North Cumbria University Hospitals NHS Trust

West Cumberland Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

North Cumbria University Hospitals NHS Trust serves a population of 340,000 people living in north and West Cumbria. In total, the trust employs 4,272 staff and has 629 inpatient beds across the Cumberland Infirmary, Carlisle, West Cumberland Hospital in Whitehaven and the Penrith Birthing Centre.

We carried out this comprehensive inspection because North Cumbria University Hospitals NHS Trust 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. At that time there were concerns regarding inadequate governance, the pace and focus of change to improve overall safety, and patient experience; as well as slow and inadequate responses to serious incidents and a culture that did not support openness, transparency and learning. In addition, there were concerns regarding staffing shortfalls in a number of staff groups that may have been compromising patient safety, a lack of support for staff, and a lack of effective, honest communication from middle and senior managers. As well as failures in governance to ensure adequate maintenance of the estate and equipment, there were significant weaknesses in infection control practices.

We undertook an announced inspection of the trust between 30 April and 2 May 2014, and an unannounced inspection visit between 8.30am and 4pm on 12 May 2014.

Our key findings were as follows:

Mortality rates

- Since our last inspection and the Keogh review, there had been a significant improvement in mortality rates, which were now within expected limits.
- Patients whose condition might deteriorate were identified and escalated appropriately.

Infection control

- The hospital was clean throughout. Staff generally adhered to good practice guidance in the prevention and control of infection.
- Infection rates were within expected limits.

Food and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs were supported by dieticians and the Speech and Language Therapy Team (SALT).
- 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 assist those patients who needed help. We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking.

Medicines management

- Medicines were provided, stored and administered in a safe and timely way.

Medical and nurse staffing

- Care and treatment was delivered by committed and caring staff who worked hard to provide patients with good services. However:
- There were numerous consultant vacancies that were adversely affecting timely treatment for patients and effective support for junior doctors in a number of core services.
- Nurse staffing levels, although improved, remained of concern and there was a heavy reliance on staff covering extra shifts, and bank and agency staff to maintain adequate staffing levels. Adequate staffing levels were not consistently achieved in all core services.

Summary of findings

Service changes

- There had been changes to the functions within both accident and emergency and surgical services regarding the management of trauma, high risk general surgery and colorectal cancer patients, which began in June 2013. This care has now transferred to the Cumberland Infirmary in Carlisle. This has led to routine elective work being regularly cancelled at the Cumberland Infirmary, but the transfer of routine work to West Cumberland has not been as systematic as anticipated, as patients prefer to wait to have their procedure at Carlisle. The distance between the two sites appears to be a major factor in patients' decisions regarding where to have their surgery rather than the care delivered.
- This had exacerbated the trust's inability to meet referral to treatment time (RTT) targets for admitted patients, particularly in orthopaedics. The distance between the two sites was a major factor in patients' decision making.

Staff concerns and whistleblowing

- Communication from the executive team to the staff on the wards and departments had improved. Staff were positive about the executive team for the direction they have communicated regarding the future of services. However, we were concerned about the lack of openness of the culture within the trust as we received a high number of anonymous whistleblowing concerns about this hospital before, during and after the inspection. This indicated that staff felt unable to share concerns with the trust despite the concerns being about patient safety and the quality of services provided.

We saw some areas poor practice where the trust needs to make improvements.

- Care and treatment was not always provided in accordance with best practice guidance.
- Care and treatment was not always delivered in accordance with national expectations.
- Poor patient flow meant patients were placed in areas not best suited to their needs.
- The provision of case notes and records was inconsistent across the hospital. Storage and retrieval of patient records was poor, which meant some patients did not have a consultation at their appointments because the records could not be traced. This was particularly important because of the use of agency staff.
- Nurse record-keeping was poor in the paediatric ward.
- We did not see a formal plan in place for a replacement for the Liverpool Care Pathway for patients at the end of life, although the trust has since informed us that it has a formal plan in place.
- Audit data was incomplete in some areas and the application of learning from incidents and complaints lacked consistency.

Importantly, the trust must:

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients at all times.
- Ensure medical staffing is sufficient to provide appropriate and timely treatment to patients at all times.
- Ensure that all departments within the hospital have the required skills to meet the needs of patients at all times.
- Improve the support given to junior medical staff.
- Take action to ensure that the planning and delivery of patient care and treatment is consistently carried out in accordance with published research and guidance issued by professional and expert bodies.
- Take action to protect the health and welfare of children and young people with mental health needs by ensuring that timely health and social care support is provided in collaboration with other providers.
- Take action to improve the patient flow through the hospital to cope with the routine workload and reduce patient waiting times.
- Work towards achieving the target of no more than 18 weeks wait from referral to treatment.
- Improve the standard of nursing records in the paediatric service.
- Develop clear action plans to assess and manage the impact of the lack of a dedicated second theatre and no provision for urgent obstetric/gynaecology surgery at the hospital.

Summary of findings

- Take action to ensure that patient records are fully complete and up to date and made available in a timely way for all outpatient clinic appointments.
- Develop a formal End of Life Care standard framework to assure safe, effective care at the end of life. Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014.
- Ensure the safety and security of all patients, staff and visitors who attend the A&E department by training all the staff on the procedures to follow in the event of a security or safety incident.

In addition the trust should:

- Improve the management of people with diabetes, stroke and people with a diagnosis of dementia in line with national guidance.
- Ensure that staff have the opportunity to regularly discuss their personal development and any issues or concerns they may have.
- Ensure the security roles and responsibilities of the portering staff when dealing with violence and aggression are within the acceptable parameters of legal restraint.
- Improve access to CT/MRI scanning to ensure patients receive a scan quickly.
- Improve reporting times for radiology and CT scans so that patients receive timely results to improve the quality of treatment outcomes.
- Ensure the maternity service has the ability to undertake grade 3 caesarean sections.
- Ensure the trust's information regarding 'How to make a complaint' is accurate.
- Ensure the infrastructure is in place before establishing additional outpatient clinics.
- Ensure there is a clear vision and strategy for end of life care and provide clear leadership for end of life care, both at director and non-executive director levels.
- Provide training for staff to enable care bundles to be implemented.
- Review the lack of standardisation across trust locations, such as the availably of evening clinics for early pregnancy advice and access to termination of pregnancy clinics.
- Continue to develop robust audit processes to verify that staff are adhering to the 'five steps to safer surgery' checklist.
- Review the lack of standardisation across trust's locations, such as the availably of evening clinics for early pregnancy advice and access to termination of pregnancy clinics.

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?
Accident and emergency	Requires improvement 	The Government requires NHS trusts in England to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The hospital had met the four-hour wait target for the last six months, although for patients attending by ambulance the time to triage was not consistently meeting the 15 minutes target. The A&E service was provided in a safe and clean environment by trained, competent medical and nursing staff who demonstrated a strong culture of openness and learning from incidents. However, maintaining adequate nursing and medical staffing levels was a concern as there was a heavy reliance on locum doctors and bank staff to cover vacancies. Levels were being managed but the situation is not sustainable without adequate recruitment. There were also concerns regarding the robustness of major incidents procedures as these had not been tested for four years. The department needed to improve how it used national audit data to improve patient treatment outcomes. It also needed to improve data collection and submission rates for trauma audits and the time taken to report results for radiology scans, including out-of-hours CT scans. Staff interacted positively with patients and /or their relatives and demonstrated caring attitudes. They worked hard to respond to patients' needs.
Medical care	Requires improvement 	Medical care services were delivered by a hardworking, caring and compassionate staff that treated patients with dignity and respect. Shortages of both nursing and medical staff, combined with an ongoing inability to staff the wards within agreed safe levels and correct skill mix, meant that care and treatment was not always being provided safely. Improvements were particularly needed in the management of patients with a diagnosis of dementia, diabetes and those patients who had had a stroke.

Summary of findings

Generally, the wards/departments were well-led, although there was a lack of connection between the staff providing hands-on care and the executive team.

Surgery — **Requires improvement**

Surgical services were delivered by competent, hardworking, caring and compassionate staff that treated patients with dignity and respect. Elective surgery was being provided at the West Cumberland Hospital from Monday to Friday. A consultant was available for the surgical directorate between 8am and 10pm. However, as of March 2013, the on-call orthopaedic registrar post at West Cumberland Hospital ceased and the function was replaced by the on-call team at Cumberland Infirmary Carlisle. There was also no pharmacy service out of hours, other than from an on-call pharmacist.

Data from patient reported outcome measures (PROMS) showed the service needed to improve the outcomes for patients who had a primary hip replacement.

There were six surgical never events between November 2012 – January 2014. Shortages of both nursing and medical staff, together with pressures on bed availability, meant that care and treatment was not always being provided in a timely way. Since June 2013, services regarding the management of trauma, high risk general surgery and colorectal cancer patients have transferred to the Cumberland Infirmary in Carlisle. This has led to routine elective work being regularly cancelled at Carlisle. The transfer of routine work to Whitehaven has not been as systematic as anticipated, as patients prefer to wait to have their procedure at Carlisle because of the distance between hospitals. This had affected referral to treatment times (RTT), which were not being met for admitted patients, particularly in orthopaedics. The distance between the two sites appears to be a major factor in patients' decision-making.

Staff felt well led at ward level but the vacancies in middle management roles within the surgical team had detrimentally affected the leadership above the ward manager. The hospital lacked consistent presence at general manager level, and the shared management approach reduced accountability for the site.

Summary of findings

Critical care

Good

Staff were caring and compassionate, and patients and relatives spoke highly of the care and treatment.
There was a full complement of nursing staff in place to meet patients' needs. The unit had access to a consultant and an anaesthetist seven days a week.
There were daily consultant-led ward rounds.
Out-of-hours medical cover was provided by a staff grade anaesthetist with an on-call consultant.
Care and treatment was delivered in accordance with national guidance. Staff applied current infection prevention and control guidelines.
Cleaning schedules were in place, and there were clearly-defined roles and responsibilities for cleaning the environment and for cleaning, maintaining and decontaminating equipment.
Medicines, including controlled drugs, were stored safely and securely.
The trust ensured that patients were admitted to the unit within four hours of making the decision to admit, as well as ensuring that the discharge to the ward was within four hours of making the decision to discharge.
Multi-disciplinary working was well established and staff worked well together as a team.

Maternity and family planning

Requires improvement

We found that maternity services were delivered by committed and compassionate staff. All staff treated patients with dignity and respect. All the people we spoke with were positive about the care they had received.
However, the maternity service was not sufficiently safe. The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. We found that the identified risks were still in place and sufficient actions to mitigate them had not yet been implemented.
Risks included the lack of dedicated medical staff cover, lack of regular identified clinics, and the use of locums, which impacted on the service's ability to respond in a timely and effective manner. The obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust.

Summary of findings

The service also had significantly higher rates of elective and emergency caesarean sections compared with the national average. We did not find evidence of a clear strategy or plan for reducing the number of caesarean sections.
The service had the standard ratio of one midwife to 28 patient hospital births.
The service had undergone a review of its midwifery service, and the introduction of a midwifery governance lead had improved the approach to governance and monitoring clinical practice.
The midwifery staff felt well led, but there was a lack of clear medical leadership and strategic vision for the future of maternity and family planning services at the West Cumberland Hospital location.

Services for children and young people

Requires improvement

The medical and nursing staff were caring and worked hard to meet the needs of children and young people.
Although staff said they felt supported by senior staff, they were not fully involved in the plans and future developments for the children's ward.
The service could not show that staff understood the changes required to ensure the quality of care was consistent on the paediatric ward and special care baby unit.
Staff did not adhere to the trust's policies and procedures, and compliance with best practice guidance was also inconsistent. Environmental and care and treatment risk assessments were inadequate or had not been completed, which meant that the safety of children and young people was not always promoted.
Sufficient nursing staff were on duty, but children and babies who attended the hospital were at risk of delayed or ineffective treatment because experienced paediatric doctors were only available on site Monday to Friday between 9am and 5pm.
Safeguarding and child protection had improved because the hospital had recently taken steps to ensure that staff followed the safeguarding children policy, which had brought about positive outcomes.
Review of the trust's information identified significant time-lapses between when concerns were raised and when effective action was initiated.

Summary of findings

End of life care

Good

Care was given by supportive and committed staff that were passionate about providing a good service.

Care for patients at the end of life was supported by a specialist palliative care team employed by the Cumbria Partnership NHS Foundation Trust and there was excellent multi-disciplinary working across the hospital. Nursing staff were appropriately trained to deliver end of life care.

The hospital followed the guiding principles of the Liverpool Care Pathway but had not introduced a formal pathway, although it had introduced the AMBER care bundle.

Patients and their families were fully involved in discussions about their care and treatment needs.

Staff in the mortuary delivered a quality service. The chaplaincy service was expanding its spiritual and bereavement support. Relatives and patients were able to access multi-faith support.

However, the trust lacked vision and strategy for end of life care, which resulted in a lack of leadership at senior and board levels.

Outpatients

Requires improvement

Overall, patients received safe and appropriate care in the department. 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.

Staff treated patients with dignity and respect. Patients told us that they were very satisfied with the service. They were positive about staff attitudes and had confidence in the staff's ability to look after them well. It was clear that staff were very committed and worked to achieve the best outcomes for patients.

However, outpatient services were less effective because clinics started late and overran, which meant patients had longer waits. This was because of an inefficient system for providing patient records in time for appointments. We were informed that patients would not be seen without the notes and in some cases patients had not been seen on the day of their appointment as a result. This has already been recorded as high risk on the trust's risk register.

Outpatient clinics were generally comfortable and friendly with suitable facilities. Oncology and digital

Summary of findings

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.
There was good continuity of nursing staff in the department and they received favourable patient feedback. The team was supported by specialist nurse roles.
Although patients we spoke with did not complain about the waiting times, staff said that additional weekend clinics were needed to meet demand. Although some additional outpatient clinics had been arranged we saw that clinics were stretched. Problems with recruiting consultants also affected clinics. The general manager in outpatients had taken action to mitigate this. Senior nursing staff always ensured that all support services (staff and room) were in place to support the additional clinics, but there was insufficient strategic capacity planning, and overbooking of clinics was masking the overall picture.
The lack of CT/MRI capacity had been recognised at board level. Funding was in place to obtain new equipment and efforts were being made to recruit additional radiologists.
Overall, there was a positive view about the role of the new general manager tier of management, as they were felt to be effective.

Requires improvement

West Cumberland HospitalWest Cumberland Hospital

Detailed findings

Services we looked at
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

Contents

Detailed findings

Background to West Cumberland Hospital

Along with the Cumberland Infirmary in Carlisle, the West Cumberland Hospital in Whitehaven delivers acute care services as part of North Cumbria University Hospitals NHS Trust. The West Cumberland Hospital structure no longer meets modern needs, and a £97 million Phase 1 redevelopment of the hospital is currently underway.

We inspected the hospital as part of the comprehensive inspection of North Cumbria University Hospitals NHS Trust. This inspection follows previous inspections, including the Keogh inspection in June 2013 and a CQC inspection in October 2013.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspection: Ann Ford, Care Quality Commission

The team included an Inspection Manager, 10 CQC inspectors and a variety of specialists including a Surgical Operational Manager of Acute Trust Clinical Services; Director of Improvement, Quality and Nursing; Clinical governance expert; Consultant Physician and Gastroenterologist; Consultant Obstetrician & Gynaecologist; Consultant Paediatrician & Honorary Senior Lecturer - Neonates/general paediatrics; Executive Director of Nursing with experience in Community Services, Service Transformation, Clinical Governance, Risk Management, Prevention & Control of Infection, Emergency Planning, Safeguarding of Children; Surgical Nurse; Paediatric Emergency Nurse Consultant; Head of Midwifery and Supervisor of Midwives; Lead Nurse for Critical Care and previous Head of Nursing Development and Quality; Student Nurse and two experts by experience.

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 hospital. 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.

We held two listening events, one in Carlisle and one in Whitehaven on 29 April 2014 when people shared their views and experiences of both West Cumberland Hospital and Cumberland Infirmary. Some people who were unable to attend the listening events shared their experiences by email or telephone.

The announced inspection of West Cumberland Hospital took place on 30 April and 2 May 2014. 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.

Detailed findings

We carried out unannounced inspections between 8.30am and 4pm on 12 May 2014. We looked at how the theatres delivered care and collected further information to support our judgements around surgical care.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at West Cumberland Hospital.

Facts and data about West Cumberland Hospital

West Cumberland Hospital is a general hospital providing a 24-hour A&E, a consultant-led maternity unit and special care baby unit, a range of specialist clinical services and an outpatients service. It has 217 inpatient beds and serves the local people around rural Whitehaven in West Cumbria and the northern Lake District.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Requires improvement	Good	Good	Good	Good
Maternity and family planning	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Requires improvement	Good
Outpatients	Inadequate	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

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

Information about the service

The A&E department at West Cumberland Hospital provided a consultant-led 24-hour service, seven days a week and is part of the Emergency Care and Medicines Business Unit (ECMBU) of the trust. On average the department sees around 100 patients each day.

There was also a co-located GP-led out-of-hours service (Cumbria Health on Call (CHOC)) next to the Emergency Department (ED) main entrance, which we did not inspect. There were separate walk-in and ambulance entrances to the department. Main reception is staffed 24 hours a day. Within the main department there were three beds in the resuscitation area, one of which was used for paediatric patients when necessary. Four minor treatment cubicles and three monitored cubicles were adjacent to the staff base.

The five-bedded majors facility is open from 10am to 8pm Monday to Friday when staffing levels permit and is used to treat major cases. When this facility is closed the three monitored cubicles adjacent to the minors area were used to treat majors patients.

We spoke with 10 patients, four relatives and 18 staff, including consultants middle grade/junior doctors, operations and patient experience managers, receptionist, porters, matron, sister, student nurse and ambulance crews. We observed care and treatment and looked at treatment records. We also reviewed many items of the trust's own quality monitoring information and data.

Summary of findings

The service was provided in a safe environment by trained, competent and caring medical and nursing staff. The standard of cleanliness was good throughout the department and staff adhered to good practice guidance in terms of the control and prevention of infection.

NHS trusts in England are required to admit, transfer or discharge 95% of patients within four hours of their arrival in the A&E department. The four-hour wait target had been met for the last six months, although for patients attending by ambulance the time to triage was not consistently meeting the 15-minute target. The trust had added an additional five beds to help the flow of patients through the department. However, the flow was often delayed by a lack of available beds in the hospital.

Medicines were supplied, dispensed and stored safely. Electronic patient care and treatment records were used effectively to track the patient's care and there were good mechanisms in place to monitor patients and escalate any changes in their condition.

There was a positive culture in relation to incident reporting. There was strong evidence that incidents were reported and reviewed. Staff applied the learning from incidents to inform and improve practice.

Recruitment was underway to fill the nursing staff vacancies. In the interim, nurse staffing levels were being maintained by using overtime and bank staff.

Accident and emergency

At the time of the inspection there were five whole time equivalent (WTE) consultants covering the department, one of the posts was covered by a locum doctor. One consultant was due to leave and this would leave three WTE consultant vacancies. This would place a heavy reliance on locum doctors, which would need to be appropriately managed to ensure continued safe practice. The department also relied on porters to provide security arrangements, although they were not trained.

The department needed to improve how it used national outcome audit data to improve patient treatment outcomes. The Trauma Audit & Research Network (TARN) data collection and submission rates also needed to improve, as well as the reporting times for radiology, including out-of-hours CT reporting.

Are accident and emergency services safe?

Requires improvement

The service was provided in a safe environment by trained, competent medical and nursing staff. Cleanliness was good and staff engaged in the processes required to maintain hygiene. There was good access to medicines, which were handled safely. Electronic patient care and treatment records were used effectively to track the patient's care and there were good mechanisms in place to monitor patients and escalate their care when required, which were adhered to. There was a culture to report incidents, and clear evidence showed that staff reported and reviewed incidents and took action accordingly and therefore were learning from incidents.

There were nursing staff vacancies but these were being recruited to and the staff requirements were being met through overtime and bank. At the time of the inspection there were five whole time equivalent (WTE) consultants covering the department, of which one of the posts was covered by a locum. One consultant was due to leave and this would leave three WTE consultant vacancies. This would place a heavy reliance on locum doctors, which would need to be appropriately managed to ensure continued safe practice. There was also a reliance on porters for security arrangements within the department for which they were not fully trained.

Senior nursing staff reported that the decontamination tent, used to manage hazardous decontamination, did not have lights and the training in managing hazardous decontamination lacked frequency. Senior clinicians explained about the major incident plans but were concerned they had not been tested since 2010.

In light of all of the recent changes to orthopaedic, surgical, acute medicine and the impact on A&E services at West Cumberland Hospital and Cumberland Infirmary, we were concerned of the impact on the MAJAX and CBRN plans but could find no evidence that this had been reviewed for both hospitals.

Accident and emergency

Incidents

- Serious incidents known as 'never events' (serious events that are largely preventable) are nationally reportable. There had been no never events reported within the A&E within the last 12 months.
- The trust overall reported six serious incidents requiring investigation (SIRIs) to the Strategic Executive Information System (STEIS) relating to the department between December 2012 and January 2014. We looked at the serious investigation report from one of the recent SIRIs reported and saw that following a full investigation, an action plan had been developed and the learning from the incident had been shared with the team with further follow-up actions agreed and monitored.
- The trust provided a copy of the department's incident management report for September 2013 to February 2014 and we saw that 121 incidents were reported during this period. These incidents had been categorised and the majority were assessed as not resulting in harm.
- Staff reported incidents of concern electronically and they knew how to report incidents. We looked at two recent incident reports and saw they included incident description, contributing factors, and incident details along with the outcomes from investigations.
- We looked at the minutes from the April 2014 monthly departmental staff meetings and saw that the meetings included reviews of SIRIs, incident reports, mortality and morbidity learning points.

