perinatal mortality in February 2013 and learnings from a perinatal mortality daylong meeting held in July 2014. These actions included introduction of additional risk assessments, audits and review of care pathways. Of the 29 actions on the plan eight had been completed in January 2015 with target dates of March and April 2015 for the remaining actions.

Safety thermometer

- Information from the NHS safety thermometers (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, catheter and urinary infections) indicated that the service was performing within expected ranges for these measures. This information was displayed on the unit and was freely available for patients and staff. We were told the maternity ward was to pilot a new maternity specific safety thermometer, but this was not yet in use.
- There were additional information boards in the ward area which had monthly information such as the normal delivery rate, the number of patients seen within 30 minutes of triage and the breastfeeding rates. Staff said they used this information as discussion about their performance at ward meetings.
- We reviewed the maternity dashboard as part of the inspection. This contained clinical data against performance targets set by the trust such as numbers of birth by caesarean section, number of inductions, morbidity and mortality information, rates for health equality measures such as smoking during pregnancy and quality information such as staffing levels and complaints. We found there were strategies for improvement in place for some areas where the indicators were outside of the targets, such as high

caesarean section rates. However for others, such as high induction of labour rate for which the target was set at 15% but in November it was 34.8% there were no improvement strategies in place.
- Information from the maternity dashboard was shared with staff in the monthly newsletter. This included data, a summary of achievements against targets and when this information would be discussed further, for example a celebrating normality day to be held in May.

Cleanliness, infection control and hygiene

- Information provided by the trust showed there had been no incidences of MRSA or Clostridium Difficile in the maternity services.
- In the December 2014 report to the Infection prevention and control committee it was documented that the hand washing audit score was 100%.
- During the inspection whilst most staff were seen to adhere to the correct procedures for the prevention and control of the spread of infection we saw one senior staff member wearing jewellery which could pose a risk of the spread of infection.
- Facilities and space provided on the delivery suite for the cleaning and storing of dirty equipment and storing clinical waste for collection were inadequate. There was one small room used for this purpose and for the examination and disposal of placentas and the tissue products from termination of pregnancy. It was documented on the risk register that soiled equipment may have to be cleaned in the corridor outside this room and the storage of waste made access to this room and hand washing facilities difficult increasing the risk of cross contamination. This had been included on the maternity risk register in November 2014, however staff were unaware of future plans for improvement. In February 2015 a pilot project had been agreed on another ward in the hospital and if this was successful it may be "rolled out across the hospital including maternity." This meant in the meantime the risk of the spread of infection continued.
- We saw the other areas on the maternity unit to be clean and tidy.
- Patients were asked as part of the "Two minutes of your time" survey how clean they thought the hospital ward or room had been. In December 2014 the score was an average of 9.11 out of 10.
- Information provided by the trust showed 52% of medical staff and 71% of midwifery staff had completed training in infection prevention and control. This did not meet the trust's target of 80% and meant not all staff were aware of the correct procedures to follow.
- 99% of midwifery staff had completed training in hand hygiene which exceeded the trust's target of 95%, whilst 88% of medical staff had completed this training which meant the target for this staff group was not reached.

Environment and equipment

- Staff said they had the equipment they required to do their jobs. There were sufficient numbers of necessary equipment, such as Cardiotogography monitors.
- Equipment, such as that for resuscitation of adults and babies had been checked and staff told us this was done at every shift handover. This was recorded on a white board outside the room where the equipment was kept and this information had the date, time and staff member responsible recorded. Checklists were electronically archived by the clinical midwife manager.
- One of the emergency trolleys had a checklist completed for the day of the inspection which recorded all had been checked and was correct. We found there was incorrect storage of medicines on this trolley which had not been recorded and corrective actions had not been taken. This meant the procedure for checking and recording the correct storage of equipment on these emergency trolleys was not followed in practice.
- There was an empty portable storage trolley on the delivery suite which maternity staff said was for the adjoining surgical ward. This had a note on it dated 8 March 2015 that it was to be filled with appropriate stock. We were told this had not been completed as staff were awaiting direction as to the stock required as it was for the use of trainee doctors at night. However it had remained empty since that date which could mean doctors did not have ready access to equipment they required.
- An incident had been reported in January 2015 when a patient from the surgical ward had impeded and slightly delayed the transfer time of a baby to the special care baby unit on a resucititaire. No remedial actions were taken as a result of this incident.

- We saw that patients and staff from the surgical ward moved freely into and out of the delivery suite and this area was accessible to visitors from the surgical ward. This compromised the security of the patients and babies in this area.
- Staff told us they could not recall when they last carried out a practice drill for evacuating a patient from the birthing pool. A new safety net for this purpose had been purchased and this meant staff would not have practised using this equipment in an emergency.

Medicines

- We found not all medicines were stored in line with the medication policy of the trust. There were loose strips of tablets in an unlocked drawer of an emergency trolley on the corridor of the maternity ward. These were not in boxes and had no labels attached for accurate identification of the medicines. This meant medicines were not securely stored in that area.
- There was an open tube of ointment in one drawer of this trolley which was labelled for single use. This meant it could be re-sued, for different patients, which was not in line with infection control practices.
- One item of medicine on this trolley had no visible expiry date as it had worn off the glass container. This meant this medicine could not have been checked correctly, in line with the trust's policy, prior to administration.
- There had been two reported medicine errors in the maternity services across the trust, one in each site, in the past 12 months. We talked with staff regarding the learning from these incidents and found that specific changes had been made, such as the withdrawal of a product which was not a medicine, but was in similar packaging. However both incidents had been due to the procedure for checking the label of a product before administration not being followed and no actions to address this had been taken.
- Information provided by the trust showed that 78% of midwifery staff had completed medication management training with 70% having completed training in calculating drug dosages for adults. Of the medical staff working in the maternity services only 44% had completed medication management training with 40% having completed training in calculating drug dosages. This meant that not all staff, including 60% of the medical staff, who prescribed and administered medicines were trained to do so.
- Both of these training courses were completed once during a staff member's employment with the trust with no regular updates in place. This meant staff who had completed this training could have done so several years ago with no refresher to their practice being completed.
- Staff confirmed there were no observational checks carried out as part of their training or monitoring of their ongoing competence to administer medicines.
- At the time of the last inspection there had been an issue with the scavenger system for the safe removal of Entonox from the birthing pool room. We were told this had been resolved and this room was now safe to use.

Records

- We reviewed patient records and found the information was clear, legible and plans of care were evident with a record of the treatment a patient had received.
- Risk assessments were present in the records. These included standardised assessments such as those for venous thrombosis and any additional risks identified such as those associated with a high body mass index.
- Staff told us that the documentation to admit a patient for an elective caesarean section, was onerous and repetitive and could typically take one hour and 40 minutes to complete. They felt this should be reviewed to ensure it was less time consuming.
- The "Child Health record" (red book) was issued to mothers and advice was available on how to keep the document as a main record of a child's health.
- At the last inspection in was noted that any safeguarding information was not easily accessible in the notes. We were told this had changed and it was now clearly identified for quick reference for staff.

Safeguarding

- Midwifery staff had received training in the identification of adults and children who may be at risk of abuse or had signs that abuse might be taking place. 89% of midwifery staff had completed training in safeguarding children and young people to level 3 which is the required attained standard. 94% had completed the training in safeguarding adults to level 1 with 71% having completed level 2.
- Not all medical staff had completed the training required to ensure they would identify signs of abuse of adults and children. 58% of medical staff in the maternity unit had completed training in safeguarding

children and young people with 76% having completed this training for adults. This meant doctors may not offer the support required for patients who were at risk of or were subject to abuse.
- We were told that the current electronic information system meant the lead midwife for safeguarding was not notified if an incident form was completed where a potential issue of safeguarding for an adult or child was identified. Staff were concerned this meant these reported incidents may not brought to the attention of the correct person and the necessary support may not be offered.
- Midwives knew how to access support from other agencies outside of the trust if this was required.

Mandatory training

- Information provided by the trust showed that 65% of medical staff and 88% of nursing staff in the maternity services at North Cumbria University Hospitals trust were up to date with mandatory training. There were no targets set for this overall training performance.
- The majority of mandatory training for the medical staff did not meet the trust targets. This included 68% being up to date with fires safety, 52% for infection prevention and control and 68% for health and safety against the trust target for each of 80%. This meant not all medical staff were up to date with essential training for their role.
- Some training rates for medical staff were below the targets and highlighted as a risk on the information provided. This included 48% of medical staff having completed a self-assessment on the management of medical devices against a target of 95%, 44% had completed training on records management and keeping, with 36% completed risk management training both against a target of 80%. This meant less than half of the medical staff had received training and had the required knowledge and skills in these areas.
- There were no high risks identified in the training data provided by the trust for the maternity nursing staff. Of the 40 required training activities 30 met or exceeded the trust's target. Of the remaining basic adult life support had the fewest people trained with 60 staff members requiring this training. This meant whilst the training for nursing staff was significantly more up to date than for medical staff there remained a significant number who had not completed essential training.
- The training data for staff who worked in the gynaecology service were included in the trust wide information. We saw that managers of individual areas, such as the female surgical ward, kept their own records to ensure they knew when staff were required to complete training.

Assessing and responding to patient risk

- Staff told us that an assessment of the risks to the patient and baby were carried out as part of the ante-natal screening programme. We saw records of assessments which included past medical and maternity history and social risk which may impact on the mother or baby.
- Should a high risk factor be recognised at this stage the required support would be made available. We were told this could include multi-disciplinary specialist advice including such as diabetes in pregnancy.
- There were guidelines for the risk assessment of venous thromboembolism and staff were aware of their responsibilities to assess and reduce this risk.
- We saw equipment for managing obstetric emergencies, such as post partum haemorrhage was available and easily accessible.
- We requested a copy of the risk assessment for use of the birthing pool. This was never received from the trust.
- Staff said they carried out skills training in the management of maternity emergencies. Not all midwives or doctors were up to date with this training which meant they not be able to respond as necessary in an emergency.
- Staff used and early warning score system to assess if a patient's condition was deteriorating.
- Midwifery staff were reminded of the need to assess maternal and neonatal risk factors in the monthly newsletter. This included guidelines for group B streptococcus in the newborn where there was a learning for staff following a missed opportunity for early diagnosis of infection.
- We saw the World Health Organisations guidance for 5 steps to safer surgery was in use as part of the routine of surgical procedures. Information about how compliance with this was monitored was requested but not provided.
- No admissions to the intensive care unit from the maternity unit had been necessary in the past six months.

Midwifery staffing

Maternity and gynaecology

- An assessment of the midwifery staffing numbers using the birthrate plus assessment tool had been completed in January 2015. The final report was to be presented to the trust board. We were told that it was hoped staff numbers would increase.
- The midwife to birth ratio was 1 to 25. This was better than the England average which was 1 to 28. We were told 100% of patients had one to one care during labour.
- There was a midwife who was allocated to triage any patients who contacted the ward for advice over a 24 hour period. We were told this midwife may not be able to provide this service without taking on other duties, such as working on the delivery suite. This meant they may be unavailable to provide advice immediately, but staff said the delay was minimal.
- Staff told us the numbers were usually sufficient to carry out their duties and provide a high level of care. There were six qualified midwives on duty during the day and five at night with midwifery care assistants available on most shifts.
- Should there be a shortage of staff, for example due to sickness, an escalation policy was in place whereby community midwives would be brought into the hospital. The community midwives did not normally rotate in their duties to include working in the hospital. This could mean their skills were not kept up to date should they be required to work on the wards or delivery suite. One midwife discussed that they were going to work for three months in the community, at their request, to gain experience, but were also working one day per week in the delivery suite to keep up their skills.
- Verbal handovers took place between shifts and staff made records of the patient care and the requirements of the patients they were to support.
- Patients who were having gynaecology surgical procedures were accommodated on a female surgical ward. The staff on this ward said there were usually sufficient staff to manage the expected workload.

Medical staffing

- The trust discussed the issue of not being able to recruit medical staff to Cumberland Hospital Carlisle, despite recruitment initiatives. This had an impact on provision of some services such as the provision of epidurals due to the lack of sufficient trained anaesthetic cover.
- We were told the out of hours anaesthetic cover of one consultant and one trainee doctor to cover surgery and maternity concerned the doctors as it left the provision of anaesthesia vulnerable.
- Nurses and midwives described good support from the doctors and adequate cover to obtain medical help or advice should they need it, including out of hours.
- We were told that some doctors worked long hours with one saying it was “normal to work 24 hours non-stop which could include operating in the day and working as on call during the night.

Major incident awareness and training

- Staff were aware there was a major incident policy and knew how to access it should they be required to do so. They had not been part of a drill.

Are maternity and gynaecology services effective?

Requires improvement

Summary

At the previous inspection the service did not offer epidurals and did not have access to a dedicated anaesthetist. This impacted on the ability of the service to deliver effective pain relief in a timely manner. The trust was not meeting national guidelines of having an anaesthetist available at all times for obstetrics.

At this inspection the maternity service still required improvement to be fully effective for patients due to not meeting the NICE guidance to provide an epidural service. An action plan was ongoing and progress had been made since the last inspection. It was expected this service would be available from September 2015. The lack of this service had impacted with the higher than expected use of intramuscular diamorphine as pain relief which provided limited pain relief during labour and may have significant side effects for both mother and baby.

