

University Hospitals of Morecambe Bay NHS Foundation Trust

Quality Report

Westmorland General Hospital
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This report describes our judgement of the quality of care at this trust. 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 trust	Inadequate	
Are acute services at this trust safe?	Inadequate	
Are acute services at this trust effective?	Good	
Are acute services at this trust caring?	Good	
Are acute services at this trust responsive?	Requires improvement	
Are acute services at this trust well-led?	Inadequate	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	3
The five questions we ask about trusts and what we found	6
What people who use the trust's services say	9
Areas for improvement	9
Good practice	9

Detailed findings from this inspection

Our inspection team	10
Background to University Hospitals of Morecambe Bay NHS Foundation Trust	10
Why we carried out this inspection	11
How we carried out this inspection	11
Findings by main service	13

Summary of findings

Overall summary

University Hospitals of Morecambe Bay NHS Foundation Trust is a large acute hospital provider serving the population of south Cumbria and north Lancashire. The trust was established in 1998 and gained teaching status in January 2006. Services provided at the trust are commissioned by two clinical commissioning groups based in Lancashire North and Cumbria.

The trust provides services from three principal sites to a population of 365,000, covering south Cumbria, north Lancashire and surrounding geographical areas. The sites are: Furness General Hospital in Barrow; Royal Lancaster Infirmary in Lancaster and Westmorland General Hospital in Kendal. The trust also provides outpatient services at Queen Victoria Hospital in Morecambe, at Ulverston Health Centre and in a range of community-based facilities. The trust has approximately 5,000 staff. In 2012/13 the trust had an income of £280 million.

Furness General and the Royal Lancaster Infirmary have a range of general hospital services, with full A&E departments, critical/coronary care units and consultant-led beds. Westmorland General Hospital provides a range of general hospital services, together with a Primary Care Assessment Service (PCAS) with GP-led inpatient beds, operated by the Cumbria Partnership NHS Foundation Trust.

All three sites provide a range of planned care, including outpatients, diagnostics, therapies, day-case and inpatient surgery. In addition a range of local outreach services and diagnostic services are provided from a number of community facilities across the community.

Governance, strategy and leadership

The trust had a long history of turbulence, including a high turnover of senior leadership. There have been significant changes to the trust board since 2012. The entire board of Directors has changed since 2012 with 14 new appointments made, including the Chief Executive. In the seven months prior to our inspection four executive directors had taken up post.

Governance systems have been strengthened by dividing clinical services into five clinical divisions and appointing substantive clinical leaders to each division.

However, there was no clear strategy for the future provision of services across the trust. The strategic plans and risks were not well known at ward or team level. There was a heavy reliance on the 'Better Care Together' strategy that was still in development to address the long standing financial, geographical and service re-configuration challenges facing the trust.

In addition, there was a lack of robust data and key performance metrics to support and underpin performance and achievements. Key performance and safety information was not collected and collated in a consistent and a systematic way. We found that the trust had systems and processes in place for governance and risk management. However, the implementation and quality of the systems was variable. Risk management required improvement in a number of services across the organisation. The risk register did not clearly set out risks, controls, gaps in controls and sources of potential assurance. The issues in relation to staffing shortfalls on the CCU/HDU was a clear example of this.

The systems for reporting incidents were not consistently followed and there was a lack of clarity in some services about the range and nature of reportable incidents. Performance information and learning from the incidents that were reported was not effectively or consistently used to drive changes and improve practice.

The trust has a higher number of reported 'never events' than similar trusts. A review of outcomes of investigations, including root cause analysis of serious untoward incidents, continues to suggest areas of concern where similar themes are repeated e.g. failure to follow guidelines/protocols and embedding the learning from previous incidents. Similarly the use of information from local audits was not consistently applied to secure improvement and manage risks. We found examples of local audit identifying performance and practice shortfalls that were not adequately addressed by action planning and appropriate escalation.

There was little evidence of the impact of a cultural change programme that promoted an identity of a fully merged trust. There were different cultures in all the three hospitals we inspected and staff were loyal to their 'home hospital'. Although the clinical directors, senior medical

Summary of findings

and nursing staff within divisions were working and communicating across the three sites, the majority of other staff were not communicating with their counterparts in other hospitals. We saw little evidence of cross bay working at the time of our inspection with the exception of the productive theatre initiative.