Safety thermometer

- Information relating to patient safety was visibly displayed on notice boards in the department. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. There were no areas of concern identified.

Cleanliness, infection control and hygiene

- The department overall was clean throughout and staff were aware of the current infection prevention and control guidelines.
- We saw adequate hand washing facilities and alcohol hand gel was available throughout the department.
- We observed good practices, such as staff following hand hygiene and 'bare below the elbow' guidance, wearing personal protective equipment, such as gloves and aprons, whilst delivering care. We saw staff handling and disposing of clinical waste, including sharps, safely.

Environment and equipment

- There were ample supplies of suitable equipment. Appropriate life support and associated monitoring equipment, along with resuscitation equipment, was accessible and available within the department. Staff followed an agreed safety checklist for the equipment in the resuscitation area and checks were up to date.

Medicines

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow. Medicines were stored, managed, administered and recorded safely and appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow. Staff were seen discussing care and treatment options with the patient and /or their relatives to enable them to make informed choices. Where patients lacked capacity to make their own choices staff consulted with appropriate professionals so that decisions were made in the best interests of the patient.
- The majority of patients and/or their relative we spoke with confirmed that staff had provided clear explanations for them to make informed decisions. We also witnessed staff seeking verbal consent before undertaking treatments for example, before taking specimens and cannulation.

Safeguarding

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to escalate safeguarding concerns.
- The integrated records included triage as well as a question pertaining to child protection, which staff were expected to answer. We looked at five A&E records and saw triage had been completed in all five records.

Accident and emergency

- We noted from the April 2014 department meeting minutes that the trust's Safeguarding Board had praised the department regarding the referrals it made.
- Senior medical staff were responsible for ensuring patient discharge arrangements; internal and external patient transfer arrangements were safe and appropriate to the needs of the patient.

Mandatory training

- Staff received mandatory training that covered a wide range of subjects under a number of domains, for example, health and safety, safeguarding, moving and handling, resuscitation and medicines management.
- We looked at the department's training records up to the end of January 2014. For nurse staff, positive completion rates were reported across all domains. For example, 100% for adult safeguarding training level one and 56% for level two. 100% for safeguarding children and young people level one and 90% level 3. 90% for learning disabilities and 91% fire safety. Medical staff completion rates were variable, for example, 100% safeguarding children and young people level one and 44% level 2. 35% safeguarding adults level 1 and 19% level 2. 65% completion rate for fire safety and 58% basic life support. Paediatric life support both basic and advanced was at 69% completion rate.
- We noted from the April 2014 departmental minutes that staff were complimented on having completed their mandatory training and the department overall had scored well.

Management of deteriorating patients

- We looked at five national early warning score (NEWS) records and saw they contained internal escalation clinical response triggers to senior medical staff if a patient had a high NEWS score. Pain scores and fluid output was included within NEWS assessments.
- Walk-in patients were registered at main reception and asked to wait within the waiting area before being triaged by the nurse. If there were any immediate concerns about a walk-in patient the receptionist would contact the nursing staff to ask for immediate assistance.
- Ambulance crews confirmed their arrival by using the electronic arrival (HAS) screen, whilst at the same time notifying the team of their arrival. Systems and processes were in place to receive ambulance pre-alerts.
- Ambulance patients were brought directly to the nurse's station within the main department where a very brief history was given to enable the nurse to determine the most suitable location to treat the patient. A full handover from the ambulance staff was then given to the nurse within that area.

Nursing staffing

- Departmental staffing and skill mix had recently been reviewed and included 5.2 whole time equivalent (WTE) band 7 and band 6 qualified nurses, supported by 17.8 band 5 WTE qualified nurses along with 3.92 band two and 1.8 band three WTE health care assistants.
- Plans were in place to recruit to existing vacancies for four band 5 qualified nursing posts and this this figure was confirmed by the emergency department matron. Vacancies were covered by overtime and bank staff.
- Risks in relation to insufficient nursing numbers across the entire emergency and medicine unit were assessed and managed through the divisional risk register. We saw from the register that control measures were in place to manage the risk and these controls were reviewed monthly.

Medical staffing

- We spoke with two consultants who told us the medical staffing establishment included six whole time equivalent (WTE) consultants, 6.6 WTE middle grade/ speciality doctors and six WTE junior doctors.
- Currently, five whole time equivalent (WTE) consultants covered the department, of which one of the posts was covered by a locum. One consultant was shortly due to leave, which would leave three WTE consultant vacancies.
- Consultant presence in the department was from 9am to 9pm weekdays and 12pm to 3pm at the weekend with 24-hour/seven days a week on-call cover. 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.
- The risks in relation to the reliance on locum doctors to bridge vacancies across the division were assessed and managed through the divisional risk register. We saw from the register that control measures were in place to manage the risk and these controls were reviewed monthly.

Accident and emergency

Major incident awareness and training

- The draft version 3 of the 'Emergency Department Operational Policy' referred to the MAJAX and CBRN (major incident/accident plan and chemical biological radiological and nuclear exposure plan). It stated the policies are regularly reviewed and tested to enable the trust to respond effectively to a major incident to meet the requirements of the Civil Contingencies Act 2004 and NHS Emergency Planning Guidance 2010, but we found no evidence of review in line with recent clinical pathway changes.
- Some members of the nursing team reported they did not feel safe as the department relied on hospital porters to provide security services. One of the senior clinicians also confirmed that the porters had a role in security and the default position was to call the police.
- We spoke with three of the porters on duty and they reported they had received some training on prevention management of violence and aggression and did their best to support the staff wherever and whenever they could. From the information received, the systems and processes for managing departmental safety and security needed to be reviewed.
- We asked the senior clinicians about the major incident plans and were told these plans were last tested in 2010.
  - Senior nursing staff reported that it had recently been identified that the decontamination tent used to manage hazardous waste did not have lights and the training in managing hazardous decontamination was not a frequent event.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

Care and treatment was evidence-based and followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. Four care bundles were available in the department for use in relation to acute chronic obstructive pulmonary disease (COPD), sepsis, community acquired pneumonia and unexplained diarrhoea and/or vomiting. Appraisals and supervision of medical and nursing staff was undertaken.

However, the Trauma Audit and Research Network (TARN) data used to promote improvements in care was nine months behind. The Northern Trauma Service review team visit in February 2014 expected to see the completeness score at 50% within six months and achieving the desired 80% within 12 months, and the trust was reviewing staff resources to support improving TARN completeness.

In February 2014 it was identified that out-of-hours CT reporting needed to be reviewed to ensure timely turnaround of reporting. Conversations with staff revealed that the radiology reporting could take up to a week or more.

Therefore improvement is required in response to using national outcome audit data to improve patient treatment outcomes; improving TARN data collection and submission rates and the reporting times for radiology including out-of-hours CT reporting.

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 nationally recognised assessment tools.
- Clinical guidelines were developed and referenced with associated NICE guidance and/or other nationally recognised standards. These were approved through the trust's clinical guideline committee.
- These guidelines were available and accessible to staff electronically. Visual prompts were relayed through the trust's electronic systems to inform staff of any new guidelines released. A senior clinician informed us that the clinical guideline of the week was emailed to the team for reference.
- The Trauma Audit and Research Network (TARN) data (used to promote improvements in care through national clinical audit and show performance comparisons information on survival rates of major injury for patients who have been admitted to hospital) was nine months old and needed to be updated.
- The Northern Trauma Service review team visit in February 2014 had recommended that they would expect to see the completeness score at 50% within six months, and to achieve the desired 80% within 12 months. We saw an action point in the departmental minutes of April 2014 to review the staffing resources in support of improving TARN data completion.

Accident and emergency

Patient outcomes

- Care bundles are a set of interventions that, when used together, significantly improve patient outcomes. Four care bundles were available in the department for use in relation to acute chronic obstructive pulmonary disease (COPD), sepsis, community acquired pneumonia and unexplained diarrhoea and/or vomiting.
- We looked at three College of Emergency Medicine (CEM) audits and saw these had been reviewed and the priorities for improvement from these audits were included in the trust's 2012-2013 quality accounts.

Competent staff

- Medical and nursing staff received appraisals and supervision. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Information from the quarter 3 ESMBU safety and quality report showed an appraisal rate of 48.77% for nurses and 69% for consultants.
- We noted that the ESMBU had already begun to take action to improve its performance in this area and from the unit's risk register we saw control measures were in place to manage the risk and were reviewed monthly.
- Weekly clinical and operational leadership meetings were established and it was reported the purpose of these meetings was to monitor clinical and operational workforce governance.

Multidisciplinary working

- We saw medical and nursing staff worked well together as a team and there were clear lines of accountability, cohesive working and leadership, contributing to planning and delivering patient care. However, we did not witness comprehensive multidisciplinary team (MDT) working within the department. Nursing and medical handovers were undertaken separately.
- On the day of our inspection no occupational therapy or physiotherapy presence had been requested.

Seven-day services

- The service is consultant-led and operates 24 hours a day, 365 days a year, providing care to patients presenting as an emergency by ambulance referrals and self-referrals.
- Consultant presence in the department was reported from 9am to 9pm weekdays and 12pm to 3pm at the weekend with 24 hour/seven days a week on-call cover.
- Middle grades and specialist and junior doctors covered the rotas 24 hours a day, seven days a week/365 days a year.
- We noted from the Northern Trauma Service review team's visit to the department in February 2014 that out-of-hours CT reporting needed to be reviewed to ensure timely turnaround of reporting. Conversations with staff revealed the radiology reporting could take up to a week or more.

Are accident and emergency services caring?

Good

Staff interacted positively with patients and /or their relatives and demonstrated caring attitudes. Staff maintained patients' dignity. Patients and relatives were complimentary of the staff. They spoke positively about how well they were cared for and how well they had been involved in making decisions about their care and treatment.

Compassionate care

- We observed positive interactions between staff, patients and /or their relatives. Staff consistently demonstrated caring attitudes towards patients throughout the inspection.
- We spoke with 10 patients, four relatives and one carer. The majority spoke positively about their care and treatment and were treated with dignity and respect. Staff were familiar with the same-sex accommodation guidelines and designated patients to treatment areas in accordance with the guidelines.
- We saw staff drawing curtains around each patient's bed and individual cubicles to maintain their privacy and dignity.
- We heard staff using appropriate speech and tone when talking with patients.

Patient understanding and involvement

- Patients reported that they were included and involved in making decisions about their care and treatment. Four people specifically told us 'Staff explained everything.'
- Since April 2013, the NHS Friends and Family Test (FFT) for Accident & Emergency and Inpatient admissions has asked patients whether they would recommend

hospital wards to their friends and family if they required similar care or treatment. The A&E FFT shows the trust was performing above the England average, with December and January scoring the highest at 67. It also reflects that the most responses received were 1,538 in December 2013.

Emotional support

- We saw staff spending appropriate time talking to patients and/or their relative and responding to questions in an appropriate manner. All of the staff provided the appropriate reassurance, comfort and emotional support to patients and relatives who were anxious or worried.

Are accident and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

The service was responsive to people's needs through effective communication, and sensitive, safe handovers of information. There were specialist support teams for people with mental health problems. But the staff were unclear as to the provision of interpreter / translation services.

The four-hour wait target had been met for the last six months although for patients attending by ambulance the time to triage was not consistently meeting the 15 minutes target. The trust had added an additional five beds to help in the flow of patients through the department but the flow was often delayed by a lack of available beds in the hospital.

Therefore, patient triage times, ambulance waiting times and ambulance transfer times require improvement to cope with the department's routine workload and reduce patient waits. We noted that many of these issues are longstanding and were identified previously by the Emergency Care Intensive Support Team (ECIST) in January 2012

Service planning and delivery to meet the needs of local people

- Communication between staff was effective. Observed shift handovers involved staff providing detailed information on the risks, treatment and care for each patient, staffing requirements and patient flow through the department.
- Handovers between ambulance and nursing staff were conducted sensitively, safely and efficiently.
- 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.

Access and flow

- The Department of Health target for emergency services is to admit, transfer or discharge 95% of patients within four hours of arrival at A&E. Over the past six months the department had consistently met the target.
- Time to triage for patients attending by ambulance is 15 minutes, but the department was consistently not meeting this target.
- Ambulance staff who we spoke with confirmed the frequency and time of handover was increasing.
- Walk-in patients were registered on the trust's electronic integrated care record system at main reception.
- Patients requiring immediate resuscitation are booked in from the ambulance details and full information is then gathered and processed by the receptionist when able.
- The number of patients leaving the department before being treated is consistently lower than the England average. However, this meant that some patients were waiting a long time to be seen. The patients we spoke with did not raise this as an issue.
- To improve access and flow through the department a five-bedded major facility was recently opened to help with service demand and with the aim of reducing waits on trolleys.
- Most staff we spoke with reported continuing poor patient flow through the department and this was often due to beds being unavailable on the wards.
- The recent transfer of some services from the hospital to Carlisle had impacted on the department by increasing the number of patient transfers by ambulance. The availability of ambulances for transfer was affecting timely transfers and consequently waiting times, which hindered patient flow through the department.

Accident and emergency

Meeting people's individual needs

- We reviewed five patient records during the inspection and saw the patients' care and treatment was carried out in accordance with their needs.
- The integrated electronic care record tracked the patient through the department. The record included triage times and the triage was staffed at all times during the course of our inspection.
- There were specialist support teams for people with mental health problems between 8am to 8pm. Outside of these hours the community out-of-hours (OOH) crisis team provided cover.
- Senior medical staff told us that because of the large geographical area the OOH crisis team had to cover, response times were slower and patient waiting times increased.
- During conversations with some members of staff they told us translation/interpreter services were not available. The trust provided the inspection team with the details of the translation/interpreter services and these were available to patients.

Learning from complaints and concerns

- The ECMBU monitors and tracks complaints and identifies themes.
- The chief matron is delegated to monitor complaints at a local level and discuss these at the weekly leadership meetings.
- Reviews of complaints and lessons learned were discussed at monthly governance and departmental meetings.
- Systems and processes were in place to advise patients and relatives on how to make a complaint, but the leaflets did not have accurate information relating to the role of CQC or signposting to the Public Health Services Ombudsman Service.>

Are accident and emergency services well-led?

Requires improvement

There was a clear governance structure with meetings at relevant levels to move information and concerns through to all staff. The trust's improvement priorities were clearly displayed throughout the hospital. However, discussions with a number of medical and nursing staff revealed a concerned departmental workforce regarding the lack of formal consultation about recent service changes and an absence of a clear vision for services in the new hospital building.

Oversight for the department included a medical lead (an A&E consultant), a nursing lead (a senior matron) and a unit manager (operations service manager). The operations manager was relatively new in post and the current medical lead was shortly due to leave the service. We heard that plans were in place to appoint a new medical lead. However, it is recognised new leadership will take time to mature as a team, especially as staff morale was low.

Therefore, the absence of a strategic vision for the service communicated to staff meant they felt excluded and changes to the local leadership team required time to embed in order for the service team to feel well led.

Vision and strategy for this service

- The trust's improvement priorities were clearly displayed throughout the hospital. The ethos in the emergency department was clearly stated in its operational policy.
- We spoke with a number of medical and nursing staff and discussions revealed a concerned departmental workforce regarding the lack of formal consultation about recent service changes and an absence of a clear vision for services in the new hospital building. Some concerns were also expressed about the lack of consultation on recent service changes within the organisation and how these changes had impacted upon A&E services at this hospital.

Governance, risk management and quality measurement

- Departmental meetings were held monthly and covered a range of governance issues including operational and clinical risks, quality of the services, learning from incidents and accidents.
- The ECSUB is responsible for monitoring progress, reviewing risks in relation to emergency care and business continuity. This board reports directly to the Emergency Care and Medicine Operational Board.
- It was reported that two clinical guidelines for chest pain and gastro intestinal bleeds had recently been circulated for implementation across the trust without

being approved through the clinical guidelines committee. It was not clear or understood how this had occurred and we were told these pathways had been approved retrospectively.
- The department's operations policy that sets out the scope of the service, duties and responsibilities of staff and incorporates the operational and clinical escalation triggers, had been recently revised. The policy was still at draft stage and therefore the triggers had not been tested at the time of the inspection. We were told the policy was being presented for approval at the next monthly meeting of the Emergency Care Sub Unit Board (ECSUB).
- We looked at the A&E pathway for patients requiring admission or urgent orthopaedic advice. The pathway provided information for staff to follow. However, we did note that the pathway did not include any details of document controls.

Leadership of service

- Oversight for the department included a medical lead (an ED consultant), a nursing lead (a senior matron) and a unit manager (operations service manager). The operations manager was relatively new in post and the current medical lead was due to leave the service shortly. It was reported plans were in place to appoint a new medical lead.
- Weekly clinical and operational leadership meetings were established to monitor clinical and operational workforce governance.
- Regular monthly staff meetings gave staff an opportunity to receive trust wide updates; share lessons learned from incidents and complaints, and contribute to improving the quality and development of the A&E service.
- Many staff reported that recent and significant pressure on the department, combined with the recent relocation of some services from the hospital and change in the leadership, had impacted on their morale.
- Band 7 qualified nurses said that they were not allocated management time.

Culture within the service

- Medical and nursing staff were committed and enthusiastic about their work and worked hard to ensure that patients were given the best care and treatment possible.
- There was a positive culture within the service; staff shared their views about the service openly and constructively. They were caring and passionate about the hospital and about the care they provided to patients. Staff worked well together as a team.

Innovation, improvement and sustainability

- The design of the new hospital build that was in progress at the time of the inspection was well described by some members of staff.
- The development of an emergency nurse practitioner (ENP) role was under consideration at the time of our inspection.

Medical care (including older people's care)

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

Information about the service

The acute medical care services at West Cumberland Hospital provided care and treatment for a wide range of medical conditions. We visited Jenkin, Honister and Pillar/Patterdale wards as well as Gable ward (the stroke unit) over the course of our inspection. We observed care, looked at records for nine people and spoke with 14 patients, three relatives and 34 staff across all disciplines. We also visited the discharge lounge.

In addition to stroke rehabilitation, Gable ward provides eight beds for patients with coronary heart and associated disease and those requiring acute stroke care and treatment. We also visited the coronary care unit, observed care and treatment and reviewed a sample of care records. During our visit to the coronary care unit we talked with four patients and four members of the nursing and medical staff.

Summary of findings

Medical care services were delivered by a hardworking, caring and compassionate staff that treated patients with dignity and respect. Shortages of both nursing and medical staff, combined with an ongoing inability to staff wards to the agreed safe levels and with the correct skill mix at all times, meant that care and treatment was not being provided safely. Improvements were particularly needed in the management of patients with a diagnosis of dementia, diabetes and those patients who had had a stroke. Generally, the wards/ departments were well-led, although there was a lack of connection between the staff providing hands-on care and the executive team.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

There were systems for reporting incidents and managing risk within the service. The wards were clean and infection rates were within expected ranges. Medicines were delivered safely but antibiotic usage could be improved. The wards were adequately maintained but equipment wasn't always readily available and was often unfit for immediate use once sourced, and resuscitation trolleys were not equipped with oxygen and suction.

All the wards we inspected within the medical directorate had vacant consultant posts and trained nurse posts. These chronic 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 always being provided safely. The deanery had raised concern regarding the ability of trainees to be supervised because of the medical staff shortages.

Incidents

- There were systems for reporting actual and near miss incidents across the medical directorate. Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so. The number of incidents reported by the trust between December 2012 and January 2014 was acceptable when compared with other trusts. This showed a healthy reporting culture. Feedback was given and there were examples of learning from incidents being applied and evaluated.
- Mortality and morbidity meetings were held monthly and were attended by ward managers. These meetings discussed any deaths that had occurred within the medical directorate and any learning from the deaths. Ward managers then took the learning points back to their individual teams

Safety thermometer

- The department was managing patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, that are highlighted by the NHS Safety Thermometer assessment tool. This is 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. The hospital has performed well against the England average for all the indicators measured.

Cleanliness, infection control and hygiene

- The hospital infection rates for C.difficile and MRSA infections lie within an acceptable range for a hospital of this size.
- Antibiotic prescribing guidance was available on the trust intranet, which medical nursing staff found comprehensive and useful.
- The wards and we inspected were clean, well-organised and well-maintained. Staff were aware of current infection prevention and control guidelines.
- There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- We observed staff following hand hygiene practice and 'bare below the elbow' guidance.

Environment and equipment

- The hospital did not have an equipment library and most equipment was stored on wards. Staff told us they found this frustrating, particularly when the equipment was needed urgently, as they had to contact other wards to locate the equipment if it was not available on the ward.
- Large pieces of furniture, such as stroke chairs, were stored in bathrooms and had to be moved into a corridor to enable the bath to be used. We were informed that staff were possessive about certain pieces of equipment, that they would hide and refuse to lend to other wards.
- We checked the resuscitation equipment on all of the wards we visited and found they had been checked regularly by a designated nurse. We found that on one ward intravenous fluids which were due to expire that day, prior to the next routine check, had not been replaced. Both resuscitation trolleys on the coronary care unit were non-compliant with current guidelines as they had no fixed oxygen or suction available. New trolleys had been ordered but they had not arrived at the time of our inspection.

Medical care (including older people's care)

Medicines

- An audit of compliance against antibiotic prescribing found only 70% compliance on one ward within the medical directorate. The main area of non-compliance was identified as a failure to include a discontinuation date when writing the prescription. Actions had been put in place to prompt medical staff to include completion dates when prescribing antibiotics.
- We saw an example of good practice where a pharmacist was advising a patient about how medicines they could buy over the counter in a chemist could interact with the medication they had been prescribed during their current hospital stay.
- All ward-based staff reported a good service from the pharmacy staff, including the timely dispensing of medicines for patients on discharge.