There were not always action plans for improvement where outcomes for patients were audited and found to be below the trust’s target around post partum haemorrhage and induction of labour.

Maternity and gynaecology

The breastfeeding rate was reported on the maternity dashboard. The trust's target of greater than 68% of mother's breastfeeding was met on one month out of the previous 12. The hospital action plan in place should improve this.

The caesarean section rates were higher than the trusts' target during seven months between January and November 2014. The trust set their target at less than 25%. The highest was 36.1% with the lowest 21.5%. A strategy for the reduction of caesarean sections had been introduced and the rate had reduced from 30.8% in December 2014 to 22.6% in January 2015.

The number of instrumental vaginal births had reduced from 15.7% in November to 5.3% in January. This meant there was a reduction in intervention during labour leading to a more normal birth for the patient. There were some measures in place to monitor the competence of staff; however not all areas of practice were assessed. There were some good examples of team working although a lack of specific multi-disciplinary working to improve patient outcomes. Staff had an understanding of their role to support patients who may lack mental capacity.

Evidence-based care and treatment

- Policies we saw were based on NICE and Royal College of Obstetrics and gynaecology guidelines. Those such as the induction of labour guideline had been updated in line with reviewed NICE and RCOG guidelines.
- Guidelines and policies were reviewed within a cyclical process, and also as part of the audit process. This work was managed through the trusts' Maternity Guideline and Information Group (MAGIG).
- In the January 2015 report to the trust wide safety and quality committee it was reported that of the completed local audits 83% indicated good or acceptable practice and the remaining 17% indicated poor practice. Improvement actions had been identified.
- The lack of epidural pain relief in the hospital did not comply with NICE guidance CG190 which states "If a woman in labour asks for regional analgesia (epidural), comply with her request." This cannot be met if this type of analgesia is not available.
- The rates of post-partum haemorrhage were greater than the trusts' target of less than 1% of total births during 7 of 11 months between January and November 2014. An audit across the trust had been completed in July 2014 however this contained no conclusion or recommendations. This meant whilst audits were being completed they were not being used to improve practice.
- The induction of labour rates were higher than the trusts' target for eleven months from January 2014 to November 2014. The trust set their target at 15% of the total births per month and the highest was 34.8% with the lowest 20.3%. An audit of inductions had been carried out in 2013 and recommendations made however there had been no dissemination of the outcomes or subsequent changes to practice.
- Medical and midwifery staff stated there was a lack of sharing of knowledge and experiences between the two hospital sites in the trust. This meant opportunities to learn and change practice as a result of good or poor practice were missed. An example was the ongoing work to reduce delays in the start of caesarean sections, to ensure this met with NICE guidance, at Whitehaven was not replicated at Carlisle.

Pain relief

- The full range of pain relief in line with national guidance was not available at Carlisle hospital. There was no epidural service provided. We were told by medical and nursing staff that actions to introduce this service had begun. Posts had been offered to two additional anaesthetists with start dates to be confirmed. Doctors and midwives had started training and some had visited another hospital to view the service they offered. We were told this service should be available from September and both doctors and midwives were keen to do this as slowly as necessary to ensure it was introduced safely.
- Staff and patients said it was explained, from the beginning of their pregnancy, that an epidural service was not available at Carlisle and they could chose to give birth at Whitehaven should they want this type of analgesia. We saw that some patients had chosen to do this, however there were no accurate figures of how many patients were affected by this lack of service as we saw not all staff reported it as an incident as per the guidance they were given.
- We looked at the medication administration records for 12 patients during delivery. 67% of patients had received intramuscular diamorphine as pain relief. NICE guidance states that diamorphine will provide limited

pain relief during labour and may have significant side effects for both her (drowsiness, nausea and vomiting) and her baby (short-term respiratory depression and drowsiness which may last several days) The number of patients who received this analgesia could have been lower if an epidural service had been available. There was no audit of pain relief methods carried out.

- A birthing pool was available for patients to use for pain relief prior to giving birth, or for a water birth. We were told it was not widely used although the reasons for this were unclear some staff said it was due to a lack of confidence of midwives to use the pool. There had been 22 births in water in the past six months.
- At the time of the last inspection there had been an issue with the safety of the ventilation system in the room with the birthing pool. This was now resolved.
- Patients told us and we saw records to indicate that pain was assessed through discussion with the patient, both by midwives and nurses for gynaecology patients. The available pain relief was then provided in a timely way.

Nutrition and hydration

- The trust had achieved the Baby Friendly Initiative, however had not maintained the standard for this and lost it several years ago. This is a recognised United Nations International Children's Emergency Fund UK initiative which consists of three stages of assessment including, parents feedback with regard to support for breast feeding. An action plan was in place to regain this award which was to be assessed by Baby Friendly representatives in early May.
- The breastfeeding rate was reported on the maternity dashboard. The trust's target of greater than 68% of mother's breastfeeding was met on one month out of the previous 12. The hospital had an action plan in place which should improve this.
- Patients said they could choose which method of feeding to use and were supported in this by staff.
- Patients had access to food and drink if required. Staff could provide hot and cold snacks.

Patient outcomes

- Information from the trust is that there were 1836 births expected at Carlisle Infirmary consultant led unit in 2014. The Royal College of Obstetrics and Gynaecology define a consultant led unit with less than 3000 births per year as small. There are six consultant led units in the UK with less than 2000 births per year and therefore a comparable unit is used by the trust to benchmark their performance.
- The caesarean section rates were higher than the trusts' target during seven months between January and November 2014. The trust set their target at less than 25%. The highest was 36.1% with the lowest 21.5%. A strategy for the reduction of caesarean sections had been introduced and the rate had reduced from 30.8% in December 2014 to 22.6% in January 2014.
- One of the strategies for reducing the rate further was the development of VBAC clinics (Vaginal birth after caesarean section). These were still in the planning stage despite having been discussed for the past 12 months. Staff said they thought the development of the clinic was part of the consultant midwife's role. This meant there was a lack of clarity of the plans for reducing the caesarean section rate.
- The rate of normal births, that is those without medical or surgical intervention, was in line with the England average.
- The number of instrumental vaginal births had reduced from 15.7% in November to 5.3% in January. This meant there was a reduction in intervention during labour leading to a more normal birth for the patient.
- Information provided by the trust showed a higher than target rate of unexpected admissions of babies to the neonatal unit. The target of less than 1% was exceeded in eight of eleven months from January 2014 to November 2014 with it being over 8% in six of those months. This was being continuously audited and monitored by the maternity governance group; however there was no action plan in place to reduce it.

Competent staff

- Information provided by the trust showed 100% of midwives had received an appraisal of their work in the past 6 months.
- The local supervising authority had completed an audit of the trust in October 2014. The number of supervisors to midwives was one to eleven which was acceptable. The role of the supervisor is to protect the public through good practice. They monitor the practices of midwives to ensure the mothers and babies receive good quality safe care.

- At that audit two of the four areas of practice audited had been met with the remaining two partially met. An action plan had been developed to work towards meeting the shortfall.
- PROMPT (PRactical Obstetric Multi-Professional Training) was provided to midwives and medical staff to ensure they had practical experience of obstetric emergencies. 96% of midwives, 77% of healthcare assistants and 44% of medical staff had completed this training. We were told skills and drills training within the clinical area was adhoc dependant on the workload. This meant whilst midwives were up to date with this training not all doctors were.
- We were told there was no assessment of the competence of midwives to carry out specific tasks such as medicine administration or assisting a patient out of the birthing pool in an emergency. This meant there was no continuous monitoring of the competence of staff to carry out all aspects of their work.

Multidisciplinary working

- Midwives discussed how there was some access to multi-disciplinary colleagues, such as diabetic specialists, should a patient require additional treatment or assessment. There were no specific multi-disciplinary clinics scheduled.
- Midwives and other staff working in the maternity services discussed how they worked well as a team, supporting each other and working together for the patients.
- There was a lack of clarity from the managers regarding the role of the community midwives and communication with them. We were told some midwives were now working between the hospital and the community, spending some time in each setting. The way this was going to work was unclear as we were given conflicting information.
- We were told throughout the inspection that patients with a high body mass index were increasing and presented as potentially high risk care through their pregnancy. There were no additional measures in place to manage this patient population, including from the ante natal stage.
- Staff in the gynaecology outpatient services said they could access doctors when they were required without delay.
- On the female surgical ward where gynaecology patients would be accommodated staff said they could have some patients who were receiving medical care on the ward. If this was the case they reported there was no delay in obtaining medical assistance should it be required.
- We were told throughout the inspection that communication between the two hospital sites within the trust was poor and there was little cohesion with care pathways and guidance. This had been acknowledged and some work was underway to improve it with joint meetings for various grades of staff taking place monthly.

Seven-day services

- Staff on the maternity unit and the female surgical ward provided a seven day service. This included a triage system for ante-natal patients who may wish to access advice and support out of the normal working hours.
- The termination of pregnancy service was available on a specific day each week. There were no other services in the area, such as private facilities, for patients to attend. This did limit their access to the service and could cause a delay in them obtaining treatment. Discussions to expand this service had taken place and although medical staff were willing to extend their working hours to facilitate it, there was no availability of ward space or nursing staff to accommodate this.
- Midwives said they felt well supported by doctors at any time and they responded to requests for assistance in a timely manner.

Access to information

- Nursing and medical staff had access to Mother's records which were held securely in the office.
- Nursing charts were used and accessible to nursing staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 93% of midwives had received training about the mental capacity act and 94% in the deprivation of liberty safeguards.
- Midwives and nurses had some knowledge of how to support patients who may lack capacity and had specialist midwives they could ask for help and support if required.
- We saw that consent forms for caesarean sections were correctly completed.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

Summary

As in our previous inspection patients told us they were "very happy" with the care they had received. They said staff had been attentive and treated them with respect. Staff delivered care in a way which protected the privacy and dignity of patients. The layout of the ward created an environment which did not allow for care of all patients to be delivered in a sensitive way.

There was additional support available for patients who suffered a bereavement and those with additional support needs such as due to mental health issues. Patients could have a family member with them should they wish and they told us they were included in decision making about their own care.

Compassionate care

- In the friends and family test the hospital site scored better than the England average in the December 2013 to November 2014 survey. 89% of respondents would recommend ante-natal care; however this reduced to 73% for care in labour which was below some other trusts in the region.
- Patients told us they received "very good care" in the maternity unit of the hospital. They said they had good support from the staff who kept them informed, gave them choices and treated them with dignity and privacy.
- We saw staff protecting the privacy and dignity of patients, by closing doors, using privacy notices and keeping information confidential.
- Staff interacted with patients in a friendly but respectful manner.
- Staff on the surgical ward where women would be accommodated to recover from gynaecology surgery were aware of the potential lack of privacy and dignity for them due to the layout of the ward. Where possible they ensured a side room was used when available.
- The service for termination of pregnancy was organised such that patients were seen as part of the general surgical list. This meant their procedure could be cancelled should the operating theatre be required for an urgent general surgical procedure to be completed.
- Staff acknowledged that the layout of the ward which resulted in the close proximity of patients who were having a termination of their pregnancy to those who were in labour and delivering their child was not conducive to providing compassionate care. However despite this and senior midwives being aware no actions had been taken to reduce the negative impact on patients.

Understanding and involvement of patients and those close to them

- Patients told us they had been involved in their care. We saw discussions regarding their choices were recorded.
- Close family members were able to stay with a women in labour, if they wished.
- One partner told us they had felt included in the care of their partner during the delivery of their baby.

Emotional support

- Staff had an understanding of the need to offer emotional support to mothers throughout their pregnancy. This included additional support if they had experienced a difficult birth previously.
- There was an understanding that patients with additional mental health needs may require extra support during their pregnancy. Staff were aware of how to refer to community services if required and community nurses would provide additional support if necessary.
- There was a bereavement midwife who could offer support to bereaved parents. They also provided advice and help to other midwives in order that they could better support patients.
- Staff said one room had recently been refurbished to provide specific space for parents who had been bereaved. This room was no yet ready for patients use. Staff were unable to unlock it to show to the inspectors during the visit.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Requires improvement

Summary

At the previous inspection issues had been identified with the ventilation system within the department to remove anaesthetic gases when women were using Entonox. This had been resolved.

The service did not have dedicated beds for termination of pregnancy. . There were some improvements since the last inspection, such as the reintroduction of consultation of the local population.

At this inspection there were constraint of staff and space which could impact on the access and flow within the maternity department particularly around triage of presenting mothers. Gynaecology operations were cancelled often due to a lack of dedicated accommodation for these patients.

However, the average length of stay in maternity was within recommended guidance at 24 to 48 hours; staff were responsive to the needs of patients travelling between hospital sites and there had been no complaints in the maternity services within the past 12 months.