Front line staff did not see themselves as part of the wider organisation.

Staff Engagement

Staff reported that they felt disconnected from the executive team and from the board. They felt that, with the exception of the executive nurse, the executive team and board members were not visible and communication with front line staff was poor. This sense of disconnect was evident in the NHS 2013 staff survey, which reported the following four performance indicators as being in the lowest 20% nationally:

- The percentage of staff reporting good communication between senior management
- The ability of staff to contribute towards improvements at work
- Staff recommendation of the trust as a place to work or receive treatment, and
- Staff motivation at work

Although in relation to

- Staff recommendation of the trust as a place to work or receive treatment, and
- Staff motivation at work

There had been an improvement on the 2012 survey.

The survey did indicate that that there had been statistical improvements in 3 indicators since the 2012 survey:

- Effective team working
- Support from immediate managers (although the result for this indicator remained below the national average).
- The percentage of staff receiving health and safety training.

Staffing

In 2013, net recruitment of nursing staff (recruitment – leavers) showed a positive gain of 135 nurses. Regular updates on nurse recruitment were presented to the Board through the Risk Committee; risks were managed

through the daily staffing call and the use of bank and agency staff. However, during our inspection we identified a number of areas where staffing difficulties were having an adverse impact on patient care and safety.

We found that the nurse staffing levels in the Critical Care Unit /High Dependency Unit (CCU/HDU) at Furness General Hospital were unacceptably low and medical cover was poorly organised. We asked the trust to take immediate remedial action in this regard.

We had previously inspected the medical services provided by the trust in Ward 39 at the Royal Lancaster Infirmary in October 2013. We found that there were significant issues regarding insufficient staff to provide appropriate and safe care, and we issued a warning notice to the trust. We found at this inspection that although the trust had provided additional full time nurses there were still concerns regarding the staffing and skill mix in both Ward 39 and other medical wards within the hospital. As a result, we concluded that the trust had not yet complied with the warning notice. Our inspection found that failure to address the staffing issues in the medical wards was adversely affecting the quality of care provided to patients.

Staffing shortfalls were also identified in paediatrics and surgical services at Royal Lancaster Infirmary and in the A&E departments at both the Royal Lancaster Infirmary and Furness General Hospital. Staffing levels in the A&E department and paediatric services had been recently reviewed and business cases had been developed to secure additional staffing for these services.

Staff training

Although the trust had taken action to provide a programme of mandatory and specialist training, staff could not always access training as staffing levels meant that they were required to remain on the wards or in the departments.

Cleanliness and infection control

The hospitals were clean throughout. There were ample supplies of hand washing facilities and alcohol gels available for staff and visitors to use to minimise cross

Summary of findings

infection risks. All staff adhered to 'bare below the elbows' guidance. The trust had invested in a poster campaign that provided helpful guidance to staff, patients and the public regarding cross infection risks.

The trust had a prevention and control of infection policy. The majority of staff followed the guidance, however, we saw examples of poor hand hygiene in the Children's ward at the Royal Lancaster Infirmary.

The trust's infection rates for C.Difficile and MRSA are in an acceptable range for a trust of this size.

However, an antimicrobial audit completed by Audit North West in 2013 found poor compliance with trust policy to be a key factor in C. difficile cases, and that procedural changes made by the trust had not resulted in a demonstrated improvement. Antimicrobial prescribing was now being monitored by ward pharmacists and changes had been made to the inpatient prescription chart to try and ensure that antibiotic therapy was appropriately reviewed. Posters had been distributed to wards and there was an awareness of the need for vigilance in antibiotic prescribing initiatives among the nursing, pharmacy and medical staff we spoke with. A programme of repeat audit had been implemented; the outcomes were not available at the time of our inspection.

Medicines management

NICE (National Institute for Health and Care Excellence) recommends that pharmacists are involved in medicines reconciliation as soon as possible after admission, but pharmacy staff were not able to offer this service to every patient within the trust's own timeframe. The trust had identified this as being due to the "limited availability of appropriately trained staff and limited opening hours". Nurses reported that they valued the ward pharmacy service but a regular service was not extended to all wards. The pharmacy provided medicines in compliance aids if required to meet individual patient's needs.