Records

- During our inspection we reviewed nine sets of patient records on four wards. Documentation in all these records was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments such as the waterlow score (a tool for assessing patients at risk of pressure ulcers) and falls risk assessments were well documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good knowledge of the Mental Capacity Act 2005 and the implications of this in order to protect patients' rights. Through a review of patient records, we saw that staff had assessed patients' mental capacity to make decisions and when patients lacked capacity staff sought advice from appropriate professionals so a decision could be made in the patient's best interest. During our inspection we observed the use of an advocate for one person who had a learning disability.

Safeguarding

- There was a system 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 and all of the staff we spoke with about safeguarding had undertaken safeguarding training.

Mandatory training

- The electronic training records showed that approximately 80% of staff within the medical directorate had completed required mandatory training. However, the records we viewed held at ward level indicated that compliance with mandatory training was higher than 80%. This was because some ward managers had not been able to input the training information into the electronic system as they were awaiting the relevant system training. Therefore it was not possible to assess the actual percentage of staff that had completed required mandatory training.

Management of deteriorating patients

- The trust used the National Early Warning Score (NEWS) which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and steps had been taken to ensure staff understood how to use it.

Nursing staffing

- We found nurse staffing levels were calculated using a recognised dependency tool. Managers on all the wards we inspected reported vacancies for trained nurses that had not been filled and many reported long term sickness absence, which meant that none of the wards we inspected had a full complement of trained nursing staff. We viewed copies of duty rotas that confirmed this. We saw that the trust had a system in place for escalating staffing shortages. However, ward managers told us that they often did not get the trained nursing staff they needed, or they would be allocated a healthcare assistant when a trained nurse had been requested. Most wards relied heavily on bank and agency nursing staff, which meant that, although some bank and agency staff worked regularly on the same wards, there was a lack of continuity of care.
- We observed several nursing and medical staff handovers during our inspection. Communication between staff was effective, with staff handover meetings taking place during daily shift changes. We heard staff handover discussions that included information regarding risks and concerns relating to each patient. Discharge plans were also discussed as well as any issues that required follow-up.

Medical care (including older people's care)

Medical staffing

- Throughout the trust there were numerous vacant consultant posts. All the wards we inspected within the medical directorate had vacant consultant posts, most of which had been filled with locums, who were sometimes employed for short periods and could leave with very little notice. All the junior medical staff we spoke with in the directorate told us they felt unsupported, particularly when they first started to work at the hospital. Two junior doctors reported periods where there were no middle grade doctors and described this time as "awful and very worrying". One junior doctor commented, "Sometimes I feel I am at the limit of my knowledge and skills and there is not always someone more senior around that I can ask." Medical staff we spoke with at all levels throughout the hospital were working many additional hours voluntarily each week to provide safe and effective patient care.
- Staff informed us of the many ways in which the shortages of consultants affected patient care. One example given was the availability of a consultant to review stroke patients who required the insertion of a percutaneous endoscopic gastrostomy (PEG) tube, which meant the subsequent rehabilitation of these patients could be delayed.
- The deanery had raised concern regarding the ability of trainees to be supervised because of the medical staff shortages.

Are medical care services effective?

Requires improvement

The medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance. Patients' nutritional and hydration needs were being met.

However, the outcomes for patients in some areas needed improvement. Analysis of SSNAP and NADIA data demonstrated that particular improvements were needed in the management of patients with diabetes, especially with regard to foot care and those who had had a stroke, particularly with regard to thrombolysis.

Out-of-hours services were sparse with no routine allied health professional support, no ultrasound service and limited pharmacy service. Only newly admitted patients or those whose condition had deteriorated saw a doctor at weekends.

Evidence-based care and treatment

- There were no outliers for mortality associated with medical conditions.
- The medical wards had clinical pathways for care in place for a range of medical conditions based on current legislation and guidance. Clinical guidelines were available and accessible on the trust's intranet. Many had been recently introduced or updated and included 'care bundles' for the care and treatment of pneumonia, sepsis and stroke care. Staff on some wards, including the coronary care unit, informed us they had not received any training in using the new clinical pathways. There was evidence that the stroke pathway had recently been evaluated and a revised pathway was being piloted so that the documentation used was common throughout all the trust's locations.
- West Cumberland Hospital provided 12 hours a week of Diabetes Specialist Nurse time. Good practice suggests that the ratio of Diabetes Specialist Nurses to hospital inpatients should be 1:300, as recommended in the report Commissioning Specialist Diabetes Services for Adults with Diabetes (Diabetes UK 2010). This meant that the hospital was only providing 12 of the 22 hours a week recommended Diabetes Specialist Nurse expertise.

Pain relief

- Auditing the effectiveness of pain relief for individual patients was taking place as part of their plan of care. The medical directorate did not undertake specific pain relief audits to assess its overall effectiveness in treating pain.

Nutrition and hydration

- Most patients we spoke with were complimentary about the meals served at the trust. People had a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.
- 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 assist those patients who needed help. We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking.

Patient outcomes

- An analysis of data submitted by the trust in January 2013 as part of the Sentinel Stroke National Audit Programme (SSNAP) placed the hospital in the bottom 25% of trusts nationally for the effective management of stroke patients. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. We discussed findings from the audit with the ward manager and the manager for the service and were shown an action plan that documented a series of actions to be taken to enable the hospital to improve its performance. Several of the actions required an increase in specialist nursing and allied health professional staff. Although one stroke specialist nurse had been recruited there was no indication of how the additional members of staff would be funded.
- Particularly concerning were door to needle times for patients suitable for thrombolysis. Thrombolysis is the administration of a 'clot-busting' drug to patients who have had a stroke following a blood clot to the brain. Five patients had been thrombolysed since June 2013, but only one had received treatment within the recommended time of one hour. Three of the patients had door to needle times of over two hours, the longest being two hours 54 minutes.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was not performing well against some of the indicators analysed. Of particular concern were data showing that only 5.6% of diabetic inpatients received a foot risk assessment within 24 hours of admission, measured against an England average of 37.6%.
- Also of concern were the data showing that 11.1% of patients with diabetes were visited by a member of the diabetic team, compared with an England average of 34.5%. This was a deteriorating trend, from 26.5% in 2012.
- We spoke with the lead diabetes nurse for the Cumbria Partnership NHS Foundation Trust, who provided the diabetes specialist nurse in reach services into West Cumberland Hospital. They felt that the poor performance against these indicators was directly related to the lack of diabetes specialist nurse input into the hospital.
- An analysis of the Myocardial Ischaemia National Audit Project (MINAP) data showed that the hospital was performing in line with or above the averages for England for the provision of treatment, referred to as 'door to needle/balloon times' once the patient arrived at the hospital.

Competent staff

- Medical and nursing staff received appraisals, and staff spoke positively about the process
- It was not possible to establish accurate levels of appraisals for nursing staff. This was because some ward managers had not been able to input the information into the electronic system as they were awaiting the relevant system training. One ward we visited reported numbers of completed appraisals of 58% but could provide evidence that 100% of appraisals for nursing staff had been completed.

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. 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.
- Transfers of patients, primarily to Cumberland Infirmary in Carlisle, happened frequently and we found protocols in place to facilitate this. However, this did not always go smoothly and many patients waited several hours for transport. We observed one transfer where the patient's medical records were left behind and information had to be given over the telephone. We heard about another case where a patient who was unable to speak had to travel without support from the ward staff due to staffing shortages.

Seven-day services

- A consultant was available for the medical directorate between 8am and 10pm, with a consultant on call out of hours. Daily doctors ward rounds usually took place,

Medical care (including older people's care)

although sometimes these were replaced by 'board rounds' where the multi-disciplinary team discussed patients around a white board but did not see them. Only newly admitted patients or those whose condition had deteriorated saw a doctor at weekends.

- There was no routine allied health professional support out of hours at the time of our inspection. However, we were informed that the trust was discussing seven-day working with the Cumbria Partnership Trust, who currently provide allied health professionals to the hospital.
- There was no ultrasound or pharmacy service out of hours, although advice and support could be obtained from an on -all pharmacist, when necessary. We saw evidence that one patient had waited 36 hours for an urgent ultrasound scan before treatment could be initiated.

Are medical care services caring?

Good

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 patients' wishes into account.

Compassionate care

- Medical services were delivered by a hardworking, 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
- We spoke with 18 patients and three relatives and everyone spoke very positively about the care that they, or their family member, had received. Some comments made were, "we are treated well, they are all very good" and "the staff are good, they know what they're doing and they even laugh at my jokes."
- We also saw examples of ways in which people were encouraged to share their impression of the hospital and ways in which improvements could be made. Between October 2013 and January 2014, the trust had performed below the national average for the Friends and Family Test, which asks patients how likely they are to recommend a hospital after treatment. Out of the 31 inpatient wards there were 13 that scored below the trust average, four of which were medical wards at West Cumberland Hospital. Findings from an analysis of the most recent adult inpatient survey demonstrated that the trust had performed within expectations compared with other trusts for all areas of questioning.
- Nursing staff carried out regular 'comfort' rounds to ensure that patients' needs were met. Staff ensured that patients had drinks, were comfortable and had easy access to call bells.

Patient understanding and involvement

- Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care. Patients we spoke with told us they felt involved in their care and treatment and staff explained benefits and risks to patients about care and treatment. Patients also 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. A named nurse system was in place throughout the medical wards and most patients we spoke with were aware who their named nurse was.

Emotional support

- An analysis of the National Diabetes Inpatient Audit 2013 showed that 69.9% of patients reported that they had received enough emotional support from staff to manage their diabetes compared with an England average of 83.4%.

Are medical care services responsive?

Requires improvement

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 for the treatment of their medical condition.

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

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- The senior medical team presented to members of the CQC inspection team, three options currently under consideration to manage pressures on the medical services across the trust in the short and longer term. This demonstrated that service planning had taken place regarding the best way to deploy the medical staffing resource at all the trust's locations, including West Cumberland Hospital.

Access and flow

- The medical directorate was an active participant in the capacity and bed management meetings that were held three times a day. Staff worked hard to manage patient flow and timely discharge so the service was able to manage unplanned admissions and avoid patients being admitted to wards outside of the medical directorate.
- Medical patients admitted to wards outside of the medical directorate were well managed and were seen regularly by medical staff. Transfers across the wards were managed sensitively and without undue delay. However, three patients we spoke with had been moved several times before being admitted to the most appropriate ward for the treatment of their medical condition. One person told us, "This is my fourth ward, but I got here in the end."
- Staff on the coronary care unit provided an advisory service to local GPs regarding interpretation of ECG results.

Meeting people's individual needs

- From reviews of care plans, we established that patients received a dementia screening on admission to medical wards in the hospital, but there were no clearly defined pathways of care in place for the care, treatment or support of these patients once a diagnosis of dementia had been made. The trust had recognised this as an area that required improvement and we saw an action plan to improve performance in the care of people with a diagnosis of dementia. Although the documentation and processes around dementia care were not well embedded within the hospital, we observed several examples of good interactions and care being delivered by staff at all levels to people with a diagnosis of dementia.
- For patients whose first language was not English, staff could access a language interpreter if needed. We saw the services of an interpreter being used on one of the medical wards during our inspection. British Sign Language (BSL) interpreters were available for deaf people.
- Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food.

Learning from complaints and concerns

- Staff we spoke with were aware of the trust's complaints system and how to advise patients and relatives to make a complaint, if they wish to do so. Large prominently displayed posters informing people about how to make a complaint were visible on each medical ward and in corridors throughout the hospital. We were told how communication with relatives had been improved by the initiation of communication rounds by a senior nurse during visiting times. The communication rounds had been initiated following complaints that communication within the hospital was poor.

Are medical care services well-led?

Good

The trust had a vision and values for the organisation, which had been cascaded across the medical directorate. We found 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 lack of connection between the staff providing hands-on care and the executive team.

Vision and strategy for this service

- 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 medical wards and most staff had a clear understanding of what these involved, particularly in the medical admissions unit. Ward managers in each of the areas we visited reinforced the organisation's vision and values regularly and all ward staff we spoke with were aware of what the organisation's vision and values were or where they were displayed. However, there was no service level vision or strategy.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Information relating to core objectives and performance targets was visibly displayed in all of the areas we visited.
- Junior nursing and ancillary staff on most wards reported that they had not been consulted regarding the setting of the key objectives specific to their wards, which they felt had been rushed in before our inspection.

Leadership of service

- We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical directorate that were positive role models for staff.
- Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable. They told us that the chief executive "seemed prepared to listen" but they felt disconnected from the executive team and did not feel that the executive team appreciated the day-to-day operational challenges involved in delivering direct care and treatment to patients, particularly with the current staffing levels.

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. There was a culture of "good will" within the medical directorate, where many members of staff worked considerably beyond their contracted hours to support colleagues and to provide good patient care.
- Openness and honesty was the expectation within the medical directorate and was encouraged at all levels. We spoke to one relative who told us, "They are very honest about everything here, even when things haven't gone well."

Innovation, improvement and sustainability

- Staff we spoke with were excited about the new hospital currently under construction and were looking forward to the move to the new building.

Surgery

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

Information about the service

Surgical services at West Cumberland Hospital provided elective, ophthalmology, obstetrics and gynaecology and vascular surgery. All other surgical services are provided at the Cumberland Infirmary in Carlisle. We visited theatres, opthamology, Skiddaw and Overwater wards over the course of our inspection. We observed care, looked at records for six people and spoke with four patients, three relatives and 28 staff across all disciplines.

Summary of findings

Surgical services were delivered by competent, hardworking, caring and compassionate staff that treated patients with dignity and respect. Elective surgery was being provided at the West Cumberland site Monday to Friday. A consultant was available for the surgical directorate but out-of-hours surgical cover was delivered by the on-call team at the Cumberland Infirmary. There was also no pharmacy service out of hours, although advice and support could be obtained from an on-call pharmacist, when necessary.

Patient-reported outcome measures (PROMs) data showed requirements for improvement in meeting all nine standards for care to improve patient-reported outcomes for patients undergoing primary hip replacement.

Six surgical never events had taken place during the period November 2012 to April 2014. Shortages of both nursing and medical staff, together with pressures on bed availability, meant there were risks to patient safety. Since June 2013, trauma operative work, high risk general surgery and colorectal cancer work has all transferred to the Cumberland Infirmary in Carlisle. This has led to routine elective work being regularly cancelled there. The transfer of routine work to West Cumberland Hospital has not been systematic, as anticipated, because patients prefer to wait to have their procedure at Carlisle. This had affected referral to treatment times (RTT), which were not being met for admitted patients, particularly in orthopaedics. The

Surgery

trust had a detailed action plan but there is a clear difficulty recruiting in the North Cumbria area, which was hindering the plan. The distance between the two sites appears to be a major factor in patients' decision-making, rather than the care provided.

Improvements were needed in the dissemination of learning from incidents and complaints together with monitoring quality effectively at both ward and senior management level. Generally, the wards/departments were well-led locally, although there was a lack of connection between the staff providing hands-on care and the executive team.

Staff felt well led at ward level but the vacancies in middle management roles within the surgical team had detrimentally affected the leadership above the ward manager. There was a lack of consistent presence at West Cumberland Hospital at General Manager level, the shared management approach reduced accountability for the site.

Are surgery services safe?

Requires improvement

Services were provided by competent staff, although the staffing numbers did not reflect the ideal at all times. The wards and theatres were clean and adequately equipped. Medicines were stored and administered appropriately. There were systems in place for the escalation of patients whose condition was deteriorating.

However, there had been six surgical never events during the period November 2012 to April 2014. Shortages of both nursing and medical staff, together with pressures on bed availability meant there were risks to patient safety. However, the theatre teams were undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) checklist at the time of our inspection and this was being audited for consistency but the audit was new, lacked robustness, was non-observational and so the results were not yet reliable.

Staff confirmed that learning from incidents was shared, but we could find no evidence to show this, nor could we find evidence of regular staff meetings on the wards we visited.

As West Cumberland Hospital was no longer providing surgery for trauma patients, these patients were transferred primarily to the Cumberland Infirmary. We found a number of protocols in place to facilitate the safe transfer of patients to this location. However, there was a lack of clarity concerning which was the most current version of the protocol and there were delays in transfer because of bed pressures at the Cumberland Infirmary. The lack of clarity among staff about transfer protocols to the Cumberland Infirmary raised concerns about the safety and timeliness of transfers.

Incidents

- There have been six surgical never events (serious events that which are largely avoidable) during the period November 2012 – January 2014, which was higher than the England average for a trust of this size.
- We found that each never event had led to a full root cause analysis, with the learning disseminated throughout the trust. There was a clear process for investigating never events and patient safety incidents,

including serious incidents requiring investigation (SIRIs). However, we could find no evidence that learning was systematically shared on the wards we visited at the hospital, and we could not find evidence to suggest that incidents were discussed formally among staff, although staff said this did happen.
- Staff in the wards and theatres stated that they were familiar with the electronic incident reporting system to record incidents and near misses, and were encouraged to use it.
- The theatre staff we spoke with told us they all had access to the electronic incident reporting system, but could not give a clear answer when asked how often incidents were raised.
- Staff told us learning from incidents took place through daily multidisciplinary meetings. However, they were also unclear when asked to give an example of a recent incident for which learning was shared to aid improvement.
- There was a presentation in the staff room (booklet) that included information relating to SIRIs (serious incident requiring investigation) for staff learning.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer information was clearly displayed at the entrance to each ward. This included information about all new harms, falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections and new pressure ulcers. In all areas the trust's performance fluctuated above and below the England average.
- We noted that risk assessments for inpatient harms were being completed appropriately on admission.

Cleanliness, infection control and hygiene

- Ward areas were clean and tidy.
- The theatres were dated and aged, but clean throughout. Staff were looking forward to the new theatre suite in the new hospital.
- The theatres we inspected were clean, safe and well maintained. Daily and weekly cleaning checklists were displayed in each area and these were complete and up to date.
- Gowning procedures were adhered to in the theatre areas.
- Staff regularly washed their hands and used hand gel between attending to patients. They followed 'bare below the elbow' guidance and were aware of current infection prevention and control guidelines.
- Staff wore personal protective equipment, such as gloves and aprons, whilst delivering care.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- Infection rates for both MRSA and C.difficile were within expected limits.

Environment and equipment

- Equipment was clean and regularly checked. All the equipment we saw had service stickers displayed and these were within date.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- Staff in each theatre team were responsible for checking equipment on a daily basis and any equipment failures or issues were logged as incidents.
- Resuscitation equipment, emergency drug packs and the defibrillator were checked daily and were ready for use.

5 Steps to Safer Surgery

- We observed two theatre teams undertaking the 'five steps to safer surgery' procedures, (World Health Organisation (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.
- The trust had recently started to carry out a WHO checklist audit, but this audit consisted of checking the number of completed checklist records.
- The staff we spoke with confirmed there had been no "observational" audits to verify staff adherence to the 'five steps to safer surgery' procedures.

Medicines

- On the wards and in theatres medicines were stored correctly, including locked cupboards or fridges where necessary. Fridge temperatures were checked daily to ensure medicines were stored appropriately and safely.

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Records

- All records were kept in paper format and all healthcare professionals documented in the same place. We found that when not in use records were stored securely.
- Within theatres we looked at one patient's records. These were complete and up to date.
- Patient records showed that staff carried out appropriate checks for consent and medical history prior to starting a procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the patient records we reviewed we found that consent was sought and recorded appropriately and correctly.
- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff had received mandatory training in consent. The staff we spoke with were clear on how to ask for verbal informed consent and written consent before providing care or treatment
- A consultant surgeon told us they conducted a ward round and spoke with each patient before surgery to confirm their consent and to answer any questions they may have.
- Staff demonstrated a good knowledge of the Mental Capacity Act 2005 and the implications of this in order to protect patients' rights. Through a review of patient records, we saw that staff had assessed patients' capacity to make decisions and when patients lacked capacity staff sought advice from professionals and others as appropriate so a decision could be made in the patient's best interest.

Safeguarding

- There was a system 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 and all of the staff we spoke with about safeguarding had undertaken safeguarding training.

Mandatory training

- We looked at staff mandatory training records on the wards we visited and found that between 52% to 77% of staff had received mandatory training in the period 2013-14. However, we were informed that the trust had a robust action plan in place to ensure that all staff received their mandatory training during the current financial year.

Management of deteriorating patients

- The surgical wards used a recognised early warning tool National early warning score (NEWS) standardising the assessment of acute-illness severity. We found clear directions for escalation and staff spoken to were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within necessary time frames.

Nursing staffing

- Nursing staff numbers were assessed using a recognised staffing tool. We found that ideal and actual staffing numbers were displayed on wards we visited. Staffing rotas on the day of our inspection confirmed that staff numbers and skill mix were safe. However,staff commented that recruitment was an issue at West Cumberland Hospital and most wards we visited had vacancies.
- The hospital provided evidence for staff numbers on the surgical wards for January and February 2014. These documents showed safe staff levels for the wards. Staff levels for Overwater one and two showed that the ward had sufficient numbers for 81% and 93% of the time during January and 100% and 88% of the time during February 2014. This indicates that there were times when wards were not always appropriately staffed.
- We observed several nursing and medical staff handovers during our inspection. Communication between staff was effective, with staff handover meetings taking place during daily shift changes.
- Although handovers took place on the day of inspection, we could find no evidence that a system of documenting handovers was in place.

Medical staffing

- Within theatres, there were sufficient staff with an appropriate skills mix to ensure procedures could be carried out safely.
- The teams included the surgeon, theatre nurses, operating department practitioner (ODP), and anaesthetist and healthcare assistants.