Service planning and delivery to meet the needs of local people

- The geography of the area where the hospital is situated meant patient's journeys could be long to reach the hospital services. Staff in all departments were aware of this and tried, where possible to ensure few journeys were necessary for consultations and treatments. For example they would carry out pre-operative procedures at the consultation visit if a surgical procedure had been deemed necessary.
- There were systems in place to manage patients with complications. If a baby had specific undiagnosed complications at birth they would be transferred to Newcastle specialist unit.
- There was a high incidence of patients with a high body mass index in the area. There was no multi-disciplinary clinic for this although one consultant anaesthetist saw these patients in case of general anaesthesia being necessary.
- There were no private termination of pregnancy services in the area, including any emotional aftercare service or on going advisory service. The way the service was managed meant there was no specific support for these patients as they were accommodated with the general surgical patients.

Access and flow

- The ante-natal triage service was provided by one of the two midwives working in the ward which accommodated 13 patients for either ante-natal or post-natal care. This meant there was no dedicated triage midwife and staff said there could be a delay in attending to patients who presented at the ward due to them delivering care to those already accommodated.
- There were space constraints for patients which could cause delays as there was one room with four beds for use as a day assessment unit, triage for presenting patients and ante-natal inpatients.
- Staff reported that the discharge procedure was cumbersome with overlap of tasks which increased the workload and the time taken to discharge patients.
- In the past six months 94 gynaecology operations had been cancelled. 44 were due to bed shortages with 17 of these being on the same day as the operation. This meant these patients' treatment was delayed and they had to re-schedule for a new date.

Meeting people's individual needs

- The environment which resulted in patients who were having a termination of pregnancy being accommodated in a single room next to or opposite a room where a patient was in labour was not responsive to their emotional needs. These rooms were also used for patients from the surgical ward who were at the end of their life. This showed a lack of planning of services within the given environment.
- Staff said they could obtain help with specific religious or cultural needs of patients from advisory services should they need this.
- They were aware there was a translation service available, but staff we spoke to had not used it as they said the patient was usually accompanied by a family member if they needed help with their use of the English language. This could mean a family member was explaining clinical procedures in order to obtain consent.

Maternity and gynaecology

- Staff said if a patient needed additional support due to mental health needs or learning disabilities they would accommodate this from family members or informal carers.
- There was a midwife with a lead interest in mental health and staff said they would provide support and advice if it was required.
- Information leaflets for patients were present in the waiting rooms and communal areas.
- Patients told us they had access to the information they required. This included that given in writing and that given verbally when they attended clinics or a ward.
- As part of the "Two minutes of your time" survey patients were asked if they received timely information about their care and treatment. In the results we saw for January 2015 an average score of 9.8 out of 10 was achieved for this standard.
- The results of the CQC survey of women's experiences of maternity services in 2013 were comparable to other trusts.

Learning from complaints and concerns

- The maternity services had received no complaints during 2014. Staff said some learnings from complaints made at the other trust hospital sites may be reviewed in the monthly maternity newsletter.

Are maternity and gynaecology services well-led?

Requires improvement

Summary

At the last inspection there was a positivity about the clinical leadership but the roles were not yet embedded. Staff had welcomed the maternity dashboard which had recently been introduced. There was a lack of long term strategy and capacity to lead it.

At this inspection the leadership of the maternity services continued to required improvement in that there was a lack of clarity in planning for the future and how changes would impact on practice. The midwifery managers were not as visible as at West Cumberland Hospital leading to less promotion of change and monitoring of standards.

There had been a marked increase in auditing the quality of service provision since the last inspection; however these audits did not always lead to clear action plans for positive change. There was an open culture in the service where staff said they felt able to discuss any issues or concerns freely.

Vision and strategy for this service

- Staff were unable to discuss a vision for the future of the maternity service at Carlisle. They were aware improvements to the service were ongoing, such as the introduction of the epidural service, but other than this they could not discuss a future plan.
- Senior staff members spoke of some changes occurring within the maternity services at Carlisle, however these were not presented as a clear future strategy.
- There were some changes within the management of the team with the imminent retirement of the current head of midwifery. This planned change of leadership meant there was a lack of current forward planning within the midwifery provision.
- Medical staff spoke positively about the future of the service, although there was no specific strategy. Senior medical staff said they had awaited the outcome of the RCOG Cumbria wide review of maternity services to assist them plan for the future.

Governance, risk management and quality measurement

- At the time of the last inspection the Maternity Services Liaison Committee had not met for two years. At this inspection the meetings had been reinstated. Minutes from the past four meetings were seen and an ongoing action plan had been developed with progress documented.
- The number of cancelled inductions was not part of the maternity dashboard information. We were given conflicting information that it was or not reported on the incident reporting system. Therefore there was no understanding of the scope of this issue and no plans to improve this patient experience.
- Monthly meetings of the Maternity Governance Group were held. This was attended by clinical managers, lead midwives and consultants. Topics discussed ranged from actions required as a result of new guidance, monitoring of the maternity dashboard and discussion following meetings of other groups such as the guideline group. Action points were documented and followed up at the subsequent meeting.

- In the maternity services quarterly integrated governance report published in January 2015 the trust stated "initial analysis of the first round of audits are showing poor results of compliance as measured against the Maternity Service's own clinical guidelines and the record keeping standards in the medical records. Initial findings have also highlighted inconsistencies in practice across sites." As a result multidisciplinary workshops were carried out for the areas of clinical practice showing poor results. Clinical guidelines were to be clarified and checked against national guidance.
- There was a maternity risk register which contained all risks identified, with control measures and gaps in the control. Where gaps were identified assurance actions were documented. The risks were reviewed within an identified timescale and none had been present over 12 months.
- Individual risk assessments were carried out for equipment and the environment in the gynaecology services. They would be a part of the surgical services in terms of risk register, but they were aware of what was included in relation to gynaecology
- Individual audits for specific clinical procedures took place in the gynaecology services and all staff were included in the findings and any subsequent changes to practice.
- There were monthly gynaecology governance video conferences held between the two hospital sites. This meant ideas, action plans and outcomes could be shared between the two services.

Leadership of service

- Staff told us they rarely saw the senior managers of the midwifery services at the hospital site as their offices were situated in Whitehaven hospital. They said they knew they were available by telephone or e-mail should they need advice. This meant the leadership team were not visible to the staff.
- There were opportunities for staff to interact with the leadership of the maternity services through ward meetings and informally through an open door policy.
- In order to increase the visibility of managers since the last inspection there were now 2 "walk rounds" per week by the supervisors of midwives and the unit coordinator. These were designed to illicit the views of patients and staff and monitor the progress of actions planned from the last inspection. Staff saw this as positive as it made them accessible.
- There were meetings of the medical obstetric and gynaecology doctors to discuss the service and plan changes.

Culture within the service

- There was an open and informal atmosphere on the maternity unit. Staff said they could discuss issues with each other should they need to do this.
- They knew the senior members of their team were available should they need them; however they were not visibly accessible much of the time.
- There was a pride from midwives and nurses in the work they performed; however they did not openly discuss the future with any enthusiasm.
- We saw a good working relationship between doctors and midwives.

Public and staff engagement

- Staff said they had seen the director of nursing more over the past few months. They were approachable for staff.
- They were unaware of any workforce plans and there was some confusion about the future plans for how the community midwives would work.
- Maternity staff expected meetings and communications to take place following the publication of the RCOG review the week of the inspection.
- Public engagement had been reinstated in the form of the maternity services liaison committee and one to one discussion with patients at the managers walk rounds.

Innovation, improvement and sustainability

- A large number of midwives we spoke with had worked at the hospital for many years without being exposed to other ways of working. This could lead to a lack of innovation through stimulation of these staff.
- Staff were unsure what the future of the maternity service looked like following the publication of the RCOG report the previous week.

Services for children and young people

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

Information about the service

The children's department at the Cumberland Infirmary, Carlisle, comprised of a 24-bedded children's ward; a 12 cot Special Care Baby Unit (SCBU) and the children's outpatients department.

The outpatient department adjoins the ward through secure doors and has six consulting rooms. The rooms were permanently allocated to the individual paediatric consultants.

The ward accommodation was a configuration of single rooms with en-suite facilities, two of which had been designated isolation rooms and shared bays. Two bays were single sex designated. A third bay (Rainbow) was a medical assessment unit used by children who had direct access to the ward following either referral from their GP, the hospital's accident and emergency department or by individual arrangement. The ward also included a High Dependency Unit for children who required specialist medical intervention and one-to-one care.

There was a fold-out bed in each bed space so that parents or guardians could be comfortable if they remained overnight. Facilities included a lounge and kitchen for parents and visitors; bathrooms including a rise and fall bath; shower and toilet facilities. There was a brightly decorated treatment room. The ward had a well-equipped sensory room, which children and parents could use. Staff commented that this room was particularly popular with children with special needs.

There was also a 'chill-out' room specifically designed for teenagers. There was a large, bright, well-organised and clean play room. The ward kitchen was a good size and stocked with snacks and drinks that could be provided to children and their relatives at any-time. A seminar room and the on-call sleeping room were also a part of the unit.

At the time of our inspection there were 5 children on the paediatric ward and 6 babies on the Special Care Baby Unit.

We spoke with 4 senior doctors, 3 nursing staff on the ward, 2 members of the nursing team on the Special care unit .We also spoke with 2 sets of parents, a nurse consultant and the clinical lead.

Services for children and young people

Summary of findings

The service for Children and young people had improved since our last inspection. There had been improvements to reduce the risk of avoidable patient harm. Resuscitation equipment had been improved and was regularly checked and available for use. Incident reporting was better managed and learning from incidents shared and applied. Child Safeguarding was well managed and supported by staff training. Interagency working in this regard was well established.

Nurse staffing levels had improved and all the wards were adequately staffed, although there was still a shortage of junior medical staff that meant consultants were filling in some aspects of the junior doctor's role. Consultant paediatric cover was provided from 9am until 10pm at night with a consultant on call. Consultants often remained on site out of hours to support the care and treatment of sick children.

Care and treatment was delivered in accordance with NICE guidance. Readmission rates were now within national averages. There was a visible, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive.

Performance against an agreed set of indicators was monitored monthly and actions taken to secure performance improvement where appropriate.

The service was under review and a number of service models were being considered and evaluated in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. A decision about the future model of paediatric care had not been reached at the time of our inspection.

Are services for children and young people safe?

Good

Summary

At the previous inspection we reported the trust needed to take more action to make children safe from avoidable harm. This was because emergency equipment on the ward and SCBU was incomplete and not fit for purpose. Lack of experienced paediatric medical cover is a concern because although the hospital runs a 24-hour Accident and Emergency service, experienced paediatric doctors are only on site from 9am to 5.30pm although consultants were contactable. Entry to the ward was monitored so that children could not leave unescorted. Staff were keen to cooperate with changes that would improve the quality of the service. The safeguarding team was effective and well run.

At this inspection children and young people received their care in a visibly clean environment. There was good practice in relation to the prevention and control of infection.

Since our last inspection there had been a number of service improvements to reduce the risk of avoidable patient harm.

Resuscitation equipment had been improved and was regularly checked and available for use.

Incident reporting was better managed and learning from incidents shared and applied. Child Safeguarding was well managed and supported by staff training. Interagency working in this regard was well established.

Nurse staffing levels had improved and all the wards were adequately staffed, although there was still a shortage of junior medical staff that meant consultants were filling in some aspects of the junior doctors role.

Consultant paediatric cover was provided from 9am until 10pm at night with a consultant on call. Consultants often remained on site out of hours to support the care and treatment of sick children.

Incidents

- Staff used the electronic reporting system to report incidents and events requiring investigation.
- Staff were competent and confident in reporting incidents Staff understood the difference between a minor, moderate and serious incident.
- For quarter 3, (October –December 2014) 56 incidents had been reported, between April and December 2014 almost all the incidents reported were low risk.
- Staff were provided feedback about the outcomes of incident reviews, learning from the incidents was shared, implemented and evaluated.

Cleanliness, infection control and hygiene

- The children's wards and departments were visibly clean and tidy.
- There were dedicated rooms so that children and young people at the risk of infection could be isolated.
- There were ample supplies of hand washing facilities and personal protective equipment to support good infection control practice.
- There was 100% compliance with the most recent hand hygiene audits.
- Infection rates were lower than the national average.
- There had been no cases of Cdiff or MRSA in the service.

In the Special Care Baby Unit (SCBU)

- Facilities in the clean utility room (that contained a washing machine and a tumble drier) had improved as a hand wash basin had been installed since our last inspection. Staff could now wash their hands in this area after handling dirty or soiled items.
- Improvements had also been made in relation to the storage of breast milk. Baby milk was now labelled, dated and stored securely.

Environment and equipment

- At our last inspection we raised concerns regarding resuscitation equipment, the resuscitation equipment on the children's ward and SCBU was now fit for purpose. Improvements had been made and an identifiable discreet resuscitation trolley that was regularly checked and available for use.
- Equipment and drugs required for paediatric cardiopulmonary resuscitation were checked in accordance with the Resuscitation Council (UK) 2013 guidance.

Medicines

- Medication across the children's service was stored securely and in keeping with the Royal Pharmaceutical guidance.
- The medication administration record sheets were completed in full and provided evidence that medication was given as prescribed.

The Special Care Baby unit.

- Controlled drugs and other medication on the Special Care Baby unit at the hospital were stored in accordance with the Royal Pharmaceutical Society guidance.

Records

- Patient assessments; care plans; daily records, were accurate well maintained , dated and signed.
- Diagnostic tests and results were readily available and stored securely in the patients notes.
- Discharge information and discharge summary letters were accurate and sent in a timely way to support onward seamless care for the child.