The trust did not have a dedicated critical care pharmacist during 2013 to ensure safe and effective drug therapy. This meant the trust did not comply with the North West core service specification for Adult Critical Care. A half-time antibiotic/critical care pharmacist was appointed in January 2014.

The trust had a delayed response to two patient safety alerts. 'The adult patient's passport to safer use of insulin' (August 2012) and, 'Reducing harm from omitted and delayed medicines in hospital' (February 2011). We found that the trust was now taking action in relation to these issues through wider audits of omitted doses and the revision of the trust's procedure for self-administration.

Complaints management

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Patient experience

There were very mixed reviews from patients about their experiences of the services provided. Many patients we spoke with described very positive experiences of good and compassionate care from committed and professional staff. However, we spoke with a number of patients on the medical wards who informed us that although staff were very good and caring, staff shortages meant care was not provided or delivered at a good standard. This was a particular issue in medicine.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of services.

Are services safe?

A number of services provided by the trust require improvements to consistently secure patient safety and protect them from risks. The risks to patient safety and service quality were often as a result of staffing and recruitment difficulties and although the trust has recruited an additional 135 nursing staff, there was still a heavy reliance on bank, agency and locum staff in a number of specialities. There are particular concerns about patient safety and staffing levels in the medical wards across the Royal Lancaster Infirmary and Furness General Hospital sites. There were also serious concerns regarding nurse staffing levels on the CCU/HDU at Furness General Hospital.

There were omissions in patient risk assessments and care planning documentation that placed patients at the risk of avoidable harm. This was a particular issue on the medical wards where we found patient risk assessments incomplete and not always regularly reviewed.

Although there were systems and opportunities to share learning from reported incidents, we did not see evidence of a systematic approach to organisational learning at ward level. Staff on the wards felt the quality of feedback was variable and in some cases did not receive feedback at all. This was despite the electronic reporting system having an automatic feedback process available from 12 December 2013. As a result, the trust cannot be assured that its incident reporting is accurate or appropriate and there may well be missed opportunities to learn from incidents that would improve the quality and safety of services.

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

Inadequate



Are services effective?

Patients' care and treatment was delivered in accordance with national best practice guidelines and the trust participated in national audits to monitor the quality and safety of services.

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

Good



Are services caring?

Staff worked hard to provide safe and compassionate care for patients. Patients and those close to them were complimentary about the care they received and the way staff responded to them. Staff treated patients with respect and worked hard to promote their dignity and privacy.

Vulnerable patients such as those with dementia were cared for in a thoughtful way although at times nurses felt that pressures on the wards meant that they were unable to give patients the time they needed.

Good



Summary of findings

Patients who were receiving palliative or end of life care were also complimentary about the care received. Staff were open and honest with them and explained care and treatment in a language that patients could understand. Questions were encouraged at difficult messages were given in a supportive and sensitive way.

Patients felt they were involved in decision making and that they could make an informed decision about their care and treatment. Where patients lacked the capacity to make their own decisions, staff sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Are services responsive to people's needs?

Overall, Patients' needs were met in a timely way. After targeted improvement work relating to waiting times and patient flow, the trust was meeting the national target for waiting times in A&E. Patient referral to treatment times were within acceptable limits. Similarly the number of cancelled operations and delayed discharges were within acceptable ranges for a trust of this size.

Although performance had improved over the last year the trust is still experiencing some difficulties in outpatients in relation to appointments and the availability of patient records. The trust were working hard to improve this element of the service.

Discharge planning has improved and the discharge team are securing timely supported discharge for patients ready to leave hospital. Improvement in the provision of medicines to take home is also supporting timely discharge home.

Requires Improvement



Are services well-led?

The trust lacked a clear vision for staff to align or aspire to. The lack of clarity about the trust's future left staff feeling disengaged and remote from the executive team. There were three distinct cultures across the three hospital sites and little evidence of 'trust wide' working and of an integrated organisation.

The timely recruitment of both medical and nursing staff was a fundamental concern. This had resulted in a reliance on bank, agency and locum staff in a number of wards and departments.