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- Throughout the trust there were numerous vacant consultant posts. All the wards we inspected within the surgical directorate had vacant consultant posts, most of which had been filled with locums who were sometimes employed for short periods and could leave with very little notice. This had implications for the continuity of care provided to patients and relied on accurate record keeping to ensure staff were fully aware of care and treatment plans for each patient.

Major incident awareness and training

- Staff could not say whether there was a major incident plan in place for the surgical directorate and whether or not this has been tested recently.

Safe transfer of patients

- As the hospital was no longer providing surgery for trauma patients, these patients were transferred primarily to the Cumberland Infirmary in Carlisle. We found a number of protocols in place to facilitate the smooth transfer of patients to this location. However, on discussion with staff at West Cumberland, we were told that there was a lack of clarity for them regarding the most current version of the Emergency General Surgical Pathways and Transfer protocols. We were also informed that because of bed shortages at Carlisle, transfers of patients admitted through accident and emergency at West Cumberland were sometimes delayed.

Are surgery services effective?

Requires improvement

Elective surgery was being provided at the hospital Monday to Friday. A consultant was available for the surgical directorate between 8am and 10pm and out-of-hours surgical cover was being covered by the on-call team at Carlisle. There was also no pharmacy service out of hours, although advice and support could be obtained from an on-call pharmacist, when necessary.

Surgery was managed in accordance with NCEPOD recommendations and the Royal College of Surgeons standards for emergency surgery. Policies were in place, but in ophthalmology were found to be out of date and failed to refer to national guidance. Mortality data did not demonstrate any risks.

Patient reported outcome measures (PROMs) data showed requirements for improvement in meeting all nine standards for care to improve patient reported outcomes for patients undergoing primary hip replacement. Although available, PROMs data was not regularly used or discussed.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with the NCEPOD recommendations and the Royal College of Surgeons standards for emergency surgery.
- Within the Ophthalmology department we found that all policies viewed were out of date. We were told that a regular meeting of Senior Nursing Staff used to take place where policies were discussed, but this meeting had not been held during the past 18 months.
- Within the Ophthalmology department we found policies did not reference National Guidance. However, a consultant confirmed that Royal College guidance was adhered to.
- Changes to guidance and its impact on practice were discussed at the monthly departmental meetings.
- Audits were undertaken in line with ward safety thermometer. However, staff we spoke to could not tell us about other audits to ensure high levels of quality and patient experience.
- Enhanced recovery programmes were used in specialities where relevant.
- There were 'snapshot' audits of the Monthly ward health check and safety thermometer in the areas we visited.
- Audit data for general surgical, orthopaedic and ophthalmology at a trust wide level was provided, but we could not find a route for this to be disseminated among staff.

Pain relief

- Patients were assessed pre-operatively for their preferred pain relief post-operatively.
- There was a dedicated pain team, with pain nurses seeing patients daily.

Nutrition and hydration

- Patients we spoke with were complimentary about the meals served. People had a choice of suitable food and drink and we observed hot and cold drinks available throughout the day Wards had protected 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 assist those patients who needed help. We also saw that a red tray system was in place to highlight which patients needed assistance with eating and drinking.

Patient outcomes

- Patient Reported Outcome Measures(PROMS), and mortality outlier data were available and we saw documentation which demonstrated that mortality outliers where discussed during the ES & EC governance meeting. However, the documentation provided did not demonstrate that PROMS data was discussed during the meeting.
- PROMs score for primary hip replacement showed an elevated risk due to the low proportion of cases assessed as achieving all nine standards of care measured within the National Hip fracture Database.
- Hip fracture audit data as seen in the National Hip Fracture Database 2013 report shows that 75% of patients are admitted to orthopaedic care within four hours, which was better than the England average. However, in areas such as percentage of falls assessments completed or surgery with 48 hours, this was below the England average.
- Standardised relative risk readmissions were comparable with national comparators.

Competent staff

- Medical and nursing staff received appraisals and staff spoke positively about the process.
- Staff were receiving mandatory training.

Multidisciplinary working

- Staff in the two theatres confirmed they carried out a daily multi-disciplinary team (MDT) meeting that involved all the team, together with a weekly MDT that included teams across the hospital.
- Staff were unclear about other team meetings (e.g. nursing staff team or medical staff team meetings).
- The nursing staff told us they worked flexibly across different theatre teams and worked in different theatres on different days.
- There was input from both physiotherapy and occupational therapy on the wards visited. The physiotherapy team provided an out-of-hours service.

Seven-day services

- West Cumberland Hospital did not provide a seven-day service, with only elective, ophthalmology, and obstetrics and gynaecology surgical services being provided at the site.
- A consultant was available for the surgical directorate between 8am and 10pm, However, as of March 2013, the on-call orthopaedic registrar at the hospital ceased and the function was replaced by the on-call team at Carlisle.
- Daily doctors ward rounds usually took place, although sometimes these were replaced by 'board rounds' where the multi-disciplinary team discussed patients around a white board but did not see them.
- During discussions with staff we were informed that there was a lack of ownership of acute emergency admissions at West Cumberland Hospital.
- There was no pharmacy service out of hours, although advice and support could be obtained from an on-call pharmacist, when necessary.

Are surgery services caring?

Good

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.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.
- Patients we spoke with were complimentary about the staff, the level of care they received, staff attitude and engagement. Comments received included: "the staff are very good"; "they are so kind" and "I have been treated very well". The comments received from patients demonstrated that staff cared about meeting patients' individual needs.
- We saw that patients' bed curtains were drawn and staff spoke with patients in private. Patients we spoke with told us the staff respected their privacy and dignity.

- We saw that staff respected patient dignity while transferring patients between the wards and operating theatres. We observed staff helping patients throughout the duration of our visit and noted that patients were not rushed and staff regularly checked with them to see if they needed help.
- We watched a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient privacy and dignity.
- We spoke with two patients in the theatres who spoke positively about the care they received.

Patient understanding and involvement

- Patient records showed that both verbal and written consent had been obtained from patients and that planned care was delivered with their agreement . We also found that they were completed sensitively and noted that discussions with patients were recorded.
- Staff respected patients' right to make choices about their care. The patients we spoke with told us they were kept informed about their treatment. They told us the clinical staff fully explained the treatment options to them and allowed them to make an informed decision. We observed staff speaking with patients clearly in a way they could understand.
- We noted that each patient had a named nurse.
- Patients who had been transferred from either West Cumberland to Carlisle or vice versa all stated that this made visiting difficult for family and friends.

Emotional support

- Patients we spoke to confirmed that they had access to emotional support if required, and on each ward we found appropriate information available for counselling services and services providing assistance with anxiety and depression

Are surgery services responsive?

Requires improvement

Locally, staff were responsive to people's needs although there were areas for improvement. There was no evidence to suggest that there were processes that allowed staff to learn from complaints. We noted that booklets were available on wards, but the booklet refers to the Care Quality Commission providing an independent review of complaints, which was inaccurate.

Since June 2013, trauma operative work, high risk general surgery and colorectal cancer work has all transferred to Carlisle Infirmary. This has led to routine elective work being regularly cancelled at Carlisle. The transfer of routine work to West Cumberland has not been systematic, as anticipated, because patients prefer to wait to have their procedure at Carlisle. This had affected referral to treatment times (RTT) which were not being met for admitted patients, particularly in orthopaedics. The trust had a detailed action plan, which included such measures as: additional number of procedures per month to achieve 90%; fully utilising capacity at West Cumberland and recruiting extra consultants. However, there is a clear difficulty recruiting in the North Cumbria area, which was hindering the plan. The distance between the two sites appears to be a major factor in patients' decision-making, rather than the care provided.

Service planning and delivery to meet the needs of local people

- The CQC inspection team discussed service planning and delivery with the Clinical Director, who provided evidence that key areas had been identified, current performance levels were being monitored and changes to the way the service was being delivered had been considered.

Access and flow

- Data showed that national targets for 18-week Referral to Treatment (RTT) standards for admitted and non-admitted patients at the end of December 2013 were not being met for most specialties for admitted patients and mostly being met for non-admitted patients. The data showed that for admitted patients, general surgery was above the final required position of 90% at 90.5%, whilst orthopaedics was below the final required position at 62.4%.
- The trust was aware of this position and commented that the difficulty in North Cumbria achieving its performance was due to the significant pressure on Carlisle Infirmary because of the number of high risk surgery cases being transferred there from West Cumberland Hospital.
- Since June 2013, trauma high risk general surgery and colorectal cancer surgery had all been transferred to Carlisle Infirmary. This has led to routine elective work being regularly cancelled. The transfer of routine work

has not been systematic as anticipated, as patients prefer to wait to have their procedure at Carlisle Infirmary. The distance between the two sites appeared to be a major factor in patients' decision-making.
- The trust had a detailed action plan which included such measures as: additional number of procedures per month to achieve 90%; fully utilising capacity at West Cumberland and recruiting extra consultants.
- We looked at the trust's overall performance for patients receiving surgery for fractured neck of femur within 48 hours. We noted that the trust reports an average time to theatre of 34.6 hours, an average length of stay in accident and emergency of 6.5 hours and an average length of stay of 14 days. This was well within best practice guidelines.
- We spoke with staff about transferring patients who required trauma operative work and high risk general surgery from West Cumberland to Carlisle. Staff reported that there was confusion about patient pathways and transfers from wards to Carlisle, together with challenges in getting patients transferred back from Carlisle. We could not find evidence of how this was monitored or how patient outcomes were measured regarding timeliness and length of stay.
- We found that medical outliers placed on the surgical wards were supported by a daily consultant visit, although we noted that this may not have been the patient's named consultant.
- The number of operations being cancelled was as expected. During the period April 2013 to February 2014, there were 129 cancellations for patients requiring orthopaedic surgery.

Meeting people's individual needs

- Support was available for patients who had dementia and learning disabilities and we noted that the service had implemented the Butterfly scheme to identify patients with dementia or memory impairment, which enabled them to take this into consideration when providing care. We noted on the wards we visited that two nurses had been identified as dementia champions.
- We found multiple information leaflets available on the entrance to wards for many different minor complaints, but these were only available in English.
- For patients whose first language was not English, staff could access a language interpreter if needed. We saw the services of an interpreter being used on one of the medical wards during our inspection. British Sign Language (BSL) interpreters were available for deaf people.

Learning from complaints and concerns

- Complaints were handled in line with trust policy with efforts were being made to deal with complaints initially at a local ward level. If this was not acceptable people would be directed to the Patient Advice and Liaison Service (PALS) and following this they would be advised to make a formal complaint. We noted that booklets were available on wards, but the booklet refers to the Care Quality Commission providing an independent review of complaints, which was inaccurate.
- Learning from complaints was not evident on the wards we visited.
- On speaking to staff we were unable to determine a formal process for recording patient concerns, nor could we find a process that enabled shared learning among staff once concerns had been investigated.

Are surgery services well-led?

Requires improvement

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 surgical wards and departments and some staff had a clear understanding of what these involved. There were differing levels of engagement with the trust's vision and strategy in the areas we visited. Documents provided could not demonstrate that quality improvements were discussed or that the performance dashboard was reviewed for all surgical specialities.

Staff felt well led at ward level but the vacancies in middle management roles within the surgical team had detrimentally affected the leadership above the ward manager. There was lack of consistent presence at the hospital at General Manager level, the shared management approach reduced accountability for the site.

The clinical governance system included learning from incidents and risk but there was no specific reference to quality improvements or complaints, and feedback to staff was inconsistent.

Surgery

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives. The trust's values and objectives had been cascaded across the surgical wards and departments and some staff had a clear understanding of what these involved.

Governance, risk management and quality measurement

- We saw evidence of monthly governance meetings for the surgical business unit, Orthopaedic departmental meetings, Theatres monthly governance report, the Anaesthetics department cross site departmental meeting and incidents. The documents made no specific reference to quality improvements or complaints. Although these meetings took place at a senior level and incidents were discussed, we did not find evidence on the wards we visited to suggest that there was a mechanism to feed back to staff relevant decisions or outcomes of the meetings.
- The surgical directorate provided a surgical dashboard that contained performance data. We were told that this information is disseminated to the Clinical Directors for each speciality to be discussed in their speciality governance meetings. From the meeting information provided, we could not determine if the dashboard was discussed during these meetings.

Leadership of service

- The business unit of Emergency Surgical and Elective Care was divided into five clinical business units based on specific surgical specialties. Each unit was led by a clinical director of business unit and supported by a service, clinical matrons and clinical consultant leads. However, there was a vacancy at Business Unit Director level and they were awaiting a start date for the deputy director.
- There are two general managers – both of whom are based in Carlisle but are present at West Cumberland Hospital for two and three days respectively.
- Each ward had a ward manager and a matron who oversaw all of the wards. We found in talking to staff that they felt leadership was good at this level. However, they were less positive about leadership above the level of matron.

Culture within the service

- Staff spoke positively about the service they provided for patients. We saw patient feedback forms on the wards we visited and outside in the foyer, but found no examples of feedback being embedded in practice.
- Staff appeared to work well together at West Cumberland Hospital, but they told us that they did not feel engaged with the rest of the trust.

Critical care

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

Information about the service

There are six beds allocated to provide care to patients in the Intensive Care Unit (ICU) at West Cumberland Hospital. The unit was not fully occupied at the time of our inspection. We spoke with two doctors and two nurses. We reviewed patient records and policies, procedure and guidance and audit documents.

Summary of findings

Staff were caring and compassionate, patients and relatives spoke highly of the care and treatment they had received. There was a full complement of nursing staff in place to meet patients' needs. The unit had access to a consultant and an anaesthetist seven days a week. There were daily ward rounds that were consultant-led. Out-of-hours medical cover was provided by a staff grade anaesthetist with an on-call consultant.

Care and treatment was delivered in accordance with national guidance. Staff applied 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, maintaining and decontaminating equipment.

Multi-disciplinary working was well established and staff worked well together as a team.

Medicines, including controlled drugs, were safely and securely stored.

Critical care

Are critical care services safe?

Good

There was a full complement of nursing staff, who reported a positive and inclusive culture within their particular team. We observed the unit to be clean and tidy and saw staff regularly washing their hands, using hand gel and personal protective equipment (PPE) demonstrating compliance with key trust policies. The unit's acquired MRSA/ Clostridium Difficile (C-Difficile) rates were within statistically acceptable expectations. Medicines were stored and administered appropriately and standardised nursing documentation was used. There was a critical care outreach team present at the site.

The evidence we saw during our inspection demonstrated that these services had learned from any incidents. We saw that trust wide learning from these had been recorded and disseminated. There were robust systems for reporting incidents and near misses across the critical care unit and these were regularly reviewed and the lessons learned shared. There was clear display of information on the unit relating to the safety thermometer. Our review of the number of incidents reported by the trust showed that between December 2012 and January 2014, the number of reported incidents was acceptable when compared with comparable trusts. This showed a healthy reporting culture.

Incidents

- Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so. Staff on the unit reported incidents using the online reporting system. Reported incidents were discussed at weekly "huddle" meetings to support staff learning. Staff had access to the online reporting system through "password" protected computers. The service was reporting concerns through the National Reporting and Learning System (NRLS). Copies of the trust's "Safety Newsletter" that identified guidelines of "learning when things go wrong" were available and shared with the team.
- Incidents were discussed and learning applied. Copies of investigations were seen within the records maintained on the unit and available for reference.
- Remedial actions were taken as a result of the investigation into never events for example; additional checks were now in place for the removal of a surgical femoral guide wire. In addition from 21 May 2014, longer guide wires were being introduced based on feedback received from the investigations.

Safety thermometer

- The Safety Thermometer on display within the unit provided a quick and simple method for surveying patient harms and analysing results in order to measure and monitor improvement. Examples included occurrence of pressure ulcers, catheters and venous thromboembolism (VTEs). The information was entered on the unit's computerised system that tracked the patient's progress. There were also comprehensive nurse records that supported the risk management of inpatient harms.

Cleanliness, infection control and hygiene

- We observed the unit to be clean and well organised.
- Staff adhered to good practice guidance for the control and prevention of infection by regularly washing their hands, using hand gel and personal protective equipment (PPE) between patients.
- There are no reported unit-acquired MRSA or C.Difficile infections and four unit-acquired infections (in blood) in the last year.

Environment and equipment

- All equipment was appropriately checked, cleaned and regularly maintained. Safety check-lists were completed daily.
- Transfer trolley checks were completed in a timely manner with the last one having been completed for April 2014.
- We noted that during a 'drop-in' session members of the resuscitation team stated that their 'bleeps' had been taken away and passed to the anaesthetists and had still not been returned four months later.

Medicines

- All patients' medicines were kept securely in a locked cabinet.
- Staff conducted a balance check of all controlled drugs. The controlled drugs index book was accurately maintained with identified regular balance checks completed.
- The unit had a good working relationship with the pharmacy department who took responsibility for

checking and re-stocking medicines currently in use. The pharmacy also completed risk assessments on individual patients if the need occurred in relation to self-administration.

Records

- At the time of our inspection there was only one patient admitted.
- Standardised nursing documentation was kept at the end of the patient's bed. We noted that all the other stations had all the relevant paperwork in place ready for use. Examples included height and weight charts, the source of admissions (for example, theatre, accident and emergency) as well as all the relevant assessments, including a dementia assessment and capacity to consent. The patient had an individualised daily care plan that included information regarding pain/sedation requirements, respiratory care needs and their psychological wellbeing.
- Observations were well recorded and the timing of such reflected the individual needs of the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff assessed patients' mental capacity to make decisions and if a patient lacked capacity staff sought the advice from professionals and others as appropriate to ensure that decisions were made in the patient's best interest.
- Staff were able to show us how to access the trust's intranet regarding policies and procedures relating to consent and capacity.
- Staff were aware of their duties and professional obligations relating to the Mental Capacity Act and the Depravation of Liberty Safeguards.

Safeguarding

- There was an internal system 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 and all of the staff we spoke with confirmed they had undertaken safeguarding training.

Mandatory training

- We looked at the staff mandatory training records. We observed there were discrepancies between the data provided by the trust and the ward manager. The ward manager informed us that they had updated the information on the computerised system but had not received an up-to-date hard copy version. The ward manager's training matrix showed that 85% of staff had completed their mandatory training. The matrix also identified additional training undertaken by staff for example, advanced life support and paediatric care. All staff had completed their training in the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguarding (DoLS) to Level 2.

Management of deteriorating patients

- There were tools in place for the early detection of changes in a patient's condition. Staff informed us that if a patient's condition deteriorated, they could call for appropriate and immediate medical support.
- There was a critical care outreach team on site.
- Staff on the unit / wards had access to the member of the outreach staff by phone. Their contact details were visibly on display on the unit.
- We were informed that the outreach team saw all discharges from the critical care unit within 24 hours of discharge.

Nursing staffing

- The unit had a full nursing staff complement with sickness and absences covered by overtime. We were informed that agency staff were used infrequently.
- We noted that agency staff were inducted using the trust's induction system, but this was not supported by a local induction checklist.
- We also noted that staff were frequently loaned out to other departments, although this was not deemed inappropriate. There were guidelines in place for loaned staff to be moved back to the unit if needed.
- We observed that the trust used the national competency framework regarding staffing and all new staff were supernumerary until deemed fully competent, although ward manager said that the recruitment process was slow pre-interview, which resulted in delays.

Medical staffing

- The unit had a dedicated consultant and staff grade anaesthetist between 8am and 5pm and 8pm respectively. The out-of-hours service was covered by the staff grade anaesthetists who ensured there was consistent medical cover for the unit.
- The out-of-hours service was covered by the staff grade anaesthetists.

Critical care

- Staff reported that they had no issues or concerns in obtaining the services of the on-call consultant should the need arise throughout the day or out of hours.
- Dedicated ICU hours for consultant were 8am to 5pm, and dedicated ICU hours for anaesthetists were 8am to 8pm.

Are critical care services effective?

Requires improvement

The critical care unit was able to demonstrate that the patients who use this service received effective care and treatment through the use of current best practice guidelines by competent staff. The ICNARC data did not identify any issues or concerns with regard to patient outcomes.

Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. Ward rounds took place daily with input from the consultants. At the weekend, cover was provided by the staff grade anaesthetist with an on-call system in place to access the consultant. The unit had the availability of a consultant and a staff grade anaesthetist for seven days of the week up until 5pm and 8pm respectively. Out of hours, the unit had the presence of a staff grade anaesthetist with a consultant available on-call. However, staff we spoke with said that they had not received any clinical supervision or guidance regarding regular personal development.

The unit was seeking the thoughts of patients and their families more actively through the introduction of patient diaries.

Evidence-based care and treatment

- Care and treatment was provided in accordance with appropriate NICE Guidance.
- The service submitted data regarding patient outcomes to the Intensive Care National Audit and Research Centre (ICNARC). Mortality rates and length of stay and are all within the range of similar units. We noted that all policies and procedures were accessible for staff on the Intranet. The manager informed us that all changes in policies and procedures were discussed at staff meetings.

Pain relief

- Patients' pain relief requirements formed part of care planning and were regularly reviewed and monitored for efficacy.
- We observed good interaction between the unit and the pharmacy department with regard to the timely provision of medicines, including analgesics.
- There were pain management audits in place that had been completed in a timely manner.

Nutrition and hydration

- People had a choice of suitable food and drink and hot and cold drinks were available throughout the day.Staff had easy access to a dietician who was able to support patients who were unable to tolerate an oral diet or who required specialist dietary requirements.
- Hydration observation charts were in place and accurately maintained.
- Patients who had swallowing difficulties were supported by the Speech and Language Therapist (SALT).

Patient outcomes

- The unit had plans for a greater patient involvement through a structured approach. Staff told us the unit was in the process of considering "capturing patient diaries." This is an ICU steps programme to get former patients and family members to talk about their experiences whilst at ICU.