Safeguarding

- The service had a dedicated team for children's safeguarding including Named Nurses.
- Multidisciplinary safeguarding conferences were held to promote the safety and wellbeing of children in vulnerable circumstances. There were good relationships with other child related statutory services. Communication was open and transparent and focussed on the safety and well-being of the child.
- There was a clear review process for evaluating the robustness of staff responses to safeguarding issues.
- The team used a reporting database to identify trends in the type of safeguarding concerns they referred.
- The database tracked children and flagged up those who had already been referred when they returned to the hospital. This approach supported early intervention and prompt review of the condition of the child.
- The database also prompted safeguarding staff to follow up concerns until issues were fully resolved.
- Appropriate safeguarding training had been provided to all nursing and clinical staff. The majority of ancillary staff had also received safeguarding training.
- Staff were competent and confident in recognising and escalating signs of abuse and neglect in children.

- Staff knew how to raise a safeguarding alert and how to access the safeguarding team for guidance.

Mandatory training

- Mandatory training levels were currently at 85% against a service objective of 100%. Staff were able to access eLearning sessions, although staffing pressures meant that it was more difficult to attend face to face sessions.
- Mandatory training was both generic and role specific.
- Staff were positive about the range of training provided.

Assessing and responding to patient risk

- The service used the paediatric early warning score (PEWS) for recording the vital signs of children on so that early signs of deterioration could be identified and appropriate action taken promptly.
- The trust checked the quality of the charts and staff response monthly.
- PEWS audit showed that the children's ward at the hospital had achieved on-going improvements in completing these observations for children. The monitoring of children's blood pressure had improved and remained subject to regular audit and review.
- Staff were clear about the processes in place to ensure that children were transferred to specialist children's hospitals as safely and quickly as possible.
- The lead consultant paediatrician and the senior management team were clear about the transfer process and stated that the trust had a standard operating agreement with the North West and North Wales Paediatric Transport Service (NEWTS). This is a specialist ambulance transport service which provides highly trained paediatric nurses and is suitably equipped to support a very sick child during transfer.
- Children were escorted to the High Dependency Unit by a consultant paediatrician or Paediatric Nurse Practitioner (PNP) who was a highly trained paediatric specialist nurse able to complete complex clinical procedures. However, transferring high dependency patients with the services own staff did apply additional pressure on staffing levels.
- All relevant staff had received Basic or Advanced Paediatric Life Support training.
- A safety dashboard was on display on the ward which provided information about the level of compliance in different aspects of practice; including hand hygiene and completion of the specialist paediatric observation tool called the Paediatric Early Warning score (PEWS). Each area had scored 100% compliance.
- The ward safety dashboard also provided information about the use of specialist care pathways such as pain management, the number of falls and complaints. There were high levels of compliance with good practice in these areas.

Mortality and Morbidity

- There were monthly mortality and morbidity meetings. Lessons learnt were discussed with clinical staff at a variety of meetings within the Business Unit. All child deaths were subject to the CDOP (child death overview process) that analysed in detail mortality data.
- The Paediatricians at Cumberland Infirmary were reviewing mortality with their colleagues in Maternity services to share learning and opportunities for improving patient outcomes.
- There was evidence that learning was shared and used to underpin improvements in practice.

Nursing staffing

- Planned and actual staffing levels were displayed in the ward area. The information confirmed that nurse staffing levels were appropriate to meet the needs of children on a consistent basis.
- Sickness and absence was covered by staff working bank and overtime shifts. There was a good escalation plan in place too support safe staffing levels.
- The HDU was always staffed separately and there was an effective escalation process when required to support appropriate staffing levels.
- The escalation policy gave staff guidance about requesting additional staff from managers who then sought to address the shortfall appropriately.
- Care in the SCBU was nurse led with support from medical staff as required.
- The SCBU was not always able to meet national standards in relation to the number of nurses on duty. Staff used the escalation process to seek managerial support to address shortfalls. Bank and overtime shifts were used to provide adequate staffing levels.
- There were occasions when staff were unable to leave the SCBU and attend the labour ward due to staffing pressures.

- Nurse managers were not always able to take one day per seven as protected management time as they were required to support the numbers of nurses available to deliver care.

Medical staffing

- Consultant paediatric cover was provided from 9am until 10pm at night with a consultant on call.
- There was still a shortage of middle grade doctors and this meant that consultants were covering gaps in the medical rotas to provide appropriate medical cover.
- Junior medical staff felt well supported by consultants who were seen as accessible and responsive.
- Consultants would remain on site if required to support the care and treatment of a very ill child.

Major incident awareness and training

- Staff had received relevant training to support the management of major incidents.

Are services for children and young people effective?

Good

Summary

At the previous inspection we reported the trust needs to take more action to ensure services for children and young adults are effective. Innovative plans of care and treatment were not in use. The service reported a high rate of emergency readmissions within 30 days of discharge and there was no evidence that the trust had investigated this issue.

At this inspection care and treatment was delivered in accordance with NICE guidance. Improved readmission rates were now within national averages.

Evidence-based care and treatment

- Care and treatment was delivered in accordance with NICE guidance.
- Staff had access to guidance and reference material via the intranet.
- Staff were using 'partners in paediatrics' guidance for relevant childhood conditions and illnesses.
- There were good links with the paediatric networks to support evidenced based care and treatment

Pain relief

- Young people confirmed that pain control was very good and staff offered alternatives to make sure pain was well controlled
- Staff monitored children's pain levels and pain assessments were recorded on the reverse of the paediatric early warning assessment record.
- Analgesic gel was used to numb an area so that procedures were as pain-free as possible.
- The skills of the play worker were used to distract children during blood tests or physical and intrusive examinations to minimise children's fears and anxieties.

Nutrition and hydration

- Staff used a nutritional screening assessment tool called STAMP to support and guide the meeting of each individual child's dietary and nutritional requirements. .
- The menu offered a good variety of hot and cold meals that included fresh vegetables, salads, pasta bakes and age appropriate food choices.
- Additional menus were available and utilised for patients with special dietary needs.
- Snacks and cold drinks were provided for relatives and children periodically throughout the day.
- The ward kept a number of different brands of baby milk in stock so that individual preferences could be met.

Patient outcomes

- The service participated in the national audit programme including the paediatric diabetic and asthma national audits. Where shortfalls were identified, action plans were completed and implemented to secure improvement.
- The service also participated in the National Neonatal Audit Programme (NNAP). The 2013 NNAP audit (published in Sept 2014), the 2014 audit has not been made available. Cumberland Infirmary scored below the NNAP standard for 4 of the 5 indicators.
- In addition, the service participated in a range of local audits including PEWS, hand hygiene, drug alerts and clinical indicators.
- The results of the local audit demonstrated high levels of compliance with good practice guidance.
- Readmission rates were within national averages.

Competent staff

Services for children and young people

- All staff had received an annual staff appraisal.
- Staff met with their line manager on a quarterly basis for a 1-1 session to discuss performance and development needs.
- 85% of staff had completed role specific and mandatory training.
- All relevant staff had received Paediatric Life Support and Advanced Paediatric Life Support training.
- Safeguarding Children level 3 training had been attended by 98% of paediatric staff at CIC against a trust target of 80% and 100% had received Safeguarding Adults training.
- Staff were positive about the opportunities for professional development. Staff were supported with diploma level nursing courses and additional role specific training to support their learning, confidence and competence.
- Staff had also received child mental health training and there were planned developmental days for staff who worked in the SCBU via the neonatal network.

Multidisciplinary working

- The service worked well with a range of other disciplines and multidisciplinary working was well established. Doctors, nurses and Allied Health Professionals worked well together for the benefit of children in their care.
- Patient records confirmed effective working with physiotherapists and the dietician.
- There was work underway to improve transition services for young people moving into adult service provision.
- Transition arrangements were subject to a CQUIN target, the 'Ready Steady Go initiative' was aimed at transferring young people into adult services in a seamless and timely way.
- Young people with diabetes had formal transition diaries to support transition; arrangements were also in place to support the transition of young people with asthma.
- There were local arrangements in place with a neighbouring mental health trust for young people with neurological conditions.
- Communication had improved with the children's service based on the West Cumberland site. Regular meetings were held to share information, good practice developments and management information to support service improvement.
- The Child and adolescent Mental Health Service (CAMHS) was provided by a neighbouring trust. Working relationships were positive and communication was good, although the out of hours and weekend services provided by the CAMHS team required improvement in terms of response times. This issue had been raised with commissioners and was highlighted on the services risk register. Discussion with managers confirmed that this was an on-going concern, which was not isolated to this service or trust.
- The service had access to two specialist diabetic nurses who provided support and guidance to children and young people with this condition. However the community children's nurses were not based on site and provided a more limited service. For example a young person who needed regular Intra venous medication returned to the ward daily as this service was not available in the community
- The lack of community paediatric support was a long standing issue and was identified as a risk on the departmental risk register.

Seven-day services

- The service had not yet fully implemented 7 day working.
- Emergency x-ray and pharmacy services were available out of hours but not as a matter of routine.
- Consultant medical cover was provided via an on call system outside normal working hours. Although it was not unusual for consultants to be available until 9-10pm.

Access to information

- Staff had access to readily available patient information and reports, including at weekends and out of hours.

Consent

- Best practice in assessing the ability of a child under 16 to give consent is covered by the principles of Gillick competence. Staff understood their roles and responsibilities in this regard.
- The admission assessment forms included information about the level of consent given by a parent, child or young person.
- Training information confirmed that the majority of staff in the hospital's Paediatric department had completed Mental Capacity Act and Deprivation of Liberty Safeguards training level 1 in respect of young adults.

Services for children and young people

- Young people on the ward told us that the doctors and nurses always explained procedures to them in a way that was easy to understand.
- The World Health Organisation surgical safety checklist had been completed for children who were on the dental surgery list, and this included confirmation that appropriate consent had been obtained and recorded.

Are services for children and young people caring?

Good

Summary

At the previous inspection we reported patient satisfaction surveys indicated that parents and patients were satisfied with the conduct of staff and felt the service was caring. Staff took action to provide information that would offer reassurance to parents.

At this inspection there was a visible, child centred culture within in the service. Staff were motivated and offered care that was kind, sensitive and supportive. We observed many interactions that showed how caring the staff were.

Staff recognised and respected children's needs, fears and anxieties and provided both physical and emotional support on an individual basis.

Staff recognised that having a sick child was a worrying and anxious time for parents and carers. Staff were keen to support parents and carers emotionally and include them as partners in the care of their child.

Compassionate care

- Children and young people, their families and carers felt well cared for and supported by staff. We observed children and young people being treated sensitively and kindly.
- Patients confirmed that nurses were always available and children didn't have to wait for nurses to attend them.
- Children's needs were met in an individualised way, care planning took into account the child's needs and preferences as well as recognising and supporting the child's cultural or religious needs.
- Children were positive about their interactions with the staff and the Family and friends test indicated that parents and children were 'extremely likely' to recommend the service to others.

Understanding and involvement of patients and those close to them

- Parents confirmed that staff included them in the decision making process and that they were well informed as to their child's condition and treatment.
- When children and young people did not have family support available in terms of involvement in decision making. Best interest meetings were held to ensure the child or young person's needs were central to the decision making process.
- Play therapy services included preparation for invasive/ non-invasive procedures, distraction therapy, emotional support and pain management.

Emotional support

- Staff recognised that having a sick child was a worrying and anxious time for parents and carers. Staffs were keen to support parents and carers emotionally and include them as partners in the care of their child.
- Children and young people's emotional needs were considered as part of the care planning process. Staff provided good emotional support to children and young people and were open and honest in their communication with patients to establish and foster a relationship build on trust and empathy.

Are services for children and young people responsive?

Good

Summary

At the previous inspection we reported evidence confirmed that systems in place for responding to foreseeable concerns, such as short-term staff shortages were flexible and effective. Information from the trust demonstrated that the service responded to complaints or concerns from patients or their relatives. However, this evidence did not confirm that outcomes were routinely analysed and used to influence the changes at ward level.

Services for children and young people

At this inspection the children's and young people's service was under review and a number of service models were being considered and evaluated in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. A decision about the future model of paediatric care had not been reached at the time of our inspection.

The service was responsive to the needs of children and young people and there were facilities and support services in place to meet their individual needs. Complaints were managed in a timely way, and lessons were learned and shared.

Service planning and delivery to meet the needs of local people

- The children's and young people's service was under review and a number of service models were being considered and evaluated in order to better meet the needs of children and young people and maximise resources effectively. A decision had not been reached at the time of our inspection.
- In the interim, the service continued to meet patient's needs under the existing model of care.

Access and flow

- The children's ward had 24 beds that operated as 8 assessment beds and 16 inpatient beds from 08:00 hours – 20:00 hours, and overnight with 16 inpatient beds only.
- Children were admitted to the ward following referral from either the A&E department, through direct access from GP referrals or through direct access agreed as part of a discharge plan.
- There were times when children arrived on the ward from A&E without an escort as the emergency department could not release staff. However this was an infrequent occurrence.
- There were also times due to a shortage of medical staff that patients on the ward could wait for long periods of time before seeing a doctor.
- Plans in place to transfer children requiring specialist support to other hospitals in a timely way.