The governance arrangements and risk management structures in place were not consistently applied throughout all the departments or divisions. Local audits and risks were not always escalated and responded to in a timely way. Patient safety information was not accurately maintained on the wards and departments; this resulted in unreliable local performance data and metrics. Consequently assurances taken from this information may not have been robust.

Inadequate



Summary of findings

All of these matters had been raised with the trust following our investigation into the emergency care pathway in 2012 and again in our follow-up to the investigation in 2013. The long standing nature of the problems indicates that the leadership within the trust lacks the capacity to effectively manage these challenges in a prompt and timely manner.

Summary of findings

What people who use the trust's services say

Survey data

The Friends and Family Tests have been introduced to give patients the opportunity to give feedback on the quality of care they receive. The trust can be seen to be performing lower than the England average for the inpatient component of the test, while the A&E score is higher than the national rate. Overall the trust's score is higher than average. However, the response rates are low and this can adversely affect the results of the indicator. (NHS Family and Friends Test July 2013-October 2013).

The Care Quality Commission undertook a survey of the people who had recently used the services of University Hospitals of Morecambe Bay NHS Foundation Trust (CQC Inpatient Survey 2012). The trust scored worse than other trusts for the A&E department. However for the specific questions, the responses are still within the statistically acceptable range in comparison to others trusts.

Areas for improvement

Action the trust **MUST** take to improve

- Ensure staffing levels and skill mix in all clinical areas are appropriate for the level of care provided.
- Continue to actively recruit medical and specialist staff in areas where there are identified shortfalls.
- Improve the nurse record keeping on the medical wards.
- Improve its incident reporting. All staff must be aware of their responsibilities to both report incidents and implement remedial action and learning as a result.
- Ensure that appropriate action is taken in response to audits where poor practice is identified.
- Ensure that accurate and timely performance information is used to monitor and improve performance in all clinical areas.
- Ensure the timely availability of case notes and test results in outpatients department.
- Ensure that its performance information is consistently and systematically collected and collated in order to support service improvement.

Action the trust **SHOULD** take to improve

- Review the numbers of elective caesarean sections carried out in the maternity services.
- Review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.
- Consider its investment into the diagnostic and imaging services to respond to increased demand.
- Improve communication with staff on the wards.
- Review its facilities and equipment in A&E so that patients who are subject to delayed transfer do not receive sub-optimal care.
- Review the opportunities to engage the workforce in the 'better care together' initiative so staff are aware of the future of the services they work in.

Good practice

Our inspection team highlighted the following areas of good practice:

- There were some strong and positive role models, particularly in surgery, that were enabling and leading staff well.

University Hospitals of Morecambe Bay NHS Foundation Trust

Detailed Findings

Hospitals we looked at

Furness General Hospital; Royal Lancaster Infirmary; Westmorland General Hospital

Our inspection team

Our inspection team was led by:

Chair: Jane Barrett Consultant Oncologist.

Head of Hospital Inspections: Ann Ford, Care Quality Commission.

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

Background to University Hospitals of Morecambe Bay NHS Foundation Trust

University Hospitals of Morecambe Bay NHS Foundation Trust became a foundation trust on 1 October 2010 and provides a comprehensive range of acute and support hospital services for around 350,000 people across North Lancashire and South Cumbria, with over 740 beds.

The trust operates from three main hospital sites at the Furness General Hospital in Barrow, the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal. The Queen Victoria Hospital in Morecambe provides outpatient services and Ulverston Community Health Centre provides nutrition, dietetics and breast screening. This inspection will focus only on the Acute services provided at Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital.

Detailed Findings

The Care Quality Commission (CQC) carried out an investigation of University Hospitals of Morecambe Bay NHS Foundation Trust in January 2012, using our powers under s48 (1) (2) (a) of the Health and Social Care Act 2008. Our investigation focused on the emergency care pathway and also looked at the trust's governance and management systems at a number of levels. It assessed the systems and procedures that the trust had in place to make sure that people were protected against the risk of unacceptable standards of care and treatment.

We published our report in July 2012 and made 40 recommendations for action by the trust. Our follow-up visit was conducted in April 2013.