Competent staff

- Staff completed an equipment competency framework to assess their ability and review the effectiveness of the guidance provided.
- Nursing staff received appraisals and staff spoke positively about the process. It was not possible to establish accurate levels of appraisals for nursing staff because the ward manager's data did not correlate with the data provided by the electronic system. The ward manager confirmed that all staff had received their annual appraisal.
- Staff we spoke with said that they had not received any clinical supervision or guidance regarding regular personal development. However they did say that the ward manager had an open door policy and was available for a "chat" to discuss any issues or concerns they may have.

Critical care

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure co-ordinated care for patients. MDT decisions were recorded and care and treatment plans amended to include changes.
- The trust had a critical care outreach team present at the site. Staff on the unit / wards had access to the members of the outreach staff by phone. Their contact details were visibly on display on the unit. The outreach team would see all discharges from the critical care to the ward within 24 hours.

Seven-day services

- A ward round took place daily with input from the consultants. At the weekend, cover was provided by the staff grade anaesthetist with an on-call system in place to access the consultant. The unit had the availability of a consultant and a staff grade anaesthetist for seven days of the week up until 5pm and 8pm respectively. Out of hours, the unit had the presence of a staff grade anaesthetist with a consultant available "on-call."
- Patients' rehabilitation needs were assessed within 24 hours of admission to the critical care unit with clear guidance regarding their individual needs. The unit had the resource of an outreach team to provide follow-up service for patients discharged from ICU.

Are critical care services caring?

Good

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

The evidence seen demonstrated that the trust was good at involving patients, family and friends in all aspects of their care and treatment.

Compassionate care

- The service was delivered by hardworking, caring and compassionate staff. Patients were treated with dignity and respect.
- Patient records were completed sensitively and detailed discussions with relatives had been clearly documented. Staff told us that family and friends were encouraged to visit and visiting times, at the discretion of the ward manager, were flexible to "fit in" with family commitments. Arrangements were in place for a rapid discharge in relation to securing a preferred place of care for patients at the end of life.

Patient understanding and involvement

- During our visit, wherever possible, the views and preferences of the patient were taken into account in the planning and delivery of care and treatment.
- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that patients were able to voice any concerns or anxieties.
- Staff told us were in the process of introducing patient diaries to provide an overview of what events had taken place while the patients were ventilated and therefore not conscious.

Emotional support

- The ward manager informed us that following admission to the unit, the consultant covering the unit would arrange to talk with families to provide an update on their relative. The family members would also be given an overview of the intended plan and prognosis for the patient alongside what they could expect from the unit.
- Where necessary, further face-to-face meetings would be organised to ensure family members were kept updated and had the opportunity to have their questions answered.

Are critical care services responsive?

Good

The evidence seen 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. The records showed that medical patients were admitted to the unit within the governed time of four hours of being admitted or transferred to a ward.

We noted that non-clinical transfers from ITU were low. However, the ITU consultant we spoke with expressed concern that demand for services was increasing and that

the unit has recently seen an increase in non-clinical transfers. The trust needs to monitor this to ensure that these types of transfers do not adversely impact on patient care.

Access and flow

- The evidence we saw showed that the trust ensured that patients were admitted to the unit within four hours of making the decision to admit, as well as ensuring that the discharge to the ward was within the four hours of making the decision to discharge.
- We noted that non-clinical transfers from ITU were low. However the ITU consultant we spoke with expressed concern that demand for services was increasing and that the unit has recently seen an increase in non-clinical transfers. The trust needs to monitor this to ensure that these types of transfers do not adversely impact on patient care.
- The number of delayed discharges of over four hours was 17% and is an improving picture and better than similar trusts. Readmission to the unit is below that of similar units.

Meeting people's individual needs

- Patients on admission underwent a dementia assessment as well as ensuring that their individual and cultural needs were met. Staff had access to external multi-disciplinary teams as well as the internal 'link' nurse to support the needs of patients with learning disabilities.
- The team could accommodate the cultural needs of patients in terms of religious beliefs and specialist dietary requirements.
- Staff could access multi-faith spiritual leaders to support patients' spiritual needs.
- Staff told us they had received equality, diversity and human rights training.
- For patients whose first language was not English, staff could access the service of a language interpreter if needed.

Learning from complaints and concerns

- Evidence of trust wide learning from complaints was demonstrated through the trust's staff briefing and team meeting minutes. This meant that the trust was able to respond to any concerns raised by people who use the service. We observed posters on display throughout the hospital informing people about how to make a complaint.
- Staff were aware of the trust's complaints policy and confirmed that any complaints were addressed through the trust's complaint procedure as required. The records read showed that the unit had not received any complaints this year. Complaints were recorded on the trust's incident system.

Are critical care services well-led?

Good

Most staff told us that they felt well supported at a local team level, although we identified some staff concerns about the variability of leadership. This was supported by good governance processes, although we noted that identified risks did not always reflect the risks perceived by staff. There was a mixed response to the new hospital as some staff were unclear of their position after transition.

The trust had a vision and values for the organisation, which were on display throughout the hospital. Staff found there was a lack of visibility of the trust leads.

Vision and strategy for this service

- Staff said they were aware of, and able to identify the trust's "wheel" that outlined its vision and values. Staff we spoke with said that they found the wheel too busy and had difficulty in absorbing the content displayed. However, there was no unit vision or strategy.

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 and monitoring of performance. Risks were articulated, documented and escalated by the service appropriately.
- Identified performance shortfalls were addressed by action planning and regular review.
- Information from weekly management triangulation meetings was shared with staff during the daily "huddle" meetings". Areas addressed included incidents, complaints and staff-related matters.

Leadership of service

- Staff felt supported by their line manager.

Critical care

- Some staff told us that they felt that staff morale was quite low at this time and that there was a lack of visibility of senior trust leaders at front line services.
- Staff felt there was variability in the quality of leadership within the hospital.

Culture within the service

- Many staff spoke enthusiastically about their work and told us they loved their job. Staff reported a positive and inclusive culture within their particular team. Concerns and issues were raised in an open and honest way and staff felt managers listened to their concerns.

Public and staff engagement

- Some staff expressed anxiety about the move to the new hospital as they were unsure of their deployment and whether the new hospital would have an impact on their working role. Other staff we spoke with stated that they were looking forward to the transition to the new hospital. Staff felt they would benefit from more clarity about the new hospital and would appreciate increased visibility from senior managers in this regard.

Innovation, improvement and sustainability

- The provision of the new hospital was seen overall as a positive change in terms of an improved environment and new facilities that would enhance patients experiences of the hospital.

Maternity and family planning

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

Information about the service

The maternity service provided care and treatment for maternity and family planning for the population of Whitehaven. The inpatient units included a range of maternity services at the West Cumberland Hospital with other services available at another location in Carlisle. Services included delivery suite, antenatal care (outpatients/inpatient), post natal (outpatients/inpatient), ultrasound and "level 3" family planning. The service also included community midwifery services providing antenatal care, home birth and post natal care.

During our visit we spoke with nine staff, 10 relatives, and patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for seven of the patients. We gathered further information from data that we had requested and received from the trust. We also reviewed information regarding their internal quality assurance and 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.

The service averaged 1,400 births a year and had recently undergone a midwifery review across the trust's service.

Summary of findings

The maternity service at the hospital was delivered by committed and compassionate staff that treated patients with dignity and respect. All the people we spoke with were positive about the care they had received.

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. The obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust.

The higher than national average use of surgical intervention in child birth increases the risk to both mother and baby, which reduces the overall safety of the service provision. We did not find evidence of a clear strategy or plan to reduce the number of caesarean sections.

There was a lack of dedicated medical staff cover, a dedicated second theatre, pressure on space and lack of compliance with key NICE guidance, which impacted on the service's ability to respond in a timely manner and deliver a safe and effective service.

The service had the standard ratio of one midwife to 28 hospital births. There had been a review of midwifery services and the introduction of a midwifery governance lead had improved the approach to governance and monitoring of clinical practice. Although the specialist

Maternity and family planning

midwife roles had been welcomed, the clinical lead roles and business unit manager roles were not yet fully embedded. This meant that staff were not clear about roles and responsibilities.

The midwifery staff felt well-led, but there was a lack of capacity in medical leadership and no evidence of an articulated strategic vision for the future of maternity and family planning services at the West Cumberland location.

Are maternity and family planning services safe?

Requires improvement

The maternity service at West Cumberland Hospital was not sufficiently safe. The service had identified its own risks and was monitoring its own performance against national and local maternity indicators. We found that the risks identified were still in place and sufficient actions to mitigate the risks had not yet been implemented.

The issues identified by the maternity service with the lack of dedicated medical staff cover, locums and regular identified clinics impacted on the services ability to respond in a timely manner and deliver an effective service. There was no dedicated second theatre available for obstetrics; this may impact on fetal/maternal care due to a delay in accessing theatre.

The maternity service had reported on its risk register the risk of suboptimal care due to the lack of permanent middle grade staff and the use of long term locums. The majority of night cover at the location is covered by agency locum staff.

Incidents

- Staff reported incidents and were confident and competent in doing so. The data available from the trust showed that no never events had been reported by the service. The obstetrics and gynaecology service accounted for 29% of all incidents reported across the trust, which is one of the highest number of patient incidents across the trust. We found that the service classified the majority of its patient incidents with a moderate degree of harm. The incidents related primarily to 3rd degree tears following labour.
- The maternity service monitored all its risks and had a local risk register. We reviewed the risks identified by the service.
- There was no dedicated second theatre available for obstetrics; this may impact on foetal/maternal care because of the delay in accessing theatre. We found that there had been delays on three occasions but no harm had resulted. We did not see evidence of clear actions to resolve this risk. We also found that that there is no provision for urgent obstetric/gynaecology surgery at

the West Cumberland Hospital site. This would have an impact on the service's ability to undertake grade 3 caesarean sections. The trust was monitoring the number of patients affected by the lack of dedicated theatre time through the monthly maternity governance group.

- The service had reported adverse incidents and complaints from both staff and patients regarding the locum staff working at the hospital. The maternity service risk register showed risks of suboptimal care due to the lack of permanent middle grade staff and the use of long term locums. The majority of night cover at the hospital is covered by agency locum staff.

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 reviewed the maternity dashboard as part of the inspection and found low puerperal sepsis rates compared with nationally expected figures. The service outcomes were within expected limits for most of the indicators except the number of caesarean sections.

Cleanliness, infection control and hygiene

- The unit was clean and tidy and each room was stocked with appropriate personal protective equipment.
- MRSA and C. Difficile rates for the service were within acceptable range.
- Staff observed 'bare below the elbow' guidance.
- There was an ample supply of hand washing facilities and hand gel.
- However, we observed poor hand hygiene practice as some staff were not washing their hands or using hand gel between patients.

Environment and equipment

- Equipment required in case of a cardiac arrest and the resuscitation of a new-born was stored on suitable trolleys that were able to contain the equipment safely if it was moved.
- We found that different sites across the trust had different equipment available for maternal emergencies. One staff member told us that this could be confusing if they were working in different sites. There was no consistency in how equipment was provided across sites to manage maternal emergencies, such as post-partum haemorrhage.
- There was some evidence of inadequate checking and recording of equipment. We found that the emergency equipment daily checklist had a gap of three days when it had not been completed. We raised this with manager who told us that this would now be included as part of the daily handover to ensure that this was completed.

Medicines

- Staff records showed that midwives had received appropriate training in line with professional standards for the management of medicines. Staff we spoke with were clear about the drugs they used and confirmed that they had received the relevant training.
- Medicines were stored correctly in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Records showed clear documentation of medication, with standardised medication charts across the service.

Records

- We reviewed eight sets of patient records. Documentation in all the records was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. The records were in paper format.
- The 'Child health record' (red book) was issued to mothers and advice was available on how to keep the record as the main record of a child's health, growth and development.
- Midwives completed regular documentation audits and results were fed back through statutory supervision and professional development days.
- An external assurance visit for safeguarding noted that although safeguarding information such as risk assessments and vulnerability assessments were included in the notes, they were not easily accessible and the service had plans in place to ensure that summaries were available and located clearly within the records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were policies and procedures in place regarding the Mental Capacity Act 2005.

- Patients' consent was sought appropriately. We looked at records for a patient who had undergone a caesarean section and found that the appropriate documentation had been completed with informed consent recorded in the documentation.
- Staff had received training in maternal mental health and if required had access to appropriate clinical support for acute peri maternal health issues.
- The service had clear policies and procedures for the management of the acute mental health needs of a patient.

Safeguarding

- Women and their babies were protected from abuse and staff were trained to deal with suspicions of abuse and neglect. Staff were aware of the signs of abuse and the appropriate actions and systems for escalating safeguarding concerns.
- The use of lead midwives for safeguarding had a positive impact on the staff and they felt well supported to manage safeguarding concerns.
- An external assurance visit for safeguarding noted that safeguarding information such as risk assessments and vulnerability assessments were in place and completed.
- 92% (61 of 66) of staff had completed level 1 safeguarding training, but only 58% (7 of 12) had completed level 2 safeguarding training. Some staff told us that they felt they would like further, more detailed training, but felt well-supported by their supervisor.
- Pregnant women were assessed in the community as part of their antenatal care and information about patients who were at risk was shared appropriately.
- There was good evidence of multi-agency liaison and communication for women deemed high risk.

Mandatory training

- Staff were encouraged to complete their mandatory training prior to our visit. Staff we spoke with were aware that the service had achieved 92% completion rate for mandatory training, but some staff told us they would have preferred less "e" learning and more practical sessions as part of the mandatory training.
- The service had developed a robust training needs analysis to ensure that maternity services provide training in accordance with the national recommendations for all professionals working in maternity services. Staff we spoke with confirmed that they had access to professional development days and regular PROMPT (Practical Obstetric Multi professional training) sessions were held, which included all members of the maternity service.

Management of deteriorating patients

- The service had processes in place to ensure the recognition of severely ill women during their pregnancy, delivery and postnatal period. It had introduced a modified early obstetric warning scoring system (MEOWS) to help improve the detection of life-threatening illnesses. There were clear directions for escalation printed on the reverse of the observation charts. Staff we spoke with told us that they were aware of the actions to follow.
- The staff also showed us a "Sepsis 6" pathway, which was used as appropriate for the management of sepsis.

Midwifery staffing

- Arrangements were in place to ensure a sufficient number of staff to provide safe care. The information provided by the trust outlined how staffing levels were calculated. The service had the standard ratio of one midwife to 28 patient hospital births. Figures showed that 100% of women had one-to-one care in established labour, and staff confirmed this.
- We noted that staff had reported several incidents when staffing had not been adequate on the unit. They told us that they knew how to access more staff if required, and they were aware of the escalation policy for short term management of staff shortages/capacity issues.
- The service had trialled an acuity tool to assess the dependency criteria for maternity patients and had plans to introduce a formal acuity tool such as Birth Rate Plus, a recognised tool developed for maternity services to assess the staffing levels needed. However, the service was not using a formal acuity tool to assist in the calculation of appropriate staffing levels.
- Shift handovers promoted clear communication and continuity of care.
- Postnatal services are also provided in the community (women are transferred home to the care of the Community Midwives until at least the 10th and up to the 28th day following delivery).

Medical staffing

- We found that there were no medical trainees at the West Cumberland Hospital. The service was staffed by long term locums. The service reported that it had

difficulty in recruiting middle grade medical staff and, as of 19 March 2014, it had only two middle grade doctors in post to cover days (9am to 9pm).The trust had reported incidents involving delays in commencing urgent caesarean sections as there were no junior doctors on the obstetric rota after 10 pm on the site. We were told that the clinical director had given assurance that the surgical registrars were available to cover grade 1 caesarean sections and this was being monitored on a weekly basis.

- The service also reported difficulty in sustaining consultant-delivered obstetric services at West Cumberland hospital. Staff told us they were unclear about plans for medical staffing at the location.
- Staff told us that there was no dedicated obstetric anaesthetist at the location, and records showed this. The trust is not currently meeting national guidelines of having an anaesthetist available at all times for obstetrics. We were told that at night the resident trainee anaesthetist covers several different areas, including obstetrics, so may not be available for cover. There is a voluntary arrangement in place for on-call anaesthetic consultants to come in from home to support junior staff.
- Rotas showed that the locum middle grade had no junior support out of hours, which had a potential impact on the safety of patients. Occasionally a locum consultant could be covering a locum middle grade. As far as possible the service was using locums who were familiar with the unit, but we did not see evidence of a detailed induction pack for medical staff on the unit other than an initial checklist.
- The medical staff carried out regular handovers during the day and in the evening on the labour ward to ensure clear communication and handover of care for patients.

Are maternity and family planning services effective?

Requires improvement

Maternity services required improvement to become more effective. The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). The department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. However, we found that the guidance was not always followed. Staff told us, and records showed, that some staff were not following the policy for induction of labour on the maternity unit.

The trust's data and the maternity dashboard showed that the maternity service had lower than national rates for normal delivery. The service also had significantly higher rates of elective and emergency caesarean sections when compared nationally. We did not find evidence of a clear strategy or plan to reduce the number of caesarean sections.

The inspection team did not feel that a responsive service was being offered. The service at West Cumberland Hospital does provide an epidural service 24 hours a day, seven days a week to those mothers who wish to have this method of pain relief. However, we noted that the service's own information leaflet on epidural pain relief stated "the hospital does not have an anaesthetist dedicated to the labour ward… although we strive to provide this service within 30 minutes of request; there are very occasionally prolonged delays in provision of an epidural, particularly out of hours."

We were told that the termination of pregnancy service was not currently able to provide more than one clinic a week at West Cumberland. This meant that it was not meeting the Royal College target of seeing women within five days. This meant that the service was not as effective as the trust's other location.

Evidence-based care and treatment

- The delivery of care was based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE). Records showed that the department had developed some clinical care pathways to ensure that patients received care appropriate to their needs. These included pathways such as "obstetric haemorrhage" and the "severely ill women and management of acute collapse." However, we found that the guidance was not always followed. Staff told us, and records showed that some staff were not following the policy for induction of labour on the maternity unit.
- There was a variety of information based on research and NICE guidance, which were available to inform mothers such as "emergency caesarean section".

Maternity and family planning

Pain relief

- Mothers were offered access to various pain relief such as entonox and pethidine. The service at West Cumberland Hospital does provide an epidural service 24 hours a day, seven days a week to those mothers who wish to have this method of pain relief. However, we found the service did not have access to a dedicated anaesthetist, which meant they could not always provide epidurals.
- We noted that the service's own information leaflet on epidural pain relief stated "the hospital does not have an anaesthetist dedicated to the labour ward…although we strive to provide this service within 30 minutes of request; there are very occasionally prolonged delays in provision of an epidural, particularly out of hours." This impacted on the ability of the service to deliver effective pain relief in a timely manner. The trust is currently not meeting national guidelines of having an anaesthetist available at all times for obstetrics.

Patient outcomes

- The service also completed a maternity dashboard to monitor key maternity indicators. We reviewed the data provided as part of our inspection. The trust's data and the maternity dashboard showed that the maternity service had lower than national rates for normal delivery (58.1% in comparison with 60.7% for England). The service also had significantly higher rates of elective and emergency caesarean sections when compared nationally. Elective caesarean sections were 12.8% compared with 10.7% in England and emergency caesarean sections were 17.3% compared with 14.6% for England. During discussions with the clinical leads we did not find evidence of a clear strategy or plan to reduce the number of caesarean sections.
- We noted the higher than average unexpected admissions to the special care baby unit (SCBU). In discussions with medical and midwifery staff, we found that the service had a low threshold to admitting babies, as well as low threshold for giving babies antibiotics. This was in response to a clinical incident in the local health economy. Plans were in place to re-audit the admissions to the NICU and revisit the criteria for admission.
- We were shown a policy on breast feeding and were told that the service had recently appointed an infant feeding coordinator.

Competent staff

- The service had clear systems in place for supervision and appraisal. Some staff felt that they would like more time to discuss cases and junior staff we spoke with told us that they would welcome more support from senior clinical staff.
- There were sufficient numbers of supervisors of midwives (SOMs) within the hospital. 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. As supervisors, they provide support, advice and guidance to individual midwives on practice issues, while ensuring they practice within the midwives rules and standards set by the Nursing and Midwifery Council(NMC).
- All midwives had an annual review by their allocated supervisor.
- The service had recently implemented a review of midwifery staffing and had introduced several specialist midwife roles to lead specific areas of practice, such as safeguarding, governance and obesity.

Multidisciplinary working

- We saw evidence of clear multi-disciplinary working across all professional groups.
- Maternity staff were regularly asked to attend multi-agency meetings and contribute to pre-birth plans.
- There was good communication between the primary care and community health services.
- The location of the community maternity team meant that there were close working relationships with the maternity unit, and the communication processes were clear and effective.
- The midwives were aware of their responsibilities to communicate with GPs during antenatal care/discharge, and we saw examples of clear communication between GPs and midwives.
- The staff had clear procedures for the transitional care of babies from SCBU to postnatal care, and worked closely with colleagues to support the mothers and babies.

Seven-day services

- Services were available seven days a week, but the service had identified some delays in access to medical staff out of ours, which limited the effectiveness of the service to provide care in a timely manner.

Maternity and family planning

Are maternity and family planning services caring?

Good

We found that maternity services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect. All the people we spoke with were positive about the care they had received.

Compassionate care

- We found that maternity services were delivered by committed and compassionate staff. We observed that all staff treated patients with dignity and respect.
- All the people we spoke with were positive about the care they had received. Two people asked to speak with us to tell us about the positive care they had received – both for their recent pregnancy and previous deliveries.
- We found that patients were encouraged to give feedback on the service and systems were in place to gather their views by using the "Two minutes of your time" questionnaire to gain feedback.
- The Friends and Family test results for the service were comparable with the England average.
- Results from CQC's survey of Women's experiences of maternity services 2013 were in line with other trusts nationally for both care and information and explanations given by clinical staff.