Meeting people's individual needs

- There was an ample supply of play equipment available to accommodate a variety of ages and needs in both inpatient and outpatient areas. Toys could be provided at the bedside as well as age appropriate games and books.
- Staff were competent and confident in meeting the diverse needs of children and young people using the service.
- Parents were supported and encourage to remain with their child and there were facilities to allow parents and carers to stay overnight if they wished to do so.
- There was a comprehensive range of information leaflets available including post-operative tonsillectomy care, asthma action plan , wheeze action plan , Isolation care, and transfer information that gave patients and those close to them information about care and treatment in a way they could understand.
- Children with learning difficulties were managed in a sensitive and person centred way
- The service provided a translation service for children and those close to them whose first language was not English.
- The service had good links between children and young people's services and the child and adolescence mental health service (CAMHS). However staff felt that due to the demands in this service there was sometimes a delay in children and young people being seen after being referred.

Paediatric outpatients

- The outpatient clinic was covered by two paediatric consultants.
- The department was comfortable and child-friendly.
- The waiting area was uncrowded and children were seen promptly on arrival.

Learning from complaints and concerns

- The service did not receive high numbers of complaints; there had been only two complaints since our last inspection in May 2014.
- Complaints where possible where resolved locally, staff were familiar with the complaints procedure and there where leaflets in the service to help me people make their complaints and concerns known.
- Staff would also refer patients to the PALs service when appropriate to do so.
- Learning from complaints was shared to support improvements in the service.

Services for children and young people

- The service also displayed a 'You said, We did ' board that highlighted the actions taken by the service in response to feedback

Are services for children and young people well-led?

Good

Summary

At the previous inspection we reported the staff we talked with spoke positively about the management team. They felt encouraged to voice their opinion and information about CQC's focus groups and meetings for staff had been posted in the staff room. The leadership on the paediatric ward and special care baby unit at the Cumberland Infirmary needs time to follow through on plans in order to make sure that changes are fully embedded. There was a strategic overview of the service but this seemed patchy. However, plans are in place to improve the quality of the service.

At this inspection the services for children and young people were well led locally. Line managers were visible and accessible and staff felt well supported. Staff were engaged locally and were keen to improve the service they offered.

Staff were sighted on the trusts vision and values and were aware that work regarding the longer term strategy for children's services was under discussion and a decision had not yet been made.

Risk management had improved and there were regular reviews of the departmental risk register, mitigating actions and controls.

Performance against an agreed set of indicators was monitored monthly and actions taken to secure performance improvement where appropriate.

Vision and strategy for this service

- Staff were cognisant of the trusts vision and values and were aware that work regarding the longer term strategy for children's services was under discussion and a decision had not yet been made. They were also aware that the review of the future of the service may result in some service reconfiguration and there was a mixture of support and anxiety regarding the future of children's services in the hospital and across Cumbria as a whole.

Governance, risk management and quality measurement

- There had been improvements to risk management and governance processes.
- The risk register better articulated risks, mitigating actions and was regularly reviewed at the monthly child health business unit governance meetings.
- The meetings also considered results and actions from audits, current performance, new developments, incidents and complaints.
- Actions agreed were recorded and followed up. Opportunities for learning were identified and shared.

Leadership of service

- Staff were positive about their line managers and felt supported to voice their opinion and share their concerns openly.
- Managers were visible and approachable and responsive.
- Staff felt supported and valued by managers.
- The service did not have a Matron and staff felt that this was a missed opportunity to drive changes and improvements.

Culture within the service

- There was positive culture in the service.
- Staff were keen to improve the service and were proud of the work they did.
- Staff demonstrated a commitment to children and those close to them.

Public and staff engagement

- Although staff were aware of the vision and values of the trust and the plans to take the service forward. They were less sighted on the plans for the children's service and some did not feel fully informed or engaged in the change process.
- Staff actively sought feedback from patients and those close to them about the service provided. Responses to the Family and friends test were positive with most recommending the service as a good place to receive care and treatment. However, response rates were low.

Services for children and young people

- The 'you said we did' initiative demonstrated some positive changes made as a result of patient feedback.

Innovation, improvement and sustainability

- Plans for the future of the children's service were still under discussion at the time of our inspection with a number of service options under consideration. No decision had yet been made.

End of life care

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

Information about the service

Care for patients at end of life was provided on individual medical wards in the Cumberland Infirmary. We visited six wards where end of life care was being provided. We also visited the hospital mortuary, chapel of rest and the chaplain service.

Some patients and families with more complex palliative and end life care needs were provided by Cumberland Partnership Foundation Trusts' Specialist Palliative Care Team (SPCT). The current contract with the Cumberland Partnership was to supply the Trust with four palliative care beds. This was provided on the Loweswater Suite at the West Cumberland hospital.

The SPCT worked collaboratively with clinical teams to support end of life care and we were told about good working relationships throughout the two hospitals particularly with the acute oncology services. The SPCT offered a five-day a week service. Cover after 5.30pm and at weekends was provided via telephone advice by the local Eden Valley Hospice, this was an ad hoc arrangement without a service level agreement.

The number of patients referred to the SPCT had increased in recent years. During 2013/2014, approximately 635 new patients were referred to the service in comparison to approximately 500 in the previous year. This was across both sites.

As part of this inspection we visited six wards looking specifically at end of life care and we reviewed the medical records of 12 patients and 12 "do not attempt cardio-pulmonary resuscitation" (DNACPR) records.

We observed care being delivered on the wards and spoke with eight patients, who were identified as requiring end of life care. We also spoke with three sets of relatives.

We observed a weekly multi-disciplinary patient review meeting. We met and spoke with 30 members of staff including doctors, nurses, porters, specialist nurses and ward managers. We met the chaplain and the mortuary manager and were shown the resources and facilities they had available to them.

We carried out focus group meetings for doctors, nurses, allied health professionals, administration and clerical staff.

End of life care

Summary of findings

As part of our previous inspection in April 2014 we found a lack of a trust wide vision and strategy for end of life care including governance and assurance mechanisms. There was a lack of executive leadership, substantive consultant leadership and DNACPR records lacked consistency and accuracy. There was no bereavement office and infection control and equipment concerns were identified. At this inspection we found that the concerns raised at the last inspection relating to the mortuary had been addressed and porters had received training in the transfer and care of deceased patients. Equipment in the mortuary had been replaced, a manual to explain about last offices had been developed by the Bereavement and End of Life Group and the mortuary now adhered to infection control procedures. A risk assessment was undertaken on all patients who had died from blood borne diseases.

Space had been identified to develop a bereavement office on the site. A bereavement Information booklet was not yet completed though this would be available in the near future.

In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life Care Plan had been developed. This was in a draft format. A pilot study of this had taken place in two wards at the Cumberland Infirmary but this had not yet been implemented fully.

The substantive consultant post for specialist palliative care post had yet to be filled as the trust was experiencing difficulties in recruiting and Do not attempt cardio-pulmonary resuscitation" (DNACPR) forms were still inconsistently completed.

The Trust had reviewed how it was going to provide and enhance care provision for patients at the end of their life. A draft End of Life Strategy which had recently been disseminated.

Arrangements were being developed so the Trust Board received an annual report outlining progress against key priorities articulated within the strategy.

An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration staff, porters and other external providers of care. The Director of Nursing had taken the executive lead role for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and addressed at board level.

End of life care

Are end of life care services safe?

Requires improvement

SUMMARY

The substantive consultant post for specialist palliative care post had yet to be filled as there were difficulties recruiting. This lack of permanent consultant cover was felt to be impacting on the effectiveness and quality of care. This was also impacting on the education and training provided to staff in relation to effective end of life care. However, two Palliative Care Consultants had been appointed permanently by Cumbria Partnership NHS Foundation Trust to provide the Trust with structured clinical leadership.

We saw 12 "do not attempt cardio-pulmonary resuscitation" (DNACPR) forms some of which were inconsistently completed. This was supported by the Trusts annual audit figures for DNAR which showed 170 forms out of 542 forms were not fully completed. This could result in inappropriate resuscitation taking place.

Incident reporting was good. Recent concerns had related to delayed transfers and pressure area care which the hospital was aware of and addressing.

Infection control concerns regarding the care to patients after death from the last inspection were being addressed with improved outcomes reported.

Equipment concerns in the mortuary had been addressed by the hospital and they continued to increase the supply of syringe drivers to meet the increasing demand. However the documentation for use with the syringe drivers needed to be more consistent.

Anticipatory prescribing was in according to national guidance and was discussed at the weekly multi-disciplinary team meetings within the Loweswater Suite.

The SPCT provided advice from the team and they were always helpful and supportive. A palliative care link worker scheme had been introduced.

Duty of candour was observed.

Incidents

- Staff who cared for patients at the end of their life and staff working in the mortuary were aware of their responsibilities to raise concerns and report incidents.
- There was evidence that action had been taken as a result of the reported incidents and lessons had been learnt. Staff received feedback from incidents being shared through regular team meetings and monthly newsletters.
- Between October 2014 and January 2015 there were eight incidents reported for patients receiving end of life care. Three incidents related to the delay in transfer of patients from the Cumberland Infirmary and the West Cumberland Hospital. The other five incidents were related to pressure area care.

Cleanliness, infection control and hygiene

- At the last inspectionconcerns were raised about patients being transferred from the wards to the mortuary without 'last offices' being properly undertaken by ward staff. Last offices are the care given to a deceased patient and their family or carer from the time of death in hospital until the body is released to the Funeral Director. A manual had been developed to explain about last offices by the Bereavement and End of Life Group. Ward staff had the opportunity to make suggestions on the content of the manual. This was now used on the wards and staff told us they frequently rang the mortuary staff for advice about preparing the body prior to transferring to the mortuary. Mortuary staff confirmed that the use of the manual and increased communication with ward staff had resulted in patients being better presented at the mortuary.
- At the last inspection concerns were raised relating to patients with an infectious disease being transferred to the mortuary without appropriate preventative measures in place and concerns with the air ventilation system. The mortuary now adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.
- Staff on the ward now informed mortuary staff if there was a patient being transferred with a hospital acquired infection and if the patent was being transferred out of working hours porters complete a form to notify the mortuary staff of the infection.
- Porters told us about how they were now trained to transfer deceased patient from the ward to the mortuary. We were told; 'we treat them as if they were

our own family and we move them as if they were still alive. Such as putting a hand under the head to protect them. We make sure all the curtains are closed on the ward before we move the patient'.
- The risk of infection had been reduced and the number of staff was limited in order to reduce infection. Risk assessments are undertaken when necessary.

Environment and equipment

- A new mortuary table had been delivered and installed in response to the last inspection.
- The National Patient Safety Agency recommended during 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. The Graseby syringe driver had been withdrawn from the hospital and all the nursing staff were using the McKinley syringe driver.
- However, we saw different documentation to support the use of the syringe drivers being used.
- Staff raised concerns that syringe drivers were often in short supply and staff had to borrow from other wards. At the time of the report the Trust had 33 syringe drivers five of these were new. The Trust had recently ordered 15 additional syringe drivers.
- A number of changes had been made to the mortuary to make it more personal and family orientated. There was art work on the walls, comfortable seating and new floor covering. New furniture had been procured and once the furniture arrives, we were told there would be an 'open day' for staff so they can have a look around and understand better how the mortuary worked.
- Due to the high volumes of patients following major incidents and disasters in the area, security arrangements were now in place to enable emergency storage of bodies in the event of a major disaster.

Medicines

- Staff told us patients who required end of life care medicines were written up for anticipatory medicines. We examined the records of four patients receiving end of life care and found that anticipatory medication was appropriately prescribed.
- Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms. This is based on the grounds that although each patient is an individual many acute events during the palliative period can be predicted and measures can be put in place to reduce these events in advance.
- We also noted that anticipatory prescriptions were discussed at the weekly multi-disciplinary team meetings within the Loweswater Suite at West Cumbria Infirmary.

Records

- Following the national withdrawal of the Liverpool Care Pathway, the Trust piloted new documentation at the Cumberland Infirmary to support their new priorities of care. 19 patient case notes had been audited but only one had used the new end of life care plans, the results were being collated and would be presented to the End of Life and Bereavement Group in April 2015.
- It was envisaged the newly revised care plan would be used throughout the North East and North Cumbria University Hospitals Trust and Morecombe Bay Trust. Staff were currently working across all areas to develop a variety of teaching methods including video's, e-learning, face to face teaching to support the implementation of the new documentation.
- We saw 12 DNACPR forms were inconsistently completed. This was supported by the Trusts annual audit figures for DNACPR which showed 170 forms out of 542 forms were not fully completed. For example three of the forms we saw were signed by a junior doctor but not been countersigned by a consultant.

Duty of Candour

- The Duty of Candour regulation requires being open with patients when things go wrong and providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm.
- In consultations with patients and relatives, we found evidence of staff being open and transparent.
- We saw effective systems in place to report and learn from mistakes which had occurred in their service.

Safeguarding

- All the staff we spoke with who cared for people receiving palliative care understood their safeguarding responsibilities and were aware of the policies and procedures to follow.