We also carried out inspections of the Royal Lancaster infirmary in October 2013. We found shortfalls in staffing on Ward 39 and served the trust a formal warning notice. When we re-inspected the trust in January and February 2014 we found that the trust had still not fully met the requirements of the notice and that patient care and safety was being compromised as a result.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. University Hospitals of Morecambe Bay NHS Foundation Trust has been selected as one of the early trusts to be inspected under CQC's revised inspection approach. The trust was selected for inspection as a trust where there were known risks to service delivery.

This hospital had also been subject to enforcement action relating to unsatisfactory staffing levels on the medical wards following our unannounced inspection of the trust in October 2013.

How we carried out this inspection

In planning for this inspection we carried out a detailed analysis of local and national data sources that was used to inform our approach and enquiries. The trust was given an opportunity to review the data and comment on its factual accuracy. Corrections were made to the data pack in light of the response.

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

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

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

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

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

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

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

As part of our inspection we spoke with patients in each of the service areas and actively sought their views and the views of those close to them so we could develop a rich understanding of the services provided at the hospital. We held a number of well attended staff focus groups as well as interviews with the Senior Management Team and Board

Detailed Findings

Directors. We looked closely at staffing levels and spent time examining notes and medical records. We also checked departmental records for cleaning and maintenance checks.

We also returned to the trust unannounced on Sunday 16 February and visited Royal Lancaster Infirmary and Furness General Hospital.

Are services safe?

Summary of findings

A number of services provided by the trust require improvements to consistently secure patient safety and protect them from risks. The risks to patient safety and service quality were often as a result of staffing and recruitment difficulties and although the trust has recruited an additional 135 nursing staff, there was still a heavy reliance on bank, agency and locum staff in a number of specialities. There are particular concerns about staffing levels in the medical wards across the Royal Lancaster Infirmary and Furness General Hospital sites. There were also serious concerns regarding nurse staffing levels on the CCU/HDU at Furness General Hospital.

There were omissions in patient risk assessments and care planning documentation that placed patients at the risk of avoidable harm. This was a particular issue on the medical wards, where we found patient risk assessments incomplete and not always regularly reviewed.

Although there were systems and opportunities to share learning from reported incidents, we did not see evidence of a systematic approach to organisational learning. Staff felt the quality of feedback was variable and in some cases did not receive feedback at all. As a result, the trust cannot be assured that its incident reporting is accurate or appropriate and there may well be missed opportunities to learn from incidents that would improve the quality and safety of services.

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

pressures to reduce the effect of the Norovirus on patients in the hospital during the winter months. There were ample supplies of hand washing facilities and gels throughout all areas and staff had access to appropriate protective clothing to reduce infection risks. However, practice throughout the trust was inconsistent and in the paediatric ward at Royal Lancaster Infirmary, hand hygiene practices were poor. In addition, the audits for hand hygiene on the paediatric unit at Royal Lancaster Infirmary had highlighted this risk, yet no remedial actions to improve practice were documented.

Equipment

There were ample supplies of suitable equipment on all three sites that was clean, safe and ready for use.

Staffing

The trust has recruited an additional 135 staff. However, we identified staffing difficulties in a number of services that were having an adverse impact on patient care and safety.

We found that the nurse staffing levels in the Critical Care Unit /High Dependency Unit (CCU/HDU) at Furness General Hospital were unacceptably low and medical cover was poorly organised. We asked the trust to take immediate remedial action in this regard.

We had previously inspected the medical services provided by the trust in Ward 39 at the Royal Lancaster Infirmary in October 2013. We found that there were significant issues regarding there not being enough staff to provide appropriate and safe care, and we issued a warning notice to the trust. We found at this inspection that there were still concerns regarding the staffing of both Ward 39 and other medical wards and that the trust had not yet complied with the warning notice. Our inspection found that failure to address the staffing issues in the medical wards was adversely affecting the quality of care provided to patients.

Staffing shortfalls were also identified in paediatrics and surgical services at the Royal Lancaster Infirmary, and in the A&E departments at both the Royal Lancaster infirmary and Furness General Hospital. Staffing levels in the A&E department and paediatric services had recently been reviewed and business cases had been developed to secure additional staffing for these services.

The Paediatric staff business case was presented to the Executive Directors Group (EDG) meeting on 28 January

Our findings

Hygiene and cleanliness

The hospitals were clean throughout. The trust had improved its arrangements for the prevention and management of infection control.