Patient understanding and involvement

- Staff planned and delivered care in a way that took account of the wishes of the patient. We saw staff obtaining verbal consent when helping patients with personal care.
- Women were informed and involved in decisions about their care. Patients told us that they had been involved in their care and felt very involved in decision making. One couple told us "They have explained everything we have felt totally involved."
- The use of records held by mothers encouraged them to be aware of their birth plans and provided further information on any specific tests or investigations that may be needed throughout a pregnancy.

Emotional support

- Arrangements were in place to provide emotional support to patients and their families in a sensitive manner.
- The service had a bereavement midwife to support women and their partners following the loss of their baby. We saw examples of further follow-up in the community if required to support women following bereavement.
- "Memory boxes" were provided with foot/hand prints/ photos for the family.
- We observed and staff told us that advice and support for antenatal complication and termination of pregnancy was managed sensitively.
- Staff we spoke with were very aware of the need to provide emotional support for mothers, and carried out assessments for anxiety and depression.
- If, at any time, mothers wanted to talk through what happened the service had a post natal listening service. Information about how to contact the service was available in information leaflets available on the maternity ward.
- We found that breast feeding support was available across the service.

Are maternity and family planning services responsive?

Requires improvement

There was a lack of standardisation across the trust's locations as to the availability of evening clinics for early pregnancy advice and access to termination of pregnancy clinics. This needs to be addressed to allow the services to respond to the needs of the local population.

The lack of an agreed service specification made it difficult to assess the delivery of the service against the needs of the local population. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this population of patients.

The service governance lead had developed a maternity service integrated governance action plan to capture all the learning from audits and incidents.

Maternity and family planning

Service planning and delivery to meet the needs of local people

- The service had systems in place to manage patients with complications. Babies with particular complications were transferred to the tertiary centre in Newcastle.
- The Maternity Services liaison Committee had not met for two years. We were told that a meeting to establish the committee was planned for the week of our inspection to seek the views of women using the service. This was being led by the consultant midwife.
- The lack of an agreed service specification made it difficult to assess the delivery of the service against the needs of the local population. We were told that there was a high incidence of obesity in the area and the service had started to audit its service for this population of patients.

Access and flow

- Policies were in place to escalate staffing issues on the unit and staff were aware of how to access extra support if required.
- The inspection team found that the Early pregnancy Advice Unit (EPAU) service did not provide an evening clinic at the West Cumberland site and patients did not have access to the same level of support for level 3 family planning services as the Cumberland Infirmary location in Carlisle.

Meeting people's individual needs

- The service had systems in place to meet people's religious and cultural needs.
- Leaflets were available for mothers to help them decide where to have their baby. The leaflet outlined the choices available for women, including the difference between midwifery-led care, consultant-led care and the options for home births or the Penrith birthing centre. Other leaflets were also available such as "pain relief in labour". This helped women and their partners to make informed choices and decisions.
- The needs of the women were assessed and birth plans were developed to meet those needs. Staff told us and records showed that each patient had a comprehensive assessment utilising nationally recognised pregnancy record documentation. This included a full medical history, personal preference plans for pregnancy, birth and parenthood. This took into account the individual mother's wishes such as preferences for birth and any specific wishes with regards to breast feeding.
- Patient risk assessments were in place within the service. We saw copies of completed risk assessment for venous thromboembolism (VTE) to assess women's risk for blood clots, which was completed at booking, all antenatal admissions, and labour admissions and postnatal. Where risks were identified, treatment plans were in place, which included anti embolic stockings.
- Staff explained how they could access interpreters when required. A translation service is available, but we saw no signs or leaflets for translation services.
- We did not find evidence of information available throughout the service in different languages or formats such as braille or audio versions for the visually or hearing impaired.

Learning from complaints and concerns

- Staff reported that the new role of governance lead for the service had resulted in an increased awareness in risk and that feedback on lessons learned had improved.
- Feedback was given and we saw examples of learning from incidents being applied and implemented, such as improvements to communication and discharge to community services.
- Some staff told us that they had not had any training in complaints and would welcome some practical sessions in managing patient concerns.
- We found that some complaint leaflets were available, but information for both the role and contact details for the Care Quality Commission was out of date and inaccurate.
- We saw information on who to contact if people had concerns and information on the Patient Advice and Liaison Service (PALS).

Are maternity and family planning services well-led?

Good

The midwifery staff felt positive about their clinical leadership, but felt that the roles were not yet embedded. They did not fully understand the roles of the clinical leads, and the role of the business manager.

Staff welcomed the maternity dashboard, but the inspection team was told that it had only recently been

introduced so the data could not yet be compared with previous year's activity. Staff were not clear what the trust's vision was for the location, and they had anxieties about the provision of care.

Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Vision and strategy for this service

- The staff we spoke with told us that they had attended awareness sessions about the trust's vision and values. Not all staff clearly understood the information boards on the walls on each unit.
- Staff were not clear what the trust's vision was for the location, and had anxieties about the provision of care in the longer term.
- We noted that the service had a draft service specification but did not have a clearly documented overview of the maternity service provision nor an articulated vision for future service delivery.

Governance, risk management and quality measurement

- Monthly departmental governance meetings had a set agenda with certain standing items including the review of incidents and monitoring of the maternity dashboard.
- Staff welcomed the maternity dashboard but the inspection team was told that it had only recently been introduced so the data could not yet be compared with previous year's activity.
- We reviewed the maternity service integrated governance action plan. This had been developed by the service governance lead to capture all the learning from audits and incidents to improve service quality and safety. The integrated action plan monitored all complaints, learning from incidents and audits, to check whether care was provided in line with Royal College Guidelines (RCOG), relevant NICE guidance and NHSLA Authority maternity standards. We saw audits for obesity in pregnancy, care of women in labour, perineal trauma, hand hygiene and the management of diabetes in pregnancy. We saw evidence that participation in national audits had improved, and the staff we spoke with told us that they welcomed the introduction of the lead midwife for risk and governance.
- The maternity service monitored all its risks and had a local risk register. The service had a monthly Maternity Governance group that reviewed all incidents. This committee also reviewed relevant national guidance published each quarter to ensure that they were assessing themselves in line with appropriate current national standards.

Leadership of service

- The midwifery staff felt positive about their clinical leadership, but felt that the roles were not yet embedded. They did not fully understand the roles of the clinical leads, and the role of the business manager.
- Staff welcomed the post of the midwife consultant as a leadership role. The consultant post had a remit for Public health-Obesity, but none of the leadership roles had a clear remit to promote 'normality' in childbirth. The inspection team felt that the role was not clearly defined and the capacity to lead on public health and 'normality' was limited due to the significant management component of the role in managing the specialist midwives.
- The lead obstetrician for maternity was based at the trust's other location in Carlisle. The clinician was acting as lead for risk, diabetes, twins and obstetrics, as well as lead for the termination of pregnancy services. The inspection team felt that this suggested no long term strategy and a lack of capacity to lead strategically in all the required areas.

Culture within the service

- There was a positive culture among the midwives. They acknowledged the recent challenges with the service review but were now positive about the changes. They had concerns about future sustainability of services at the location. Some staff told us "There is good team work" and "I feel leadership is good in maternity."

Public and staff engagement

- Although we found evidence of feedback from patient questionnaires and local informal feedback from mothers and partners, we did not see evidence of any formal meetings to engage with members of the public about the maternity services.

Innovation, improvement and sustainability

- We found that the service had made significant improvements in regards to developing an improvement culture.

Maternity and family planning

- Staff had been engaged with the development of new roles and now felt they were receiving feedback on complaints and starting to learn from incidents. One person told us that they felt some of the reviews were being rushed and they would welcome more support to ensure that the service learned from incidents.
- The inspection team noted that the lack of information systems was having an impact on the ability of the service to adequately record information with regard to the clinical care of women and the complexity of their cases. We were told that approval had just been given to introduce the IT data systems required to assist in developing innovation and improvements.

Services for children and young people

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

Information about the service

West Cumberland Hospital children's services comprised of a 15-bed children's ward (Fairfield) and a 10-cot special care baby unit (SCBU) (Thirlmere).

There is one six-bedded bay, which was used to medically assess children who attended the unit following direct referral from their GP or from the hospital's accident and emergency department. There were eight side rooms.

Facilities included a lounge area and small kitchen for parents and visitors; bathrooms, shower and toilet facilities; treatment rooms and other clinical areas; a kitchen area used by staff to prepare snacks and drinks for patients; a large well equipped play room and a staff room.

There were five patients on the ward and we talked with three of the parents and the parent of a baby in the SCBU.

We reviewed the records and information available on the ward. We interviewed two medical doctors, including the consultant on duty; the ward matron; the ward sisters on duty on the ward and SCBU, a staff nurse and student nurse. We also talked with the play worker for the ward.

We interviewed a member of the Child and Adolescent Mental Health Service (CAMHS) team who visited the ward during the inspection.

Summary of findings

The medical and nursing staff were caring and worked hard to meet the needs of children and young people.

However, the service could not show that staff understood the changes required to ensure the paediatric ward and SCBU provided a safe, caring, effective, responsive and well-led and sustainable service. Staff were not fully involved in the plans and future developments for the children's ward. However, they said they felt supported by senior staff.

The quality of service provision was inconsistent. Staff did not adhere to the trust's policies and procedures and compliance with best practice guidance was also inconsistent. Environmental and care and treatment risk assessments were inadequate or had not been completed, which meant that the safety of children and young people was not always promoted.

Sufficient nursing staff were on duty, but children and babies who attended the hospital were at risk of delayed or ineffective treatment because experienced paediatric doctors were only available on site Monday to Friday between 9am and 5pm.

Safeguarding and child protection had improved because the hospital had recently taken steps to ensure that staff followed the safeguarding children policy, which had brought about positive outcomes. Review of the trust's information identified significant time-lapses between when concerns were raised and when effective action was initiated.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We found that the trust needed to take more action to make children's services safe and protect children from avoidable harm.

The trust did not ensure that care and treatment was always provided in keeping with good practice guidelines such as guidance from the National Institute for Health and Care Excellence (NICE) or Royal Society of Obstetric and Paediatrics guidance. There was appropriate security in accessing the ward, but the security of rooms once on the ward was inadequate.

Systems available were not always used to ensure that the individual needs of the child were met, and staff did not always demonstrate that they had received appropriate training or were following best practice guidance in delivering care.

The service for children at the hospital is inherently unsafe because although the hospital runs a 24-hour Accident and Emergency service, experienced paediatric doctors are only available on site to provide high quality paediatric medical intervention Monday to Friday from 9am to 10pm.

Incidents

- There were no never events reported by the trust through the National Reporting and Learning System for the children's ward (Fairfield) at West Cumberland Hospital.
- Incidents on this ward were reported to the trust auditors through the electronic incident reporting system.
- We talked with nursing and medical staff and found that a number of nursing staff on Fairfield ward did not have access to the incident reporting system or knew how to complete a report. We were told that incidents would be recorded in the patient's nursing records and reported to senior staff.
- This was contrary to the trust's strategy as the Board Risk and Assurance Framework 2014/2015 states that all staff would receive guidance about using the electronic reporting system.
- Staff responsible for reviewing incident reports did not always understand what had to be reported. For example, a senior member of staff told the inspection team that the admission of children and young adults with mental health needs did not need to be reported. This was supported by notes written on the incident record report viewed by the inspectors who visited the special baby care unit.
- This contradicts the paediatric risk register dated 21 March 2014, which identified the admission of children and young adults with mental health needs as one of the major risks for the organisation.
- We were informed that a weekly meeting was held at Cumberland Infirmary Children's ward in Carlisle to review incidents. There was no evidence that information about trends and lessons learned were shared with the paediatric or SCBU nursing staff at West Cumberland hospital.
- Staff we talked with could describe incidents that had been reported, but could not provide examples of changes made to practice to prevent the recurrence of incidents.
- There was no evidence to show that the lessons learned from reviewing incidents were used to improve the quality of care and safety of children on the Fairfield Ward.

Safety thermometer

- A safety dashboard provided information about the level of compliance in different aspects of practice, which included hand hygiene and completion of the specialist paediatric observation of vital signs called the Paediatric Early Warning score (PEWS). Each area had scored 100% compliance.
- We asked nursing staff about the audits that had informed the findings of the information on display. They said that the dashboards on display were a relatively recent addition and they were unsure about how the figures had been arrived at.
- The dashboard for the ward did not include information about all the elements of safety and harm-free care recommended by the NHS Thermometer guidance, such as medication management or completion of specialist paediatric care pathways in addition to the PEWS observations.

Cleanliness, infection control and hygiene

- All the rooms and areas we visited on Fairfield ward were clean and tidy.

- We saw that hand washing instructions were displayed above each hand basin.
- Hand basins were situated on the ward and in the bay areas.
- Hand wash liquid and paper towels were in plentiful supply.
- Automatic antiseptic hand gel containers were also situated at the entrance and other locations on the ward.
- We saw that all clinical and direct 'hands-on' staff were 'bare below the elbow' in keeping with best practice guidance.
- Staff used hand gel or washed their hands between patients and on entering or leaving the ward or bay area.
- There were a number of checklists and cleaning schedules on display on Fairfield ward, which were up to date.
- There were single rooms that could be used to isolate patients as required.
- The trust provided data from its most recent infection control audit dated March 2014. This showed that Fairfield ward was fully compliant and effective with regards to infection prevention.
- The audit did not include a review of antibiotics prescribed on the ward. This did not meet good practice guidelines such as the Department of Health ARHAI Antimicrobial Stewardship Guidance 2011. The trust plans to have a "Coast to Coast" paediatric antimicrobial guideline, but this was not in place at the time of the inspection.
- This meant that the trust did not have a complete picture about management of all infection control and management systems. This was unsafe because we saw that doctors prescribed antibiotics contrary to NHS guidance, which precludes the use, unless under specific circumstance, of antibiotics for viral infections and other self-limiting infections.

In the Special Care Baby Unit.

- There was a cleaning schedule but this was not kept up date.
- We saw that expressed breast milk was not stored securely and there was a risk of cross-contamination or tampering.
- Single use pacifiers (dummies) were not discarded but placed in boiled water for two minutes and reused for the same baby contrary to the manufacturer's instructions. This meant there was a risk of contaminated or perished dummies being used.

Environment and equipment

- Resuscitation equipment was placed in a convenient position on the ward.
- The contents were complete and held a range of children and young adult-sized oxygen masks and other required equipment.
- There was an equipment checklist and signatures showed that staff checked the equipment each night.
- Maintenance labels showed that the portable oxygen had been serviced, in keeping with the manufacturer's recommendations.
- We noted that a number of portable electrical items did not have stickers confirming that the required yearly test had been completed.
- The ward staff did not know where to access information about the maintenance schedule, although we were informed these were present on the ward.
- We saw that the ward was not safe because a number of rooms and cupboards, including the clinic room, were kept unlocked, which meant children and young adults could access these areas unobserved.
- One unlocked room also contained a sharps box and sterile needles within easy reach of children who could have entered the room unobserved.
- We discussed whether an environmental risk assessment had been completed for the ward and the matron was uncertain.
- It was unclear how ward safety was assessed, as ongoing ward safety risk assessments (safety huddles) were not undertaken on the ward.

In the Special Care Baby Unit

- There was good storage facility on SCBU although we noted that the rooms were cluttered.
- Staff on the unit had signed to confirm that they had completed training on different pieces of equipment, but this was difficult to corroborate because there was no independent verification.
- There was no evidence that staff competency was reviewed following this training.

Services for children and young people

Medicines

- Medication on Fairfield ward 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.

In the Special Care Baby unit.

- Controlled medication was not stored in keeping with the Royal Pharmaceutical Society guidance. This was because the controlled drugs cabinet, which stored medication that needed to be stored and administered under close supervision, was also used for storing general items such as money. This meant an accurate record of who had opened the cabinet could not be kept because staff had access for reasons other than administering or checking medication.
- Equipment was also in poor repair, as the light to indicate that the controlled drugs cabinet was unlocked was broken. This meant staff would not have been alerted if medication that required additional security was left unsecured.

Records

- There were five children who were inpatients on the ward at the time of our inspection. We reviewed the nursing file records for three of the children.
- None of the files we looked at had been labelled with hospital identification labels.
- The initial assessments, care plan, daily records and other correspondences were loose and unbound.
- The records were untidy, which meant they needed to be reorganised before the patient's treatment journey could be assessed.
- Written information was legible.
- Staff used a white board to communicate certain needs of patients, and used a code instead of a name to identify each patient. This was in keeping with the 'Code of Practice on Protecting the Confidentiality of Service User Information'.
- The trust's health records information group completed a clinical audit of medical records on Fairfield ward. The 2013/2014 report showed a rating of 'amber', which meant improvements were needed. This report also suggested changes, an action plan and timescale for a follow-up review.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (Gillick Competencies / Fraser Guidelines)

- The trust's most recent ward-based training record for April 2014 showed that the majority of staff on Fairfield had completed training in consent, Mental Capacity Act and Deprivation of liberty safeguards.
- Information about Gillick Competencies / Fraser Guidelines dealing with consent for children and young people under 16 years old were not available.
- We reviewed the children's ward 'patient details and assessment' form which nurses completed on admission. This did not include information about the child's ability to give consent or make decisions about their treatment or care and so did not fully support staff in considering the Gillick Competencies / Fraser Guidelines when assessing them.

Safeguarding

- The trust has a dedicated team for safeguarding including named nurses.
- There was a clear review process to check the quality of safeguarding issues, which included safeguarding assurance visits to wards.
- The report from the safeguarding assurance visit on 6 March 2014 identified areas for improvement, such as the need to make staff aware of how to make appropriate safeguarding referrals.
- The visit also identified areas of ongoing concern which needed improvement. The most significant was the care and treatment of children and young adults with mental health needs on Fairfield ward.
- The team used the reporting database to identify trends in the type of safeguarding concerns referred, such as the number of children who missed outpatients appointments.
- The database kept a track of the children and highlighted children who had already been referred if they returned to the hospital. This meant early intervention and review of the child's condition.
- The database also prompted safeguarding staff to follow up concerns until issues were fully resolved.
- We saw reports and observed telephone conversations that confirmed that there was a multidisciplinary approach to dealing with safeguarding concerns and included conversations with other statutory services including school, health visitor, GP and social services.

- The training records provided by the trust dated May 2014 showed that safeguarding training had been provided to all nursing and clinical staff. The majority of ancillary staff had also received this training.
- Ward staff we talked with knew how to recognise signs of abuse in children.

Mandatory training

- The mandatory training record provided by the trust for May 2014 showed that all staff were up to date with Safeguarding Children & Young People Level 1 and Level 2 training, and 62% (8 of 13) staff were up to date with level 3 safeguarding training. Also 62% (8 of 13) had completed Paediatric Life Support (PLS).

Management of deteriorating patients

- The ward uses the paediatric early warning score (PEWS) for recording the vital signs of children on the ward so that early signs of deterioration can be identified and remedial action taken.
- The trust checked the quality of the charts and staff response on a monthly basis. The report we reviewed covered the months between July 2013 and February 2014 with the exception of October 2013.
- This PEWS audit showed that the trust needed to take more action to ensure that children with deteriorating health were quickly recognised and given appropriate medical intervention, as staff consistently failed to complete the document in full meaning that an inaccurate score was recorded.
- We reviewed a serious incident concerning pa**e**diatric care that had occurred in 2012. The action plan highlighted one of the improvements required was the use of the paediatric early warning score.
- In light of that recommendation and the findings in relation to the use of PEWS, it is evident that ward staff are not sufficiently aware of their role in preventing a similar incident reoccurring.
- We discussed the management and transfer of the deteriorating child with ward staff. We found that the nurses were unclear 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 Transport service. The information did not highlight to staff the need to use the PEWS observation tool to assess the stability of the patient's condition and help to ensure the correct level of clinical support was provided.

Nursing staffing

- The staffing compliment for the day shift was two band 6 and one band 5 registered paediatric nurses, one band 3 health care assistant and a play worker.
- Although the number of staff was sufficient, the ratio of three registered nurses to 15 paediatric patients (1:5) is below the Royal College of Nursing (RCN) recommendation of 1:4.
- This staffing compliment did not take into account the RCN requirement of 1:3 for children and babies under two years old.
- The night shift staffing was two registered nurses (a ratio of 2:7.5) and one health care assistant. This was better than the RCN recommendation of 1:5 qualified nurses.
- The trust's ward staffing report for December 2013 confirmed that this was the staffing ratio approved by the trust for this ward and that this was the minimum number of nurses on duty.
- The staffing report showed that additional nursing staff were available because staff hours had been 16% above establishment in December 2013.
- The matron told us that the average ward occupancy was 60%, which indicates that the ward was not overly busy.
- Best practice guidelines state that there should be a band 7 nurse on duty. The matron stated that recruitment for this grade of nurse was ongoing.
- The trust's escalation policy gave staff guidance on how to request additional staff. However this did not provide an assessment or acuity tool to help staff assess the risk to patients on the ward in relation to the needs of the patients or staffing numbers.
- The matron, nursing staff and senior paediatric consultant said that there was flexibility in the nursing roster to allow regular staff to work additional shifts when this was required.
- The matron, nursing staff and senior paediatric consultant each confirmed that additional staff would always be made available to provide one-to-one support for children with special needs.