End of life care

Mandatory training

- Staff had attended all mandatory training.
- The palliative care end of life training (Sage and Thyme) was to be classed as mandatory training as of the 1st April 2015. This training included advanced communication skills training.

Nursing staffing

- The Cumbria Partnership Trusts' Specialist Palliative Care Team (SPCT) provided nursing services to North Cumbria University Hospitals NHS Trust through the Northern England Strategic Clinical Network (NESCN) agreement.
- There was one full time Macmillan nurse post which was a job share. The two part time Macmillan nurses covered both the hospital sites. There was no additional cover for annual leave or sickness.
- Palliative care link workers for end of life care had been identified on each ward at the West Cumberland Hospital. These link nurses had yet to meet for the first time, roles and responsibilities had yet to be agreed. Training was also being discussed at the newly formed Task and Finish Group.

Medical staffing

- Although the Trust had advertised for a substantive consultant post for specialist palliative care, the post had yet to be filled, as there were no applicants. However, the SPCT had made the two locum consultant posts for specialist palliative care into permanent posts, but these posts were mainly for community support and support to the Loweswater Suite. This lack of permanent consultant cover for end of life care was felt to be impacting on the effectiveness and quality of care as medical staff were very stretched. This was also impacting on the education and training provided to staff in relation to effective end of life care.
- The recruitment process for the post of specialist palliative care consultant was carried out in November 2014 but the post was not filled. This means the education and training for medical staff may remain a concern.
- However, two Palliative Care Consultants had been appointed permanently by Cumbria Partnership NHS Foundation Trust to provide the Trust with structured clinical leadership.

Assessing patient risk

- Patients were referred to the SPCT by staff on the wards by telephone or a FAX. Nursing staff told us that if they were unsure they could ask for advice from the team and they were always helpful and supportive.
- We were told the SPCT could respond to deteriorating patients quickly and told us ward staff usually telephoned if a referral was urgent.

Major incident planning

- The mortuary has its own major disaster plan and had in the past received high volumes of patients following major incidents and disasters.

Are end of life care services effective?

Requires improvement

SUMMARY

In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life pathway had been very recently developed. This was in a draft format. Wards had palliative care and end of life care resource folders available to them containing advice and guidance. However, these were new and there was no system in place to ensure that staff knew of and utilised the resource.

Out of hours service support was delivered through Cumberland Partnership Foundation Trust and the Eden Valley Hospice. These were not supported by service level agreements.

The Trust had not participated in the Care of the Dying National Audit. However, we were given assurances by members of executive team; the trust would participate in 2015. There were limited systems in place to monitor that all patients received good end of life care. However, we did see evidence from patient's notes that good care was given.

The mortuary department had a programme of audits which were improving the use of appropriate procedures to the right standard.

For end of life care, staff recognised the complexities of pain management for this group of vulnerable people and used a range of pain assessment and management interventions to address this ranging from simple analgesics through to the use of opioids.

End of life care

31 nurses had undertaken palliative care end of life training (Sage and Thyme) and as of the 1st April 2015 this was to be classed as mandatory training. Training to support the implementation of the new end of life documentation had been discussed and was part of the Bereavement and End of Life Groups Task and Finish working group agenda.

Staff could describe to us what mental capacity assessment (MCA) meant and understood the procedure to use if a patient did not have capacity to make choices including utilising the mental health crisis team. This team ran an on call system and would respond in a timely manner.

Evidence-based care and treatment

- In response to the national withdrawal of the Liverpool Care Pathway, a new End of Life pathway had been developed. This was in a draft format. Staff were unclear about this documentation which had appeared on the wards the week previous to the CQC inspection. Some staff we spoke with had not seen the documentation.
- Most of the supporting documentation and care plans for End of Life care we saw had been developed by the Northern England Strategic Clinical Networks. These included End of Life Core Nursing Care Plan, Agitation and Restless Core Care Plan, Pain Core Care Plan. The Northern England Strategic Clinical Networks were created in 2013 to drive improvement in the quality and equity of health care for its 3.1 million population. This covers the North East, North Cumbria and Hambleton and Richmondshire.
- The mortuary department had a programme of audits which looked to ensure the appropriate procedures were carried out to the right standard. We reviewed samples of audits to confirm this.
- An audit on the documentation for patients on end of life care which showed 88% of the notes documented discussions with the patients and 42% documented discussion with relatives. This identified more work should be taken to improve documentation around communicating with relatives.
- The Trust had an organ donation policy, which adhered to national guidelines. The framework process makes reference to specialist nurses, clinicians and nursing staff supporting the family throughout the process.

Pain relief

- Staff recognised the complexities of pain management for this group of vulnerable people and they used a range of pain assessment and management strategies to address this by using pain management interventions ranging from simple analgesics through to the use of opioids.
- Some staff described how they would assess pain in patients who couldn't communicate such as; through observations of behaviour, facial expressions and movements.
- Staff used the Abbey Pain Scale. The Abbey Pain Scale is a tool used by staff to assess pain in patients who were unable to articulate their needs.

Nutrition and hydration

- Patients told us they were happy with the quality and quantity of the food and felt they had plenty to drink. One patient told us, 'the food is very good especially the different types of soup'.
- We noted at the weekly multi-disciplinary meeting that most patients referred to the SPCT also had a referral to the speech and language therapy service and occupational therapy and discharge coordinator.
- We saw patients being offered drinks at regular intervals.
- However, one patient told us 'the food had been heated up several times and is dry and tasteless'. We were told the family were bringing in food for the patient to eat.

Patient outcomes

- The Trust had not participated in the Care of the Dying National Audit. However, we were given assurances by members of executive team; the trust would participate in 2015.
- There were no systems in place to monitor that all patients received good end of life care. However, we did see evidence from patient's notes that good care was given.
- We also saw good evidence of the use of the Abbey Pain Scale and personalised dementia care bundle; 'this is me'.

Competent staff

- All staff received appraisals.
- Thirty one nurses had undertaken palliative care end of life training (Sage and Thyme) and as of the 1st April 2015 this was to be classed as mandatory training.

End of life care

- Training to support the implementation of the new end of life documentation had been discussed and was part of the Bereavement and End of Life Groups Task and Finish working group agenda.
- We were told link palliative care nurses had been identified on each ward but had not had any training as yet, and once the training was ready to be presented, the link nurse and matron from each ward would be the first to receive this training.
- Further training at ward level would then be cascaded via the link nurses and matrons. We were told medical staff would receive this training.
- Other training for nurses included use of syringe drivers.
- Allied health professionals such as; Radiographers, Occupational Therapists and Physiotherapists receive training in end of life care and communication training.
- End of Life training for junior medical staff (Foundation Year1) was delivered by the SPCT in March 2015 and Foundation Year 2 doctors were due to receive further training from the SPCT in June 2015.
- There were also formal seminars to medical students, Foundation Year1, Foundation Year 2 and Specialist Registrars on a variety of topics such as symptom control, communication skills including 'breaking bad news'.
- Following an incident in the mortuary and in response to the last inspection, portering staff had receiving moving and handling training and training to use a hoist. A number of bank and new staff were also trained in transferring patients to the mortuary.

Multidisciplinary working

- We were told about good multidisciplinary (MDT) working arrangements with the SPCT and consultant's within the hospital.
- There was a weekly SPCT MDT attended by an occupational therapist, discharge coordinator, chaplain and SPCT medical and nursing team. We noted that patients had good holistic assessment and there was evidence of emotional support and anticipatory prescribing
- The Trust had two GP Registrars two sessions per week who were supervised by the SPCT. We were told this had improved the sharing of information about patients and had improved the referrals between services.

Seven-day services.

- The SPCT based on Loweswater Suite offered a five-day a week service.
- Cover after 5.30pm and at weekends was provided via telephone advice operated by Cumberland Partnership Foundation Trust. This was ad hoc with no service level agreement
- Out of hours telephone support was also provided by the Eden Valley Hospice. This was ad hoc with no service level agreement

Access to information

- We asked for information relating to the number of patients referred to the SPCT, the number of patients who died at their place of choice and the number of patients who were currently identified as using an end of life pathway. This information could not be supplied to us at the time of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff could describe to us what mental capacity assessment (MCA) meant and understood the procedure to use if a patient did not have capacity to make choices.
- Nurses did not undertake MCAs as they would call the mental health crisis team. This team ran an on call system and would respond in a timely manner.
- Staff had undertaken MCA and Deprivation of Liberty Standards (DoLS) training.
- The Trust wide figures for attendance at MCA training were; Level 1: 91% and Level 2: 76%.

Are end of life care services caring?

Good

SUMMARY

We observed patients at the end of life being looked after in a caring and compassionate manner. Patients and relatives told us about their care and how involved they were with planning their care. Information was shared with them so they could be fully informed on what would happen to them.

Mortuary staff confirmed that the use of the new last offices manual and increased communication with ward staff had resulted in patients being better presented at the mortuary.

End of life care

Porters confirmed they were trained to transfer deceased patients from the ward to the mortuary. We were told; 'we treat them as if they were our own family and we move them as if they were still alive. Such as putting a hand under the head to protect them. We make sure all the curtains are closed on the ward before we move the patient'.

The chaplaincy team supported ward staff and other professionals delivering end of life care. The chaplain attended the Bereavement and End of Life Group meetings and was instrumental in developing the end of life strategy and documentation.

Compassionate care

- Nursing and medical staff provided compassionate and empathetic care. A manual to explain about last offices had been developed by the Bereavement and End of Life Group. Ward staff had the opportunity to make suggestions on the content of the manual. (Last offices is the care given to a deceased patient and their family or carer from the time of death in hospital until the body is released to the Funeral Director).
- The manual was now used on the wards and staff told us they frequently rang the mortuary staff for advice about preparing the body prior to transferring to the mortuary.
- Mortuary staff confirmed that the use of the manual and increased communication with ward staff had resulted in patients being better presented at the mortuary.
- Due to the high number of road traffic accidents and incidents with mountain climbers, we were told by senior staff about how compassionate and skilled the mortuary technician was in reconstructing deceased bodies so that they look as peaceful as possible prior to families viewing the body.
- Porters were trained to transfer deceased patients from the ward to the mortuary. We were told; 'we treat them as if they were our own family and we move them as if they were live patients. Such as putting a hand under the head to protect them. We make sure all the curtains are closed on the ward before we move the patient'.
- One relative who had a child with a learning disability told us about a nurse who brought in some colouring books and pens as she knew he likes to draw.
- Patients told us: 'nursing staff are cheerful, helpful and caring and nothing is too much trouble'. 'Doctors instil confidence and know what they are talking about'.

Patient understanding and involvement

- Patients told us they were informed about their care and understood the treatment and choices open to them.

Emotional support

- At the last inspection concerns were expressed that the patients' panel had raised funds for patients to have a separate room for the delivery of bad news. At this inspection, there were no specific rooms for 'breaking bad news'. However, we were told staff could use rooms on the wards such as the MDT room or an office.
- The chaplaincy team worked with ward staff and other professionals for patients receiving end of life care.
- The chaplain attended the Bereavement and End of Life Group meetings and was instrumental in developing the end of life strategy and documentation.
- The chaplain worked 25 hours across both sites from Monday through to Friday and is on call during the evenings.
- There were two Roman Catholic chaplains who worked five hours per week and two bank chaplains were used to cover the weekends and time off.
- Referrals to the chaplain had increased over the last year.

Are end of life care services responsive?

Requires improvement

SUMMARY

At the last inspection there were insufficient palliative care beds and patients often had to be cared for on busy medical wards. At this inspection this was still the case. However, staff tried to ensure patients at the end of their lives would be given a side ward if possible.

The contract with Cumberland Partnership Trust was for provision of hospital support through the SPCT and access to the four palliative care beds in the Loweswater Suite.

There were no dedicated facilities for relatives but there were quiet rooms which could be utilised.

End of life care

There was little provision for relatives who visited their loved ones from a distance. We were told relatives could be offered a reclining chair or a 'Z' bed if they wanted to stay overnight. Drinks were supplied by the nursing staff along with sandwiches when necessary.

There were plans for a bereavement team to be established, along with Bereavement Officers to support the team.

As part of a pilot, the 'supporting care in the last hours of life' document 'Guidance for care of dying patients' was being used for information for family or carers. This was also used to collate their views on the care being delivered.

As a result of an external review of end of life services, relatives or carers would be taken to view the body in the mortuary by the mortuary technician. This ensured that relatives and carers were being looked after by a person who worked in the mortuary and could ensure this was done in a timely manner. Changes to the management of a person's belongings meant relatives did not have to revisit the ward.

Staff worked closely with the discharge liaison nurse who attended MDT meetings with the SPCT in order to enhance early discharge where possible.

Complaints were used to make improvements with their services such as a complaint about a particularly complex issue which resulted in improving how different members of staff communicate with each other. A full report showing trends, themes and learning from complaints had yet to be developed.

Service planning to meet the needs

- The current contract with SPCT was to supply the Trust with four palliative care beds.
- There were no dedicated facilities for relatives but there were quiet rooms which ward staff would use in similar circumstances.
- A Bereavement Team has yet to be established, along with Bereavement Officers to support this.
- Work continues with the chaplaincy teams to ensure spiritual needs of patients were met and chaplaincy expertise continues to influence service provision.
- Information for families on end of life care was seen when visiting some of the wards.