There was a very visible advertising campaign running across the trust to alert patients, staff and visitors to the need to ensure hand hygiene when in the hospitals. This initiative had been part of forward planning for winter bed

Are services safe?

2014. We were informed that the business case required further work and when it was re-presented at EDG on 18 February 2014 it was approved and recruitment subsequently commenced.

There was also a shortage of middle grade doctors in a number of services that had led to a reliance on locum staff and consultants providing out-of-hours cover as well as managing their own workloads.

Incident reporting

An electronic incident reporting system is in place and incidents are monitored and investigated by managers. However, incident reporting was inconsistent across the hospital sites. Some staff were unclear about the range and nature of reportable incidents and some staff admitted to not reporting incidents or delegating the reporting to others.

Staff reported that they did not always receive feedback, and when they did the quality of feedback was variable and did not always result in shared learning. Learning was shared and cascaded through a range of mechanisms: intranet, email and ward/unit meetings, although ward staff reported that these did not always take place and were often cancelled due to staffing pressures. As a result, the trust cannot be assured that its incident reporting is accurate or appropriate and there was a risk of missed opportunities to learn from incidents that would improve the quality and safety of services.

The trust uses 'safety crosses' as a method for surveying patient harms and analysing results so it can measure and monitor local improvement and harm free care over time. The safety cross system is not systematically applied in all relevant services; consequently the trust cannot be assured of the accuracy of the information that is collated from this tool.

Monitoring safety and responding to risk

Data from the NHS safety thermometer (a method for recording and monitoring harm free care) indicates that the proportion of patients being cared for by the trust suffering new pressure ulcers including those in patients aged over 70, was consistently above the England average from November 2012 to November 2013 (with the exception of patients over 70 in November 2013). The trust has begun

work to understand and reduce the numbers of pressure ulcers acquired by patients in hospital and has agreed with commissioners to focus on four high profile areas known locally as the 'Safety Four' inpatient harm preventing pressure ulcers is a key feature of this work. However, we were informed by the local Clinical Commissioning Group (CCG) that the trust is not yet meeting its target in this area.

Nursing documentation included risk assessment tools to identify patients at a high risk of developing a pressure ulcer so that staff could plan and deliver care in a way that reduced the risk of a patient developing an ulcer. The tool was used in most clinical areas. However, in the medical wards at both Furness General Hospital and the Royal Lancaster Infirmary, there were a number of patients whose risk level indicated that a pressure relieving mattress would help avoid a pressure ulcer, but they were not provided with a suitable mattress. This meant that staff were not using appropriate equipment to minimise the risks to vulnerable patients.

There were early warning tools to monitor the patient's condition so that if the condition deteriorated then medical staff could be alerted quickly.

Safeguarding

Staff were trained to identify issues of adult abuse and neglect. Staff were able to describe abuse and also how they would escalate their concerns. We found examples of staff escalating safeguarding concerns appropriately.

Anticipation and planning

The trust had a plan to deal with emergency pressures during the winter months and plans had been put in place to improve discharge arrangements. We found that the improved discharge arrangements were working effectively. However, the success of the wider planning for winter pressures (aimed at improving patient flow and reducing the numbers of patients placed in wards that were not in the required specialty) were partly reliant on the recruitment of additional staff. This had proven difficult and consequently had not resulted in the desired reduction in the numbers of patients who were accommodated on wards and areas that were not best suited to their particular needs. This was a particular issue in medicine.



Are Services Effective?

(for example, treatment is effective)

Summary of findings

Patients' care and treatment was delivered in accordance with national best practice guidelines and the trust participated in national audits.

Where audits had identified service shortfalls, action plans were developed to secure improvement and reported at board level.

However, we found examples where local audits been carried out which identified practice shortfalls that had not been addressed or escalated appropriately. Action plans were not always implemented and evaluated to see if actions had secured improvement.

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

Our findings

Using evidence-based guidance

Care and treatment was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. The trust had implemented care pathways in a number of services, including surgery and IT.

The trust was regularly participating in national clinical audit to monitor the quality of services.