Services for children and young people

Medical staffing

- The trust provided a medical staffing record, which showed that the service did not provide 24-hour paediatric consultant cover.
- On most days, paediatric consultant cover was provided until 5pm.
- 24-hour on site cover was provided by a staff grade paediatrician four nights a week and an FT2 doctor three nights a week.
- An experienced paediatrician was available through the on-call system, which operated at night and weekends.
- The duty rosters for February and March 2014 showed that when a junior doctor covered the night shift, a consultant paediatrician would be resident at the hospital.

Major incident awareness and training

- The training record confirmed that the majority of staff had up to date fire safety training, but a practice evacuation had not taken place.

Are services for children and young people effective?

Requires improvement 

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 had a high rate of emergency readmissions and there was no evidence that the trust had investigated this issue. We found that the trust's response to improving services for children and adolescents with mental health needs has been slow and does not reflect the seriousness of the risk to children with mental health needs who access the service.

Evidence-based care and treatment

- The trust wide policies we reviewed were based on the appropriate best practice guidelines and legislation, such as National Institute for Health and Care Excellence (Nice); the Mental Health Act 1983 and NHS Executive guidance.
- We reviewed the trust's monthly audit of the use of NICE and other best practice guidelines but this information was not specific to a ward or department.
- We found that staff did not readily refer to the trust intranet for guidance and said they would ask a senior member of staff if they were uncertain about a procedure.
- We reviewed the nursing records and assessments for three children and saw there was very limited use of formal risk assessment tools or standardised integrated paediatric nursing care pathways.

Pain relief

- We reviewed the nursing records for three children and talked with three parents. We saw that the pain assessment on the reverse of the paediatric early warning assessment tool had not been completed. One child was a baby.
- There was no supplementary pain assessment tool seen to be in use.
- We saw that action was taken to prepare children to make procedures as pain-free as possible.
- The skills of the play worker were used to distract children during blood tests or physical and intrusive examinations.
- The medication administration record sheets did not provide an opportunity to record a pain score with each administration of analgesia to allow the effectiveness of the medication to be reviewed and changed accordingly.

Nutrition and hydration

- Each nursing record we reviewed held a copy of a nutritional screening assessment tool called STAMP. However, of the three records, one was blank and the other two were incomplete.
- We found that insufficient steps had been taken to properly assess the risk of a patient with a specific health need which affected food and nutrition.

Patient outcomes

- The trust's Clinical Audit Annual Report 2013/14 confirmed that it participated in the expected national and local paediatric audits to support service improvement.
- The report highlighted areas of improvement and required further improvement for each of the audits.
- The quality performance dashboard, April 2013 and February 2014, showed that the emergency readmission rate within 30 days of discharge for the paediatric division was 10.2%. The information did not distinguish between the ward at West Cumberland Hospital in

Whitehaven and the children's ward at Cumberland Infirmary, Carlisle. This was above the trust's target set within its performance dashboard, which was equal to or below 6%. We did not receive information about any action taken by the trust in relation to this finding. Neither had the finding been highlighted in the trust's paediatric risk register.

- We were not provided with information about any action that the trust had taken in relation to this finding, and the finding had not been highlighted in the trust's paediatric risk register.

Competent staff

- The trust's Report to the Safety & Quality Committee held on 18 February 2014 showed improvements in staff appraisal.
- Appraisal for non-medical (nursing and ancillary) staff stood at 89.1% for the third quarter. This was an increase from 74% for the previous quarter.
- Appraisals for consultants increased from 68% to 78% for the same period.
- The trust's training needs analysis 2 May 2014 confirmed that nurses working on the paediatric and special care baby unit at West Cumberland Hospital completed ongoing specialist paediatric training.

Hospital security

- Porters at the hospital acted as security staff and so were expected to support a young person if they challenged the service. The information provided by the trust showed there were 35 porters employed at the hospital and each had completed safeguarding children training level 1.
- Furthermore none of the porters had received conflict resolution training.

Multidisciplinary working

- The transfer to adult services policy for children with long term conditions only related to children with diabetes. This stated that the transition to adult services would begin at 16 years of age and involve the patient and multiagency working.
- Staff we talked with had varying criteria for the upper age limit for a young person to be admitted to the children's ward.
- The diabetes transition policy stated that children between 16 and 18 years would be given a choice of using adult or children's services.
- We were also informed that there was some flexibility in the upper age limit for young people with special needs still at school full time.
- We were informed that teenagers were placed in a side room, which was separate from young children and toddlers. However, on the day of the visit we saw that this was not always possible.
- Staff were aware of the Child and Adolescent Mental Health Service (CAMHS) and made referrals to the team as required.
- However CAMHS staff were only available during the week. This meant there could be a delay of three days before appropriate assessment or intervention could be provided.
- None of the staff on Fairfield ward had received additional mental health training to enable them to complete basic mental health risk assessments and provide safe interim support.
- We interviewed a member of the CAMHS team who acknowledged that there was a shortage of local CAMHS staff and specialist services for children with mental health needs.
- The nursing records we reviewed for children with CAMHS referrals did not include mental health assessment or specialist care pathway.
- Records showed that the intervention provided by staff was ineffective because symptoms had not improved.
- Staff informed us that the admission of children with mental health needs had been a cause for concern for "quite a while".
- This was borne out by the information in the July 2013 staff meeting records, which identified a significant increase in the number of children with acute mental health needs being admitted to the ward over the previous months.
- The trust board was also aware that children and young adults with acute or ongoing mental health needs did not receive the best care and treatment and support from CAMHS in a timely manner.
- The trust flagged a lack of CAMHS provision and need for mental health training for staff as a high or 'red' risk on its paediatric risk register dated 21 March 2014.
- Discussion with the management team confirmed that this was an ongoing concern, which was not isolated to the trust. This had been raised with commissioners.
- At the time of the inspection no steps had been taken mitigate this risk and no training had been offered to staff.

Services for children and young people

- The trust did not offer enough support and supervision to nursing staff to ensure that assessments and plans of care met the needs of children with mental health needs.

Seven-day services

- 24-hour specialist paediatric medical cover was not available onsite for children attending the West Cumberland Hospital.
- Unless they were admitted between 9am and 5pm Monday to Friday, there could be a significant delay in children being examined by a person with expert skills to make sure best care and treatment was consistently provided.

Are services for children and young people caring?

Good

Patient satisfaction surveys indicated that parents and patients were satisfied with the conduct of staff and felt the service was caring. We talked with three parents. Two felt that they had received sufficient information about the care and treatment of their child. Observation of the interaction between staff and patients confirmed that staff were attentive and treated patients and their parents with dignity and respect.

Staff took action to provide information that would offer reassurance to parents.

Compassionate care

- Observation of the interaction between staff and patients confirmed that staff were attentive and treated patients and their parents with dignity and respect. The matron, nurses, doctors, play worker and other staff we talked with were committed and dedicated to their work and were very caring towards the patients.
- The trust did not provide information regarding action taken in response to the result of the survey or comments made by participants.
- In the 'Better Care, Better Experience' report for quarter 4 (2013/14) the Family and Friends score for the ward showed a rating of 100% satisfaction for pain management and over 90% satisfaction in other areas, except for consistency and coordination, which scored at 85.7% satisfaction, which was down slightly on the two previous months.
- One of the parents spoken with during the inspection told inspectors they had received confusing and contradictory information from the doctors and nurses about the symptoms and treatment for their child.

Patient understanding and involvement

- We talked with three parents. Two felt that they had received sufficient information about the care and treatment of their child.
- The nursing records showed that staff had asked the parents or patient for their opinion, and in one case it was evident that the patient's opinion had been respected and action had been taken. The records included the comments made by the patient which, though positive, also highlighted issues in relation to communication.

Are services for children and young people responsive?

Good

Children treated as inpatients were attending the ward following referral from the A&E department; returning to the ward through direct access from GP referrals or through direct access agreed as part of the discharge plan. This demonstrated that the admissions process was flexible and responsive.

Evidence confirmed that the systems in place for responding to foreseeable concerns, such as short-term staff shortages, were flexible and effective. Information from the trust demonstrated that although the service responded to complaints or concerns raised by patients or their relatives, there was no evidence that the outcomes were, as yet, routinely analysed and used to influence the development of the service at ward level.

Service planning and delivery to meet the needs of local people

- Staff followed the trust's escalation policy to alert bed managers when the ward became busy.

Services for children and young people

- We saw that effective action was taken to ensure that the service remained responsive to patients' needs, such as alerting ambulance services and so ensuring that admissions from this route were diverted to other children hospitals.

Access and flow

- Fairfield is a 15-bedded ward. On the day of the visit, five children were being treated as inpatients, and were attending the ward following referral from the A&E department; returning to the ward through direct access from GP referrals or through direct access agreed as part of the discharge plan. This meant that the admissions process was flexible and responsive.
- The matron informed us that bed occupancy for the unit was usually 60% that is within the 85% 'maximum' recommended by the Department of Health.

Meeting people's individual needs

- The trust has a translation policy and access to a translation service, but when we asked about people who did not have English as a first language, staff did not tell us about accessing the service.
- There was a small kitchen and we saw that drinks and simple snacks could be prepared.
- The milk room was clean and the ward kept a number of different brands of baby milk in stock.
- The ward provided leaflets about aftercare for common childhood conditions.
- Provision of information was confirmed as a part of the patient discharge process.

Learning from complaints and concerns

- Information in the recent quarterly audit report for October, November and December 2013 showed that seven complaints or concerns had been raised about the ward. The audit showed that each had been resolved.
- The report did not show an analysis of trends regarding these complaints and there was no indication of lessons learned from the investigations.
- One complaint was investigated as a part of a serious incident review.
- All complaints had been closed.
- Complaint data for 2014 had not been analysed at the time of the inspection.
- We saw that complaints leaflets were readily available on the ward.
- We saw 'I want great care' questionnaires on the Fairfield ward because this programme of patient consultation was about to commence for children on the ward.

Are services for children and young people well-led?

Requires improvement

The leadership on the paediatric ward and special care baby unit at West Cumberland hospital requires improvement. There was no comprehensive and robust strategy in place to identify all the areas that required improvement so that good quality and safe care and treatment was consistently provided on the children's ward or SCBU.

This meant that processes in place did not inter-relate so that comprehensive and sustained improvements could be achieved. The trust had not taken sufficient steps to engage staff with the changes required to promote good quality and safe care and treatment.

Vision and strategy for this service

- The operational leadership for the hospital's children's ward had experienced recent changes and it was not clear what longer term strategies would be put in place to improve and sustain improvements in the service.
- Senior managers confirmed that the trust board was considering commissioning a high level independent peer review of the paediatric service.

Governance, risk management and quality measurement

- The risk register lacked depth and did not fully address and reflect the risks highlighted in the various reports, data and quality measurements available to the service and trust.
- There was insufficient evidence that action to mitigate risks had been followed through, for example, staff training for using equipment on the children's ward or in the SCBU.

Services for children and young people

Leadership of service

- The leadership team in the paediatric department could not provide evidence that children's medical, social and emotional needs were consistently being risk assessed and planned for in accordance with good practice guidance.
- Information provided by the trust showed that the most recently recorded team meeting on the paediatric ward at West Cumberland Hospital had taken place in July 2013, meaning that an effective forum for sharing information had not been used. Although we were informed that meetings had been held in 2014.

Staff engagement

- Although we were told meetings with staff were held, they were not documented. For staff to be meaningfully engaged in the delivery and improvement of the service there needs to be active, documented engagement and actions from that engagement.

End of life care

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

Information about the service

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

We spoke with staff on each of the wards which we visited. We also spoke with members of the Cumbria Partnership NHS Foundation Trust's specialist palliative care team and with the Macmillan nurse who supports end of life patients and their families.

We reviewed care records and policies and procedures as part of the inspection of this service. We reviewed performance information and received comments from the listening event.

Summary of findings

The hospital followed the guiding principles of the Liverpool Care Pathway but had reviewed its use of the formal protocols and effectively used end of life care plans. Care was given by supportive and committed staff that were passionate about providing a good service.

Care for patients at end of life was supported by a specialist palliative care team employed by the Cumbria Partnership NHS Foundation Trust and there was excellent multi-disciplinary working across the acute trust. Nursing staff were appropriately trained to deliver end of life care.

Patients and their families were fully involved in discussions about their care and treatment needs. Staff in the mortuary delivered a quality service. The chaplaincy service was expanding its spiritual and bereavement support and relatives and patients were able to access multi-faith support.

There was a lack of trust and local vision and strategy for end of life care and a consequent lack of leadership at senior and board levels.

End of life care

Are end of life care services safe?

Good

Services for people at the end of life were good. They were assessed and care delivered safely including medicines. Ward staff received training from the specialist palliative care team and from the local hospice.

The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.

DNA CPR forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves, or where that was not appropriate, it had been discussed with the patient's relatives. Patients who did not have capacity to consent to end of life care were treated appropriately.

Incidents

- The mortuary technician informed us that transfers from the wards were appropriately managed and there had been no incidents that required reporting.

Cleanliness, infection control and hygiene

- Ward areas were clean and we saw staff regularly wash their hands.
- We saw that bare below the elbow policies were adhered to.
- The mortuary adhered to infection control procedures and a risk assessment was undertaken on all patients who had died from blood borne diseases.

Environment and equipment

- Equipment such as syringe drivers was readily available for patients in need and once a patient had been identified as having palliative care needs.

Medicines

- Anticipatory medication was appropriately prescribed.
- Out of normal hours, staff were able to access medication, such as for pain management and syringes, by contacting the on-call pharmacist or by accessing the medication stored on other wards, particularly the Loweswater Suite.
- The Macmillan Nurse, employed by Cumbria Partnership Trust was a nurse prescriber.

Records

- Patients' care and treatment were recorded in individualised care plans that were regularly reviewed. Patients' wishes were recorded and met appropriately.
- DNA CPR (Do not attempt cardio-pulmonary resuscitation) forms were appropriately completed and we found that the decision had either been discussed with the patient themselves, or where that was not appropriate, with other professionals and in consultation with the patient's family so that a best interest decision was made.
- Care needs for patients at the end of life were shared and discussed on a continual basis at shift handovers, by using a communication book and at weekly ward meetings.
- In response to the national withdrawal of the Liverpool Care Pathway (LCP), staff informed us that they understood the trust was developing its own End of Life care guidance.
- Staff were currently using end of life care plans rather than the formal LCP documentation

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to review the needs of a patient with fluctuating capacity to consent in response to their changing needs.
- Staff discussed care options with the patient and /or their relatives to enable them to make informed choices. If patients lacked capacity to make their own choices staff consulted with appropriate professionals so that decisions were made in the best interests of the patient.

Mandatory training

- Ward staff received training from the specialist palliative care team and from the local hospice to support best practice for patients at the end of life.
- Wards were involved with using the AMBER care bundle, an alternative communication method to highlight when there was clinical uncertainty about whether a patient may recover and to ensure that their preferences and wishes around end of life care could be identified and met.

Nursing staffing

- A MacMillan Nurse supported ward staff to care for patients at the end of life.

End of life care

- Hospice at home support nurses came on to the wards to provide additional one-to-one support to patients.

Medical staffing

- There was no substantive consultant in post for specialist palliative care.
- The 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 also impacted on the education and training able to be provided to staff in relation to effective end of life care.
- Out-of-hours cover (weekend and nights) was provided by the doctors providing medical services cover.
- Handovers were conducted by the nursing staff to maintain continuity of care.

Are end of life care services effective?

Good

Staff told us that they followed the guiding principles of the Liverpool Care Pathway but following a review the trust no longer formally followed the processes and protocols of this Pathway. Staff informed us that the trust was in the process of developing alternative documentation to use for people who were at the end of life, which must be in place by July 2014.

All staff reported excellent multi-disciplinary working between the Loweswater Palliative Care Suite and the palliative care team operated by Cumbria Partnership NHS Foundation Trust, and patients in the medical wards. Telephone advice was available on a 24-hour basis.

Evidence-based care and treatment

- Staff told us that they followed the guiding principles of the Liverpool Care Pathway but the trust no longer formally followed the processes and protocols of this pathway.
- Staff identified that having a clear 'pathway of care' for end of life would improve the service they could offer and felt the loss of the Liverpool Care Pathway as a professional tool.
- Wards maintained files containing strategic information, policies and procedures on end of life and palliative care.
- The hospital had acted on the Department of Health's National End of Life Strategy recommendations. They had introduced the AMBER care bundle. This is an approach used when clinicians are uncertain whether a patient may recover and are concerned that they may have only a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should end of life care be planned.

Pain relief

- Pain and discomfort was well managed for patients at the end of life.
- Staff were able to access medication, for pain and equipment such as syringe drivers out of hours, by contacting the on-call pharmacist.
- The palliative care team supported staff in prescribing and reviewing appropriate pain relief.

Nutrition and hydration

- Most of the patients we spoke with were complimentary about the meals served at the trust. People had a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.
- Staff were able to meet peoples' religious and cultural needs regarding food.
- Patients' dietary requirements were appropriately met and there was specialist support for patients who were unable to take diet and fluids orally.

Patient outcomes

- At the request of the North Cumbria acute trust, the Cumbria Partnership NHS Foundation Trust specialist palliative care team had recently completed an audit of end of life care patients across the trust, looking at 19 sets of patient notes.
- The audit indicated that about half of the patients reviewed had been involved with the palliative care team.
- Other key findings were: all patients had an appropriately completed DNRCPR form, most patients had been prescribed 'just in case' medication, the majority had records of conversations with families, and all had documented discussions with patients.

End of life care

- From our conversations with staff it was apparent that they were working to the principles of the Leadership Alliance for the Care of Dying People guidance, but this could not be supported with documentation.

Competent staff

- Staff told us they received regular specialist palliative care training from Cumbria Partnership's palliative care team and from Hospice at Home.
- There was guidance available on the wards to support staff in providing good quality care for patients at the end of life.

Multidisciplinary working

- All staff reported excellent multi-disciplinary working between the Loweswater Palliative Care Suite and the palliative care team operated by Cumbria Partnership NHS Foundation Trust.
- Staff mentioned regular positive communication between themselves, and an excellent relationship with the specialist palliative care team provided by Cumbria Partnership NHS Trust.
- They had good communication with other wards and other colleagues such as occupational therapists, physiotherapists and radiologists.
- There was good communication with GPs, and for those patients who wished to die at home discharge arrangements could be fast tracked within 24 hours.

Seven-day services

- The palliative care team based on Loweswater Suite was available from 9am to 5pm Monday to Friday to staff and patients in West Cumberland Hospital.
- Out-of-hours support was provided by telephone hotline to the Loweswater Suite and to wards, operated by Cumbria Partnership NHS Foundation Trust, and by a telephone hotline to the local hospice.

Are end of life care services caring?

Good

Throughout our inspection we saw patients being treated with compassion, dignity and respect. Staff were very supportive to both patients and those close to them and offered emotional support to provide comfort and reassurance. The bodies of deceased patients were treated with dignity when going from the wards to the mortuary.

Compassionate care

- Throughout our inspection we saw patients being treated with compassion, dignity and respect.
- Staff worked hard to help individual patients to achieve their wishes at end of life that included facilitating people to get married on the ward and to visit local places of special meaning to them.
- Normal visiting times were waived for relatives of patients who were at end of life.
- Mortuary services offered a well-appointed and appropriately furnished viewing room, although the initial reception area was very small and cramped.
- The bodies of deceased patients were treated with dignity when going from the wards to the mortuary.

Patient understanding and involvement

- Ward staff told us they worked hard to understand and support the needs of patients with dementia or with a learning disability, and checked with patients' relatives what they believed the patient's wishes to be.
- Staff worked hard to establish a good rapport with patients and those close to them.
- Staff encouraged patients to ask questions about their care and responded openly and honestly.
- Patients and their families were fully involved in discussions about their care and treatment needs including discussions about whether to be transferred to a room within the Loweswater palliative care Suite or to remain on the medical ward.

Emotional support

- Staff were very supportive to patients and those close to them and offered emotional support to provide comfort and reassurance.
- We found patient records were completed sensitively and staff had undertaken detailed discussions with patients and relatives.
- Staff referred patients to other support services such as the chaplaincy.
- The hospice at home nurse came onto the wards to meet with families and patient before discharge to offer one-to-one psychological support

End of life care

Are end of life care services responsive?

Good

Palliative care was offered on all wards and supported by the Loweswater Suite. Service support was available 24 hours a day. Wards were using the AMBER care bundle, an alternative communication method to highlight when there was clinical uncertainty about whether a patient may recover and to ensure that their preferences and wishes around end of life care could be identified and met.

Where possible, side rooms were prioritised for patients at their end of life and when appropriate, patients were transferred to the Loweswater Suite for palliative care where all rooms were single. However, staff felt there were insufficient palliative care beds. Patients often had to be cared for on busy medical wards. This situation should be improved when the new unit is built, which will offer 30 beds with ensuite cubicles.

All faiths were able to use the chapel. A prayer room and prayer mats were available and the chaplaincy was available 24 hours a day, seven days a week.

Service planning and delivery to meet the needs of local people

- The palliative care team based on Loweswater Suite were available 9am to 5pm Monday to Friday to staff and patients in West Cumberland Hospital.
- Out-of-hours support was provided by telephone hotline to the Loweswater Suite and wards, operated by Cumbria Partnership NHS Foundation Trust, and also by a telephone hotline to the local hospice.

Access and flow

- Where possible, side rooms were prioritised for patients at their end of life.
- When appropriate, patients were transferred to the Loweswater Suite for palliative care where all rooms were single occupancy.
- There was good patient flow between Loweswater Suite and Copeland Unit to accommodate acute hospital patient admissions.
- GPs can admit patients directly onto the Loweswater Suite and 'on-call' medical cover is now provided by Cumbria Health On Call Ltd.
- Staff felt there were insufficient palliative care beds. Patients often had to be cared for on busy medical wards. This situation should be improved when the new unit is built, which will offer 30 beds with en-suite cubicles.
- Staff informed us that they worked closely with the discharge liaison nurse, the community matrons and the hospice at home nurse to enable patients to be discharged home if that was their preferred location to die.
- They were able to 'fast track' patients to return home within 24 hours.