Meeting people's individual needs

- There was little provision for relatives who visit their loved ones from a distance. We were told relatives could be offered a reclining chair or a 'Z' bed if they wanted to stay overnight. Drinks were supplied by the nursing staff along with sandwiches when necessary.
- As a result of the external review of end of life services, relatives or carers would be taken to view the body in the mortuary by the mortuary technician. This ensured that relatives and carers were being looked after by a person who worked in the mortuary and could ensure this was done in a timely manner.
- Patient's belongings would be sent directly to the families Funeral Director so that when families come to view their loved ones they are not given the patients valuables and belongings.
- One relative told us the ward staff had allowed more flexible visiting as she had to travel from Devon.
- There was access to translation services for people whose first language was not English.
- At the last CQC inspection in June 2014 concerns were raised about relatives having to wait a long time at the mortuary out of working hours. As a result, relatives or carers would be taken to view the body in the mortuary by the mortuary technician. This ensured that relatives and carers were being looked after by a person who worked in the mortuary and could ensure this was done in a timely manner.
- The mortuary has facilities to provide ritual washing for Muslims but we were told mortuary staff had never been asked to provide this.

Access and flow

- At the last inspection there were insufficient palliative care beds and patients often had to be cared for on busy medical wards. At this inspection this was still the case. However, staff tried to ensure patients at the end of their lives would be given a side ward if possible.
- We observed discussions about a patient's discharge plans and referral back to the patients' GP. Pre populated handover sheets were used to cover these plans and referrals.
- Staff told us they worked closely with the discharge liaison nurse and this nurse also attended MDT meetings with the SPCT in order to enhance early discharge where possible.

Learning from complaints and concerns

End of life care

- The service received a low number of complaints about end of life services.
- People knew how to raise a concern or make a complaint.
- A full report showing trends, themes and learning from complaints has yet to be developed.
- As part of a pilot, the 'supporting care in the last hours of life' document 'Guidance for care of dying patients' was being used for information for family or carers. This was a communication sheet which was given to patients, relatives or carers to collate their views on the care being delivered.

Are end of life care services well-led?

Requires improvement

SUMMARY

At the last inspection staff felt that end of life care did not have a high profile within the Trust and was not recognised as a specialism. At this inspection, there had been an increase in the profile of this speciality articulated by nursing and medical staff.

The Trust had reviewed how it was going to provide and enhance the way in which they cared for patients at the end of their life.

At the last inspection there was a lack of a Trust wide vision and strategy for end of life care; a lack of clarity regarding the organisational structure to develop the service for the future; cross provision adding to the complexity of leadership and engagement at senior management and board level and lack of ownership about end of life care within the Trust.

At this inspection, we saw a draft End of Life Strategy. This had recently been disseminated across both hospitals and all wards. It should be recognised the work needed to accomplish this work taking into account the complexity of how this service was provided. Foundation work had been accomplished which set the basis to build future direction for this service.

An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration staff, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced, developed and fit for purpose.

Arrangements were being developed so the Trust Board received an annual report outlining progress against key priorities within the strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements. This was still being embedded and as yet needs time to mature.

The Director of Nursing had taken the executive lead role for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and highlighted at board level.

However, further work now needs to take place in order formalise and cement the governance mechanisms such as; a structured service level agreement with Cumbria Partnership Trust which makes clear how work will continue together, using specific parameters to measure performance and delivery.

Junior staff expressed a lack of knowledge relating to the new hospital at Whitehaven and how that might affect them. It was evident there were discussions and decisions made by senior staff which could have been better communicated.

Vision

- The Cumbria Healthcare Alliance chose Cumbria Partnership Foundation Trust as the lead organisation for end of life care for the county and so they employed and managed the Loweswater Suite and the Specialist Palliative Care Team (SPCT) who provided hospital support for end of life care for the North Cumbria NHS Trust.
- At the last inspection this had led to a lack of a Trust wide vision and strategy for end of life care; a lack of clarity regarding the organisational structure to develop the service for the future; cross provision adding to the complexity of leadership and engagement at senior management and board level and lack of ownership about end of life care within the Trust.
- At this inspection, we saw a draft End of Life Strategy. This had recently been disseminated across both hospitals and all wards. It should be recognised the

work needed to accomplish this work taking into account the complexity of how this service was provided. Foundation work had been accomplished which set the basis to build future direction for this service.

- Staff were unable to articulate the End of Life quality goals although this had only recently been disseminated.

Governance, risk management and quality measurement

- At this inspection we found the Trust had reviewed how it was going to monitor the way in which they cared for patients at the end of their life. An End of Life and Bereavement Group had been initiated in July 2014 which included representation from the chaplaincy service, medical, nursing, administration staff, porters and other external providers of care. Its remit was to review how standards for end of life care could be enhanced, developed and fit for purpose.
- The End of Life and Bereavement Group would oversee delivery of the priorities within its strategy and the Safety and Quality Committee would receive minutes of its monthly meetings.
- Arrangements were being developed so the Trust Board would receive an annual report outlining progress against key priorities within the strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements.
- The SPCT were unclear of risk reporting arrangements for End of Life Care due to the complex provider arrangements. This was mitigated by copying incidents to both Trusts and the review of all End of Life Care adverse incidents at the End of Life care and Bereavement Group.

Leadership of service

- At the last inspection there was a lack of leadership at senior and board level, staff did not appear to be aware of who in the trust had responsibility and leadership for end of life care.
- At this inspection the Director of Nursing had taken the executive lead for end of life care, along with a Non-Executive Director to ensure issues and concerns were raised and highlighted at board level.

Culture within the service

- Staff were passionate about providing good quality care to patients at the end of their lives. The support and advice offered by the SPCT was responsive, supported effective pain management and good communication with families.
- Staff felt the new Director of Nursing was changing the culture within the service.
- Staff were more positive about their roles and were proud to work for the Trust.
- Junior staff had a lack of knowledge relating to the new hospital at Whitehaven and how that might affect them. It was evident there were discussions and decisions made by senior staff which could have been better communicated.

Public and staff engagement

- At the last inspection staff were seeking direction as felt they were not engaged in the wider development of the service.
- We found at this inspection senior staff were more aware of how the service should be developed and we were told by senior staff how they were included in influencing how the service should be developed.
- Arrangements were being made to ensure there was patient and public representation on the End of Life and Bereavement Group

Innovation, improvement and sustainability

- At the last inspection staff felt that end of life care did not have a high profile within the Trust and was not recognised as a specialism. At this inspection, there had been an increase in the profile of this speciality articulated by nursing and medical staff.

Outpatients and diagnostic imaging

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

Information about the service

There was a comprehensive set of medical and surgical clinics at the Cumberland Infirmary, Carlisle. These were based in a designated outpatients area. These clinics provided services to the 293,915 patients attending across the two hospitals in the trust.

At this inspection we visited the radiology service, orthopaedic, head and neck, general medical and surgical, breast, cardiology, dermatology/ rheumatology outpatients, medical procedures unit, medical oncology, chemotherapy and radiotherapy unit, cardiac physiology department, outpatient physiotherapy, the contact centre and the hub.

Summary of findings

At our previous inspection we found elements of this service to be inadequate, notably the availability of patient records when attending for a consultation. In the course of this inspection we found that as a result of targeted work there had been a significant improvement in this regard. 95% of patient records were now available for their appointment.

The introduction of a team to support and the hub had provided the infrastructure to deliver this important element of the service. Staff were very positive regarding this major improvement and the impact it was having on performance and patient experience. The introduction of the contact centre was beginning to address the appointment delays. This had only been in place for five weeks however this was already having a significant impact on the service.

Referral to treatment times were close to meeting national targets but up to December 2014 the percentage of patients waiting longer than 6 weeks for diagnostic tests was of concern. Waiting times for outpatient physiotherapy were commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. The physiotherapy outpatient service was struggling to meet the referral rates due to low staffing numbers. These delays were having a negative effect on rehabilitation times for patients.

Outpatients and diagnostic imaging

Clinics still frequently overran and patients could wait for extended periods of time to see their doctor. Staff interactions with patients were observed to be professional, compassionate and caring.

Staff provided patients with privacy despite the lack of available space in some areas. We noted "Laurens Room" as an area of good practice which provided privacy and dignity for patients receiving difficult messages.

The vision and plans for the service was clearer, there was an OPD Improvement strategy and a comprehensive improvement plan in place. Staff reported feeling involved in the changes and supported by their line managers.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Summary

At the last inspection in April 2014 the outpatient areas were clean and well maintained and measures were taken to control and prevent infection. The outpatient department was adequately staffed by a well-trained, professional and caring team. However, a recent case note audit undertaken in March 2014 showed there had been a 25% shortfall in case notes being delivered on time or being fully complete. This presented a risk of safety of people were being treated without their records. The environment was draughty and cramped in the atrium area. Some of the equipment in the digital imaging department was very old and there was an issue with obtaining replacement parts and therefore continued safety. Funding had been agreed to start replacing the equipment incrementally.

At this inspection the availability of notes at the start of clinics had significantly improved and the department was attaining 95% of notes available at the start of clinics. The introduction of a team to support and the hub had provided the infrastructure to deliver this important role. Staff acknowledged this major improvement and the impact it was having on the clinic performance and patient experience.

The physiotherapy outpatient service was struggling to meet the referral rates due to low staffing numbers.

We visited the medical Oncology / Chemotherapy / Radiotherapy unit and saw a cohesive team delivering best practice to this vulnerable group of patients. There appeared to be no delays in access to treatment. National guidelines were readily available and utilised. Patients spoke very highly of the standard of care they received.

Incidents

- All staff in outpatients and diagnostic imaging were aware of the incident reporting process and reported incidents.
- Learning from incidents had improved with clear processes for actions to be taken and learning was disseminated to all staff.

Outpatients and diagnostic imaging

- One never event had been reported in May 2014. It was a radiology/scanning incident. This had been fully investigated and appropriate actions and training undertaken.
- Incidents tended to be around missing notes or waiting times.

Cleanliness, infection control and hygiene

- The departments were observed to be clean.
- Staff were seen to be compliant with hand washing protocols.
- Equipment was cleaned daily and recorded.
- Place audits from December 2014 reported concerns with dust in higher areas such as tops of notice boards.
- At the time of the inspection there were cases of infection on two wards and additional signage was in place to encourage people to use hand gel on entering the hospital.

Environment and equipment

- There was a shortage of clinic space due to the increased demand due to the changes in clinical pathways.
- There was adequate seating for patients waiting to be seen.
- Place audits from December 2014 reported concerns regarding the decoration in some toilet areas and some general wear and tear.
- We noted one hoist had been condemned and replacement was awaited.
- IR(ME)R regulations were being met and monitored through the Radiation Safety Committee.
- MRI Scanner to be installed in June 2015.

Medicines

- There were limited medicines in outpatients but storage of medicines was appropriate.
- The fridge temperatures were checked daily and were seen to be within the expected range.

Records

- The availability of patient records at the start of clinics was rated as inadequate at the last inspection. Notes in February 2015 were available at the start of 95% of clinics.
- A "Hub" had been developed where a dedicated team worked to ensure notes were both available and in good order.
- There was a clear process for processing the notes in the hub which had clear escalation processes supported by a daily huddle.
- The availability of records was comprehensively monitored.
- All patient records in clinic areas were stored in locked trolleys to ensure confidentiality.

Safeguarding

- Staff had received safeguarding training and were aware of their responsibilities.

Mandatory training

- Orthopaedic clinic staff had all completed their mandatory training.
- Radiology staff were having difficulties maintaining their training due to increased activity in the department but 86% achieved.

Management of deteriorating patients

- Emergency equipment was available and accessible in "grab bag" format and had been checked daily.
- Defibrillator was available on the cardiology clinic.
- Staff were aware of their responsibility should a patients condition deteriorate in clinic.

Nursing staffing

- Nurse staffing was not reported as a concern.
- Clinics we visited appeared to have enough staff to meet the needs of the patients.
- Nursing staff were covering late running clinics.

Medical staffing

- The trust challenges with consultant recruitment meant clinics were run by the relevant locums.
- Locum staff were appropriately recruited and trained.
- Many medical staff were working over the clinic times. We noted that some clinics ran late in order to meet the demands this was particularly noted in the breast clinic.

Major incident awareness and training

- There was a trust policy, which staff were aware of and could refer to.

Are outpatient and diagnostic imaging services effective?

Outpatients and diagnostic imaging

Not sufficient evidence to rate

Summary

At the previous inspection the outpatient services were less effective because of an issue regarding the management of systems for patient records, which impacted on both staff and patients through delayed clinic start and finish times and longer waits for patients. We were informed that patients would not be seen without the notes and in some cases patients had not been seen for their appointment as a result.

At this inspection the number of cancelled appointments due to the lack of medical notes had been significantly improved. However, the delays in accessing physiotherapy out patients service was having a negative effect on rehabilitation times for patients. Staff appraisal was good but there was a lack of formal supervision in some areas.

There were plans in place to offer services out of normal working hours and at weekends.

Evidence-based care and treatment

- Staff were following appropriate national guidance where it was relevant.
- The Medical oncology/chemotherapy/ radiotherapy unit accessed guidelines are accessed through the intranet ensuring best practice adhered to
- Staff adhered to local policies and procedures

Pain relief

- Pain relief was available when required.