Performance, monitoring and improvement of outcomes

Within theatres there had been some progress with "cross bay working". A productive theatre project was on-going. The project was monitoring theatre use and efficiency, aiming to reduce cancelled operations due to lack of theatre availability.

Some of the wards and departments displayed key performance and quality indicators regarding patient harm and safe care ('safety crosses') that included falls and pressure ulcers. However, completion rates were variable and inconsistent across the trust.

Multidisciplinary working and support

There was evidence of effective and collaborative multidisciplinary working in a range of core services, including care of patients at the end of life, patients undergoing surgery, critical care and care of patients who had suffered a stroke.

Multi-disciplinary teams worked well together to provide person-centred care and treatment plans for patients.

Are services caring?

Summary of findings

Staff worked hard to provide safe and compassionate care for patients. Patients and those close to them were complimentary about the care they received and the way staff responded to them. Staff treated patients with and respect and worked hard to promote their dignity and privacy.

Vulnerable patients, such as those with dementia, were cared for in a thoughtful way although at times nurses felt that pressures on the wards meant that they were unable to give patients the time they needed.

Patients who were receiving palliative or end of life care were also complimentary about the care received. Staff were open and honest with them and explained care and treatment in a language that patients could understand. Questions were encouraged at difficult messages were given in a supportive and sensitive way.

Patients felt they were involved decision making and that they could make an informed decision about their care and treatment. Where patients lacked the capacity to make their own decisions, staff sought consent from their carers or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. The patients we spoke with confirmed that staff had sought consent verbally and in writing prior to performing surgical or medical procedures. Patients felt staff explained procedures to them well and that they were aware of their treatment options in terms of benefits and risks.

Trust and communication

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

Patient information leaflets were available and accessible. However, there was limited information available for patients whose first language was not English. Similarly there was limited information in formats suitable for patients who were visually impaired or who had a learning disability.

Emotional support

Patients who were anxious or emotional about their treatment and prognosis were supported well by staff that went to great lengths to reassure patients and offer emotional support.

This was particularly evident in the palliative care and end of life services. The inpatient wards were introducing a dragonfly symbol that would alert staff to patients who as a result of their illness needed more time and support.

There was a dedicated bereavement team working across the trust with an office in each site to provide a point of contact for people recently bereaved.

The bereavement specialist nurse was able to see families in private and to direct them to other support services. Bereavement support was offered immediately to help people with cope with the difficulties of being bereaved and people were positive about their experience of this service.

Our findings

Compassion, dignity and empathy

We saw many examples of staff delivering care in a person-centred, compassionate manner and many patients were complimentary about the care and treatment they received. Staff were sensitive to patients and those close to them when giving difficult news and staff gave them the privacy and time they needed.

Involvement in care and decision making

Staff respected patients' right to make choices about their care and patients spoke positively about being involved in their care.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall, patients' needs were met in a timely way. After targeted improvement work relating to waiting times, the trust was meeting the national target for waiting times in A&E. Patient referral to treatment times were within acceptable limits. Similarly the number of cancelled operations were within acceptable ranges for a trust of this size. Although performance had improved over the last year the trust is still experiencing some difficulties in outpatients in relation to appointments and the availability of patient records. The trust was working hard to improve this element of the service.

Discharge planning has improved and the discharge team are securing timely supported discharge for patients ready to leave hospital. Improvement in the provision of medicines to take home is also supporting timely discharge home. The number of delayed discharges was in an acceptable range for a trust of this size.

Our findings

Meeting people's needs

The trust was meeting people's needs in a timely way. Performance in relation to A&E waiting times had improved and patients being referred for treatment were seen in accordance with national requirements for referral to treatment times. The numbers of cancelled operations were in an acceptable range for a trust of this size.

Patients were concerned about the length of time they sometimes waited in outpatient departments. Transport arrangements were also raised as a difficulty for patients attending the outpatients department.

Vulnerable patients and capacity

Staff were aware of their responsibilities in relation to patients who lack capacity to make decisions for themselves.

When patients lacked the capacity to make their own decisions, decisions about care and treatment were made in the best interests of the patient and involved the patient's representatives and other healthcare professionals. However, there was an occasion on a medical ward at Furness General Hospital where there was a lack of consideration of a best interest decision for one very vulnerable patient.