Meeting people's individual needs

- Patients at end of life were offered a range of alternative therapies.
- A chaplain had recently been appointed to run the service at West Cumberland Hospital. He was able to offer increased hours of support which was a jointly funded service with the diocese and was now developing the chaplaincy service.
- The chaplain was involved with designing the new spiritual centre within the new build unit.
- Whilst the chaplaincy service also included sessional chaplains and volunteers, it was felt that the bereavement support and spiritual care had previously been a 'forgotten' service in the hospital, with each department 'doing their own thing' but that the trust was now acting to rectify this.
- All faiths were able to use the chapel and a prayer room and prayer mats were available.
- Chaplaincy was available 24 hours a day, seven days a week. Staff demonstrated an understanding of and respect for the needs of patients with multi-faith needs and ward staff were able to make contact with other faith leaders through the chaplaincy service or the hospital switchboard, which holds a register of contacts for all faiths.
- The chaplaincy service and the wards were working collaboratively to offer friends and relatives the 'Family's Voice' leaflet to complete.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- The trust did not provide a bereavement office on site and all patient paperwork and belongings had to be collected from the wards.

End of life care

- Ward staff provide families with a bereavement booklet and contact numbers and families do return to the wards following the death of their family member.
- If a patient died and the family were not present, the staff ensured that they offered the family the opportunity to come to the ward before the deceased person was moved to the mortuary.
- The mortuary was going to be moved into the new build unit and the mortuary technician had been involved in the design of this unit.
- Care was delivered on the medical wards and side rooms were made available whenever possible. Arrangements could be made for a bed to be set up in the side room if family members wanted to stay with their relative at end of life.
- Telephone advice was available 24 hours a day and a form had been recently devised for referrals to the hospital palliative care team, which included recording requests for telephone advice.
- Staff had regular liaison with the local hospice.
- Staff referred patients for discharge planning to the discharge team and liaised with the District Nursing service for specialist equipment.
- Staff regularly referred patients to the hospital chaplain service.
- The trust had recently placed an advertisement for bereavement support workers.
- The mortuary technician often provided informal bereavement support.

Learning from complaints and concerns

- We saw that complaints leaflets were readily available on the ward although the information was inaccurate in relation to the role of CQC.

Are end of life care services well-led?

Requires Improvement

There was a lack of trust and local vision and strategy for end of life care and a lack of clarity of organisational structure to develop the service for the future. There appeared to be a lack of ownership about end of life care at trust level. Staff said that there was a lack of an End of Life Care strategic group operating within the trust.

Since the national withdrawal of the Liverpool Care Pathway, the trust had not yet developed a formal End of Life Care standard framework. There was a lack of leadership at senior and Board level and staff did not appear to be aware of who in the trust had responsibility or dedicated leadership for end of life care. There was no substantive consultant in post for specialist palliative care, giving a lack of consultant continuity.

Verbal feedback from patients and visitors was very positive.

Vision and strategy for this service

- There was a lack of a trust and local vision and strategy for end of life care.
- There was a lack of clarity regarding the organisational structure to develop the service for the future.
- As specialist palliative care is provided to West Cumberland Hospital by Cumbria Partnership NHS Foundation Trust, this cross provision has added complexity to the issues of leadership and engagement at senior management and Board levels.
- There was a lack of ownership about end of life care within the trust.
- It was unclear if there a Non-Executive Director with a lead for end of life care.

Governance, risk management and quality measurement

- Since the national withdrawal of the Liverpool Care Pathway, the trust had not yet developed a formal End of Life Care standard framework to assure safe effective care at the end of life.
- Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014 and no training package has yet been agreed to support these changes.

Leadership of service

- Staff were passionate about providing good end of life care and very keen to improve the service.
- The service was well led at clinical, middle management and ward level.
- There was a lack of leadership at senior and board level and staff did not appear to be aware of who in the trust had responsibility and a leadership role for end of life care.
- Staff said that there was a lack of an end of life care strategic group operating within the trust.

End of life care

Culture within the service

- Staff providing end of life care were committed, dedicated and hardworking and spoke positively about the service they provided.
- There were excellent relationships between clinical and ward staff and other services within the trust, and between the hospital staff and the Cumbria Partnership specialist palliative care staff.
- Staff had built up good personal working relationships, but felt that this was not happening at a senior or strategic level.

Public and staff engagement

- Staff were not able to articulate the organisation's quality goals and priorities for end of life care.
- Staff were seeking direction as they felt they were not engaged in the wider development of the service.

Innovation, improvement and sustainability

- Staff felt that end of life care did not have a high profile within the trust and was not recognised as a specialism.

Outpatients

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

Information about the service

The hospital's outpatients department provides services across a wide range of medical and surgical services. It offers a one-stop clinic in urology.

In 2012/2013, 293,915 patients used the outpatients departments across the trust's two hospitals.

Summary of findings

Overall, patients received safe and appropriate care in the department. 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.

Staff 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. It was clear that staff were very committed and worked to achieve the best outcomes for patients.

However, outpatient services were less effective because of an issue regarding the management of systems for patient records, which impacted on both staff and patients with 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. This has already been recorded as high risk on the trust's risk register. A recent case note audit undertaken in March showed that there had been a 25% shortfall in case notes being delivered on time or fully completed.

Outpatient clinics were generally comfortable and friendly with suitable facilities. Oncology and digital

Outpatients

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.

There was evidence of practice being supported by best practice guidance. There was good continuity of nursing staff in the department and they received favourable patient feedback. The team was supported by specialist nurse roles.

Although patients we spoke with did not complain about the waiting times, staff said that additional weekend clinics were needed to meet demand.

Although some additional outpatient clinics had been arranged we saw that clinics were stretched. Problems with recruiting consultants also affected clinics. The general manager had taken action to mitigate this. Senior nursing staff always ensured that all support services (staff and room) were in place to support the additional clinics but insufficient strategic capacity planning and overbooking of clinics was masking the overall picture. This was resulting in long waits for patients.

The lack of CT/MRI capacity had been recognised at Board level and funding was in place to obtain new equipment and efforts were being made to recruit additional radiologists.

Overall there was a positive view about the role of the new tier of management, General Managers; they were felt to be effective. The Chief Executive was felt to be a strong leader and the staff felt it was good to have stability at the top. The Chief Executive was said to be visible with a genuine desire to find out what was going on, answer questions and find out what the issues are and how to resolve them.

Are outpatients services safe?

Inadequate

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, there was a serious issue/safety breach regarding the management of systems for patient records, which impacted on both staff and patients. This has already been flagged as high risk on the trust risk register.

Incidents

- Senior staff were aware of how to escalate incidents.
- Staff and consultants regularly completed the Ulysses safeguarding incident report forms to report incidents of incomplete medical records and late arrival of records at clinics.
- Medical records staff found it challenging to find the time to complete incident reporting and were unable to put policies and procedures into place due to workload e.g. procedures for misfiling.
- The number of clinics and demand for them has increased, but the size of the medical records staff team has decreased.
- This situation with medical records has already been flagged as a high risk on the trust's risk register.
- The clinic coordinators were currently undertaking a daily audit of medical records and collecting information on time of arrival and missing information.
- The diagnostic imaging department operated a clear error reporting system.

Cleanliness, infection control and hygiene

- Clinical areas were clean and tidy and we saw staff wash their hands and use hand gel between patients.
- There was an ample supply of hand washing facilities and there was ample signage to encourage the public to wash their hands.
- We saw staff wearing clean uniforms, following 'bare below the elbow guidance' and adhering to the hospital's policy on control and prevention of infection.

Environment and equipment

- The physical environment for medical records was poor, case notes were sometimes left on floors in an unhygienic environment.

Outpatients

- Some staff expressed concerns that the situation could deteriorate if/when the medical records were moved off site.
- There were issues with storage of equipment as outpatients had lost storage when the orthotics department moved into the premises. They used to have a good supply of appliances but this is now not possible due to lack of space.

Records

- Medical records regularly arrived late for outpatient clinics and were often incomplete.
- On the day of our inspection one clinic had three sets of notes missing.
- Medical records staff were working extra hours to track lost files.
- There is a policy of archiving records but limited staff capacity to undertake the task. Staff told us that there are hundreds of sets of notes waiting to be archived.
- Patients had two sets of case notes if they were seen on, or using, services on both sites. A temporary team was working to merge the case notes but the task was not yet completed for some patients.
- Clinic staff were working extra hours to prepare case notes due to their late arrival and the need to prepare case notes quickly.
- Staff identified this as their biggest cause of concern and said that lack of records sometimes meant the service was unsafe.
- The General Manager had employed a temporary case note 'runner' at band 2 to fetch missing files to mitigate the impact on patients. This temporary appointment had now ceased due to budget issues.
- A recent case note audit undertaken in March showed that there had been a 25% shortfall in case notes being delivered on time or fully complete.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records for outpatients state that 95% of staff have received MCA level 1 training and of the specified staff groups, 100% have received level 2 MCA training.
- Trust records state that 100% of staff have received training in learning disabilities.

Safeguarding

- Staff understood and could identify issues of abuse and neglect and knew how to escalate their concerns appropriately.
- Training records confirmed that 100% of staff in the department had received safeguarding training.

Mandatory training

- If clinics were cancelled at short notice, senior staff arranged for staff to use their time by undergoing training.
- Training is accredited and senior staff undertake competency assessments, which are signed off and noted in the staff CPD files.
- Trust records state that 100% of staff have received training in learning disabilities.
- 100% mandatory training had been achieved in the radiology department.

Nursing staffing

- Clinics generally operated on the basis of 40% qualified staff and 60% health care assistant band 3.
- Health care assistants were trained to a high standard with extended skills, and were empowered to take ownership of and manage clinics with minimal supervision.
- An analysis of the corresponding nursing hours needed for the additional clinics had led to a formal request for additional nursing hours and this had been put in place in December 2013.

Medical staffing

- Medical staffing in clinics was adversely affected by the consultant vacancies. This meant that clinics were cancelled at short notice or ran late due to the unavailability of consultant medical staff. Patients waited for long periods to see a consultant in some clinics.

Are outpatients services effective?

Not sufficient evidence to rate

There was evidence of practice being supported by best practice guidance. There was good continuity of nursing staff in the department and they received favourable patient feedback. The team was supported by specialist nurse roles. Staff appraisal and supervision was not received consistently.

Although patients we spoke with did not complain about the waiting times staff said that additional weekend clinics were needed to meet demand.

Outpatients

Evidence-based care and treatment

- Audit of fine needle aspiration in digital imaging led to a change in practice in the use of scanning equipment.
- Digital imaging was following best practice in use of intravenous contrast in CT scans.
- Digital imaging was following NICE guidelines for detecting prostate cancer and risk category-use of MRI for 'active surveillance', which has increased the request for MRI scans.

Pain relief

- Medicines were stored and handled appropriately, including pain relief.

Patient outcomes

- A cardiology patient stated that they had no issue with lengthy clinic waits as "consultant does not rush you and everyone is treated fairly."
- One parent of a child told us they were extremely happy with the care their child received.
- A patient in haematology stated that they was happy with care, "staff explain everything they are doing and ask permission", "I have had to wait around on occasions but overall I'm pleased with waiting times."
- Concerns were expressed about having to travel to Carlisle in the future, as many new patient (haematology) referrals were already going there.

Competent staff

- Specialist nurses were working in the department and a specialist haematology nurse had recently been appointed.
- Health care assistants were trained to a high standard, with extended skills and were able to support and manage clinics.
- Senior nursing staff identified during appraisals the skills that nurses and particularly health care assistants needed to develop and arranged appropriate development opportunities.
- Staff said that supervision happened regularly but was on an informal basis and notes were not kept. 'Supervision' also included observed practice on a day-to-day basis. Competency assessments of staff were undertaken.

Multidisciplinary working

- There was evidence of good multi-disciplinary working in outpatients. Staff genuinely valued each other's role and contributions to service delivery.
- Clinical staff worked closely with co-ordinators to avoid clinic breaches.

Seven-day services

- Staff said that additional weekend clinics were needed to meet demand.

Are outpatients services caring?

Good

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 caring and worked to achieve the best outcomes for patients.

Compassionate care

- Patients and relatives waiting at clinics were all very positive about the care provided by staff.
- Staff spoke with patients respectfully and were open, caring and friendly in their approach.
- Staff listened to patients and responded positively to questions and requests for information.
- One senior nurse said, "We treat everyone like our own family members."

Patient understanding and involvement

- Patients we spoke with said they felt that they had been involved in decisions regarding their care.
- Patients expressed concern about the hospital outpatients closing, as they would not want to travel to Carlisle.

Emotional support

- Patients and relatives told us they were supported when they had arrived at the service and were helped to find the correct clinic and kept informed of waiting times by supportive and helpful staff.
- Reception and nursing staff spoke very sensitively and softly with a patient who was tearful and in pain, offering reassurance and comfort.

Are outpatients services responsive?

Outpatients

Requires improvement

Although some additional outpatient clinics had been arranged we saw that clinics were stretched. This was compounded by the required six weeks' notice of cancellation of clinics by consultants, which quite often did not happen, resulting in a high level of short notice clinic changes. Problems with consultant recruitment also affected clinics. This was particularly noticeable in gastroenterology, respiratory, dermatology and cardiology. The general manager had taken action to mitigate this by placing a ban on overbooking and focusing on correctness of clinic template.

Senior nursing staff always ensured that all support services (staff and room) were in place to support the additional clinics but there was insufficient strategic capacity planning and overbooking of clinics was masking the overall picture. This was resulting in long waits for patients. Patients were verbally informed of waiting times at their clinic appointments.

The lack of CT/MRI capacity had been recognised at Board level and funding was in place to obtain new equipment and efforts were being made to recruit additional radiologists.

Service planning and delivery to meet the needs of local people

- The service has established additional respiratory clinics to meet demand and reduce waiting times.
- A one-stop clinic was operating in urology as a result of increased demand for this service following increased health promotion and public awareness. Arrangements were in place so that patients returned for results and review after three weeks.
- Some specialisms such as gastroenterology, respiratory, dermatology and cardiology were experiencing difficulties in scheduling and providing appointments as a result of problems in recruiting consultants, high patient demand and short notice clinic changes.
- Short notice clinics were frequently arranged to meet patient need, particularly in respect of the two-week waiting targets.
- Senior nursing staff always ensured that all support services (staff and rooms) were in place to support the additional clinics, but there was insufficient strategic capacity planning to tackle some of these issues robustly.
- There was an issue of overbooking at clinics, which masked capacity issues and led to long patient waits. The General Manager had taken action to mitigate this by placing a ban on overbooking and focusing on accurate clinic templates.
- The lack of CT/MRI capacity had been recognised at Board level and funding was in place to obtain new equipment. Efforts were also being made to recruit additional radiologists. A paper requesting additional funding for skilled staff and funding of additional MRI sessions had been presented to the board in September 2013. Approval had been received and recruitment had started immediately.
- Demand exceeds capacity for the scanners. Provision is currently achieved by contracting with a private provider for a mobile scanner for four days a week.
- There are plans to commission a static MRI scanner at Whitehaven.

Access and flow

- All oncology patients are seen at outpatients within the two-week timescale as per national guidance.
- The service was monitoring the 18 weeks wait at weekly meetings. Data provided by the trust showed they were meeting the 18 week wait target.
- The required six weeks' notice of cancellation of clinics by consultants often did not happen and there was a high level of short notice clinic changes.
- Patients were verbally informed of waiting times at their clinic appointments.

Meeting people's individual needs

- Patients were taken into private consultation rooms to protect their confidentiality and privacy.
- Clinics often started late and overran as a consequence of waiting for records to arrive.

Learning from complaints and concerns

- Incident reporting is fed back at the weekly governance meetings and staff now feel supported that senior management are dealing with complaints about patient care.

Outpatients

- The service has received complaints from patients about having several appointments cancelled, particularly in urology and gastroenterology.

Are outpatients services well-led?

Good

Overall, there was a positive view about the role of the new tier of management, General Managers, they were felt to be effective, but also that they had a very large remit. The Chief Executive was felt to be a strong leader and the staff felt it was good to have stability at the top. The CE was said to be visible with a genuine desire to find out what was going on/ answer questions/ find out what the issues are and how to resolve them.

Senior managers held regular departmental meetings to discuss and monitor departmental performance. 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 secure the required improvements.

Overall, staff felt valued and well-led. There were some exceptions to this. A few staff felt the organisation was not well-led and there was low morale.

Vision and strategy for this service

- The overall vision for the trust was visible throughout the outpatient area. It was available in poster format and on video.
- Most staff felt that the chief executive was cascading a strong vision that had previously been lacking and that the chief executive was clear about the trust's priorities.
- A review was taking place of the need for outpatient services across the county using data and demand analysis to determine the need for outpatient services on peripheral sites.
- While frontline staff were committed to ensuring that support was available to meet new and short notice clinics, they felt that the trust had not always undertaken sufficient advance capacity planning or considered the need for support services to be available when arranging additional clinics.

Governance, risk management and quality measurement

- Feedback from managers showed they felt the trust had now developed good governance arrangements and there was a strong audit trail of decisions and action planning.
- Monthly directorate meetings were held to discuss 'dashboard' monitoring-waiting times/actions times/ reporting times.
- Clinical section leads met weekly to discuss safety issues across modalities and issues were escalated weekly. Performance reports were provided monthly.
- Additional funding had been achieved through winter pressures funds, which had funded various initiatives including additional weekend mobile imaging provision. This funding had ceased at end of March and following a benefits realisation paper the funding was now fully included in the trust's budget.
- There was a weekly print out in digital imaging of patients waiting for each modality. Data was assessed using a capacity and demand planning tool, which ensures that patients waiting longest are seen first.

Leadership of service

- Overall staff held a positive view about the role of the new general manager tier of management, and they were felt to be effective, but staff acknowledged that they had a large remit.
- The Chief Executive was felt to be a strong leader and staff felt it was good to have stability at the top of the organisation. The Chief Executive was said to be visible with a genuine desire to find out what is going on, answer questions, find out what the issues are and how to resolve them.
- Overall, staff felt valued and well-led. There were some exceptions to this. A few staff felt the organisation was not well-led and there was low morale within the service.

Culture within the service

- Staff were very loyal, flexible and long established, from a mainly local workforce.
- There was an overwhelming view that services worked so well due to 'goodwill' of staff.
- Staff coped well with the continual challenges within the service and demonstrated a commitment to address them.
- Overall staff were positive about their future at the trust.

Outpatients

Public and staff engagement

- There were opportunities for the public to provide feedback about the service.
- Children could contribute to service evaluation by completing a new 'easy read' satisfaction survey form with faces with different emotions – unhappy to happy.

Innovation, improvement and sustainability

- The digital imaging department has been working with Northumbria University to become part of a training programme to develop and train radiographers. The hope is that this will also lead to benefits in terms of eventually recruiting 'homegrown' consultant radiologists.
- West Cumberland has been approved as a placement centre for student radiographers.
- The department is also training its own stenographers to support timely record keeping and correspondence.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure that there are sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients at all times.
- Ensure medical staffing is sufficient to provide appropriate and timely treatment to patients at all times.
- Ensure that all departments within the hospital have the required skills to meet the needs of patients at all times.
- Improve the support given to junior medical staff.
- Take action to ensure that the planning and delivery of patient care and treatment is consistently carried out in accordance with published research and guidance issued by professional and expert bodies.
- Take action to protect the health and welfare of children and young people with mental health needs by ensuring that timely health and social care support is provided in collaboration with other providers.
- Take action to improve the patient flow through the hospital to cope with the routine workload and reduce patient waiting times.
- Work towards achieving the target of no more than 18 weeks wait from referral to treatment.
- Improve the standard of nursing records in the paediatric service.
- Develop clear action plans to assess and manage the impact of the lack of a dedicated second theatre and no provision for urgent obstetric/gynaecology surgery at the hospital.
- Take action to ensure that patient records are fully complete and up to date and made available in a timely way for all outpatient clinic appointments.
- Develop a formal End of Life Care standard framework to assure safe, effective care at the end of life. Plans need to be in place to formally replace the Liverpool Care Pathway by July 2014.
- Ensure the security roles and responsibilities of the portering staff when dealing with violence and aggression are within the acceptable parameters of legal restraint.

Action the hospital SHOULD take to improve

- Improve the management of people with diabetes, stroke and people with a diagnosis of dementia in line with national guidance.
- Ensure that staff have the opportunity to discuss their personal development and any issues or concerns they may have regularly.
- Ensure the safety and security of all patients, staff and visitors who attend the A&E department by training all the staff on the procedures to follow in the event of a security or safety incident.
- Improve access to CT/MRI scanning to ensure patients receive a scan quickly.
- Improve reporting times for radiology and CT scans so that patients receive timely results to improve the quality of treatment outcomes.
- Ensure the maternity service has the ability to undertake grade 3 caesarean sections.
- Ensure the trust's information regarding 'How to make a complaint' is accurate.
- Ensure the infrastructure is in place before establishing additional outpatient clinics.
- Ensure there is a clear vision and strategy for end of life care and provide clear leadership for end of life care both at director and non-executive director levels.
- Provide staff training for the implementation of care bundles.
- Review the lack of standardisation across trust locations such as the availably of evening clinics for early pregnancy advice and access to termination of pregnancy clinics.
- Continue to develop robust audit processes to verify staff adherence to the 'five steps to safer surgery' checklist.
- Review the lack of standardisation across trust's locations, such as the availably of evening clinics for early pregnancy advice and access to termination of pregnancy clinics.