Patient outcomes

- There was a variation in outcomes for patients across the service.
- In the oncology service outcomes were very good but in the physiotherapy outpatients patients rehabilitation period was being extended due to the delays in accessing therapy.
- Patients were not being cancelled in the numbers as at the last inspection and this was having a positive effect on the outcomes for patients.

Competent staff

- Orthopaedic clinic staff had all received appraisal.
- The radiology department were challenged in the maintenance of the appropriate skill mix required. An external trainer had been arranged to provide support in April 2015.
- Radiology staff received appraisal in 86% of cases. However there was no formal clinical supervision available.

Multidisciplinary working

- All departments had team meetings and worked with a multi disciplinary approach.

Seven-day services

- Seven day services were not always available although the department was looking at options due to the increased demand since the reconfiguration of services.
- The CT Scanning team are looking at the possibility of providing a 24 hour a day service, seven days a week.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw consent was obtained appropriately.
- Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are outpatient and diagnostic imaging services caring?

Good

Summary

At the previous inspection staff working in the department respected patients' privacy and treated patients with dignity and respect. Patients told us that they were very satisfied with the service they received. They were positive about staff attitudes and had confidence in the staff's ability to look after them well during a procedure. It was clear that staff were very committed and worked to achieve the best outcomes for patients. Patients waiting at clinics stated that they found it undignified for inpatients to be moved from wards through the main atrium area in their beds or wheelchairs while wearing bed clothes when attending for diagnostic imaging.

Outpatients and diagnostic imaging

At this inspection staff interactions with patients were observed to be professional, compassionate and caring. Staff accommodated patients privacy despite the confines of some areas.

Compassionate care

- Staff interactions with patients were observed to be professional, compassionate and caring.
- Patients were observed being wheeled on trolleys through the large public atrium.
- Waiting areas in general x-ray, CT and MRI scanning were small and encroached on patients privacy. However, staff managed the space to achieve the best for patients.
- Staff were open with patients when things were not going as planned.

Patient understanding and involvement

- "You said, we did" process in place.
- Patients were involved in the decisions about their care.

Emotional support

- We saw staff supported patients in emotional situations and utilised a specially decorated room for breaking bad news.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Summary

At the previous inspection it was reported outpatient clinics were, in general, comfortable and friendly with suitable facilities. Oncology and digital imaging were meeting the two-week waiting targets for urgent patients. Targets for six weeks and 18 weeks appointments were not being met. Plans were in place to retrieve this situation by June 2014. The service was looking creatively at how to meet increased patient demand by best use of staff skills and by offering clinics at alternative locations and by expanding and developing capacity.

Patients waiting for day surgery were afforded limited privacy and the waiting area was cold and uncomfortable. Changing facilities lacked dignity and privacy and we were informed that many people became distressed at having to walk through the public area to the theatre in a night gown. Others refused to change until they were in the theatre area.

At this inspection we noted the introduction of the contact centre was addressing the appointment delays. This had only been in place for five weeks but was having a significant impact. Equipment was being reviewed for replacement.

Referral to treatment times were close to meeting national targets but up to December 2014 the percentage of patients waiting longer than 6 weeks for diagnostic tests was almost 12% against a target of less than 1%.

Waiting times for outpatient physiotherapy were commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. There did not appear to be a plan to deal with this. On 12 December 2014 49 people were waiting over six weeks for a routine physiotherapy outpatient appointment and 42 people were waiting over one week for an urgent referral.

We noted "Laurens Room" as a good practice which provided privacy and dignity for patients receiving bad news.

Service planning and delivery to meet the needs of local people

- The outpatients department was accessed from a large, airy atrium, the clinic areas were bright and signage was clear in most instances.
- The introduction of the contact centre was addressing the appointment delays. This had only been in place for five weeks but was having a significant impact.
- Prioritisation of radiology equipment for replacement plans were being developed.

Access and flow

- Intensive Support Team (IST) had been commissioned by the trust from July to December 2014 to develop capability and support the development of robust demand and capacity plans to deliver sustainable 18 week RTT standard.
- Up to December 2014 the trust 18 week RTT (Referral to treatment) objective for admitted pathways was 78% against a target of 90%, non admitted pathways was 93% against a target of 95% and incomplete pathways was 89% against a target of 92%.

Outpatients and diagnostic imaging

- Up to December 2014 in the trust the percentage of patients waiting longer than 6 weeks for diagnostic tests in the trust was almost 12% against a target of less than 1%.
- Up to December 2014 in the trust Cancer 2 Week Waits were at 89% against a target of equal to or greater than 93% and in breast cancer the 2 week wait was 92.9% against a target of 93%. The Cancer 62 Day Waits was 83% against a target of 85%.
- The trust cancer 31 Day Waits were being met in all areas.
- Weekly RTT team meeting with the service managers to review progress and address concerns.
- Waiting times for outpatient physiotherapy were commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. There did not appear to be a plan to deal with this. On 12 December 2014 49 people were waiting over six weeks for a routine physiotherapy outpatient appointment and 42 people were waiting over one week for an urgent referral.
- Waiting times in orthopaedic clinics has been reduced from 12 weeks to 4 weeks through regular review and planning.
- Cumberland Infirmary's follow up to new rate is consistently better than the England average.
- The orthopaedic clinics were challenged as activity had increased significantly since the reconfiguration of trauma services.
- A contact centre had been established five weeks before the inspection. This was reducing the backlog of referrals and aiming to ensure all patients are booked within six weeks of receipt of the referral.
- In cardiology physiology department they have experienced an increase in referrals and identified portering delays causing waits for patients.
- There is no waiting list for radiotherapy

Meeting people's individual needs

- A Contact Centre had been established to centralise the appointments process. Some teething problems were reported but this was thought to be an improvement.
- Staff in orthopaedic clinics were working flexibly to cover clinics that ran over time, weekend clinics and extra clinics to meet demand.
- Patients were kept informed of clinic running times through either verbal messages or white boards announcing delays.
- Some delays in start of clinics were still being experienced particularly in orthopaedics as consultants had to travel from the West Cumberland hospital. This was being addressed by the managers.
- Late finishes were also common in orthopaedic and general medical clinics.
- New patient fracture clinics were held at weekends to meet the needs of patients.
- Delays are commonly seen for patients waiting for admission form out patients, but the staff liaised closely with the bed management team.
- Choose and book, Skye gateway and Citrix systems used to support booking of appointments.
- Increase of 15 - 20% in radiology requests was proving challenging for the Radiology department.
- Demand for CT scanning had significantly increased, the team were available 8am to 8pm Monday to Friday and 9am to 5pm at weekends, CT team were on call from home out of these hours. The team are looking at the possibility of providing a 24 hour a day service, seven days a week.
- Chemotherapy day unit was established in November 2014 in a stand alone unit and provides excellent service supported by a clear appointments system meaning no delays in starting therapy.
- In the breast clinic we visited "Laurens Room". This was a specially decorated room used to provide privacy and dignity for patients receiving bad news. It had been named after a patient who raised the concern of the lack of dignity.

Learning from complaints and concerns

- Complaints were mainly around car parking difficulties and waiting times .
- Regular huddles were used to share learning as well as team meetings.

Are outpatient and diagnostic imaging services well-led?

Good

Summary

At the previous inspection we reported that performance was reported monthly and considered by the trust board. Plans for the service included addressing issues related to capacity planning. There was board ownership of the plans

and a commitment at all levels to Outpatients securing the required improvements. Staff had confidence in their managers and felt there was a new, strong culture of leadership.

At this inspection the vision for the service was clearer, there was an OPD Improvement strategy and a comprehensive improvement plan in place. Staff reported feeling involved in the changes and supported by their line managers. Ophthalmology remained a concern but this was being addressed. Alternative approaches were being considered to address clinic effectiveness. It was clear that the department had progressed well due to the increased efforts made to improve.

Vision and strategy for this service

- Staff were aware of the trust vision and strategy.
- An OPD Improvement Strategy had been developed and published in June 2014. It had clear performance objectives.
- A comprehensive improvement plan had also been developed and was on track to achieve the set objectives.

Governance, risk management and quality measurement

- Out patients had a risk register but it only covered three high level risks.
- Weekly out patients improvement group on orthopaedics reviews all areas of delivery including capacity planning and reducing waiting times.
- There were regular multidisciplinary meetings including clinic staff, contact centre staff, medical records staff and senior managers to promote coherent improvements.
- Ophthalmology was identified as an area of concern at the last inspection and regular capacity planning meetings were being held to address the concerns.
- Incident reports were submitted monthly.

Leadership of service

- Staff felt well supported by their managers who were readily available.
- The trust CEO had attended staff meetings which had been well received.

Culture within the service

- It was reported that staff morale had been low but recent improvements in the service had improved this.
- Staff reported being able to openly discuss concerns with their line manager.

Public and staff engagement

- Staff reported feeling engaged in the improvement changes that have been undertaken.

Innovation, improvement and sustainability

- Management were considering running evening clinics as a planned practice in the future.
- Dressings clinics regularly over ran so the managers were looking at running clinics from West Cumberland to address this.
- The electronic system for appointment triage is to be improved.

Outstanding practice and areas for improvement

Outstanding practice

- We visited the medical Oncology / Chemotherapy / Radiotherapy unit and saw a cohesive team delivering best practice to this vulnerable group of patients. There appeared to be no delays in access to treatment. National guidelines were readily available and utilised. Patients spoke very highly of the standard of care they received.

Areas for improvement

Action the hospital MUST take to improve

Urgent and Emergency care

- Improve performance against the DH target for emergency departments to admit, transfer or discharge patients within four hours of arrival. (Reg. 9(2))
- Improve the rates for consultant led trauma teams being ready for patients with an injury severity score greater than 15 on arrival (currently 41%). (Reg. 9(2))
- In relation to NICE clinical guideline CG16 (Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care) increase the number of patients who receive a clear risk assessment (currently 22%). (Reg. 9(2))

Medical Care

- Improve the number of substantive medical posts. (Reg. 18(1))
- Improve the nurse staffing levels. (Reg. 18(1))
- Improve safety thermometer results particularly on Elm B ward. (Reg. 9(2))
- Improve performance in relation to the care and treatment of patients with diabetes. (Reg. 9(2))
- Reduce the pressures on the availability of medical beds which resulted in patients regularly being cared for on wards outside of their speciality. (Reg. 9(2))
- Stop moving patients during the night without a medical reason for doing so.(Reg. 9(2))
- Provide effective leadership for the newly created team of nurse practitioners (Reg. 18(2)(a))

Surgery

- Improve the recruitment of medical and nursing staff. (Reg. 18(1))
- Improve compliance against 18 week referral to treatment standards for admitted patients. (Reg. 9(2))
- Improve number of patients whose operations were cancelled and were not treated within the 28 days. (Reg. 9(2))
- Develop a strategic plan specifically for surgical services. (Reg. 17(2)(a))

Critical care

- Ensure there is access to a consultant and middle grade anaesthetist out of hours who do not have on call responsibilities for other specialities such as theatres and maternity. (Reg. 18(1))

Maternity and Gynaecology

- Ensure the epidural service is available though plans in place to introduce this in September 2015. (Reg. 9(2))
- Ensure staff are trained in the management of maternity emergencies. (Reg. 18(2)(a))

Services for Children

- Improve the staffing position regarding the continued shortage of junior medical staff and the provision of 24-hour paediatric consultant presence on the hospital site which remained a concern as the service still offered a 24 hour emergency service for Children and young people. (Reg. 18(1))
- Conclude the children's and young people's service review in order to better meet the needs of children and young people living in the area and to maximise the effective use of resources. (Reg. 17(2)(a))

End of Life care

- Recruit to the substantive consultant post for specialist palliative care. (Reg. 18(1))
- Address the Trusts annual audit figures for DNACPR which showed 170 forms out of 542 forms were not fully completed. (Reg. 9(2))

Outstanding practice and areas for improvement

Outpatients and diagnostic imaging

- Improve the percentage of patients waiting longer than 6 weeks for diagnostic tests which is currently almost 12% against a target of less than 1%. (Reg. 9(2))
- Improve waiting times for outpatient physiotherapy which are commonly longer than four months for a routine referral and over three weeks for urgent referral against a target of one week. (Reg. 9(2))

Action the hospital SHOULD take to improve

Medical

- Continue to improve the quality of care and treatment provided to patients who have suffered a stroke.

Critical Care

- Review the nurse staffing ratios at times of high acuity of patients.

Maternity and Gynaecology

- Mitigate against the security and privacy issues in the maternity ward due to the layout of the environment.

End of Life care

- Provide a bereavement office on site.

Outpatients and diagnostic imaging

- Continue to improve referral to treatment times

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider has not ensured the provision of appropriate care and treatment that meets peoples needs. Regulation 9(2)**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Accommodation for persons who require nursing or personal care Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes for the improvement of surgical and children's and young peoples services have not been fully established. Regulation 17 (2)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Maternity and midwifery services Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider has not deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons in all areas. Regulation 18 (1)** **The provider has not provided appropriate support and training with reference to nurse practitioners and maternity staff. Regulation 18(2)(a)**