Leaving hospital

Discharge arrangements had improved and patients were being safely discharged with their medicines and appropriate support packages in place. Patients were benefitting from the recently set up 'early supported discharge team' that provided a service to patients who had suffered a stroke. A multi-disciplinary team continued patients' care and treatment after discharge. The team consisted of a physiotherapist, occupational therapist, speech and language therapist and support workers. The team worked in partnership with patients and those close to them to ensure safe discharge and appropriate support at home.

Learning from experiences, concerns and complaints

Historically the trust's handling of complaints had been an issue of concern as complaints were not always dealt with in a timely, open and transparent way. In some instances the complainant waited many months for a response and often felt the response was unsatisfactory. However, the trust has significantly improved its complaints procedure and complaints are dealt with in a more timely way. Responses are clearer and apologies are offered where appropriate. Response times are tracked and traced, and unavoidable delays are managed and supported with on-going discussion with the complainant.

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust lacked a clear vision for staff to align or aspire to. The lack of clarity about the trust's future left staff feeling disengaged and remote from the executive team. There were three distinct cultures across the three hospital sites and little evidence of 'trust wide' working and of an integrated organisation.

The timely recruitment of both medical and nursing staff was a fundamental concern. This had resulted in a reliance on bank, agency and locum staff in a number of wards and departments.

The governance arrangements and risk management structures in place were not consistently applied throughout all the departments or divisions. Local audits and risks were not always escalated and responded to in a timely way. Patient safety information was not accurately maintained on the wards and departments; this resulted in unreliable local performance data and metrics. Consequently assurances taken from this information may not have been robust.

All of these matters had been raised with the trust following our investigation into the emergency care pathway in 2012 and again in our follow-up to the investigation in 2013. The long standing nature of the problems indicates that the leadership within the trust lacks the capacity to effectively manage these challenges in a prompt and timely manner.

board is updated regarding its development via the Transition Management Board. Board members understood that the strategy should be formulated by June 2014.

The trust has not shared its vision and values with staff and we saw no visual representation of its vision and values displayed anywhere in the trust's three hospitals.

Directors, Non-Executive Directors and the Chair were all able to articulate the priorities for the trust. All raised recruitment and retention of staff, financial risks and clinical sustainability as key challenges and priorities. At the time of inspection we could not find how these priorities were articulated throughout the trust as we did not see any robust objectives that demonstrated delivery of these at either board or ward management level.

Staff at the front line were not clear about what the trust's priorities were and many knew little of the 'Better Care Together' strategy. Many were unclear and uncertain about what future provision would look like and what it meant for their service or for them as individuals.

There was a lack of robust data and key performance metrics to support and underpin performance and achievements. Key performance and safety information was not collected and collated in a consistent and systematic way. We found that the trust had systems and processes in place for governance and risk management. However, the implementation and quality of the systems was variable. Risk management required improvement in a number of services across the organisation. We found that risks identified from local audits were not always escalated and responded to in a timely way. Similarly the risk register did not clearly set out risks, controls, gaps in controls and sources of potential assurance. The issues in relation to staffing shortfalls on the CCU/HDU was a clear example of this.

The systems for reporting incidents were not consistently followed and there was a lack of clarity in some services about the range and nature of reportable incidents. Performance information and learning from the incidents that were reported was not effectively or consistently used to drive changes and improve practice.

The trust has a higher number of reported never events than similar trusts. A review of outcomes of investigations, including root cause analysis of Serious Untoward

Our findings

Vision, strategy and risks

The trust has not yet formalised a clear vision or strategy for the delivery of sustainable high quality care. Work has begun in partnership with the CCG on a strategy 'Better Care Together'. However, this work has been going on since 2012 and to date has not resulted in a clinical strategy for future service provision.

We spoke with the board about the development of the strategy, who confirmed that it work in progress and the

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Incidents, continues to suggest areas of concern where similar themes are repeated e.g. failure to follow guidelines/protocols and embedding the learning from previous incidents.

Governance arrangements

The entire board of Directors has changed since 2012 with 14 new appointments made, including the Chief Executive. In the seven months prior to our inspection four executive directors had taken up post.

Governance systems have been strengthened by dividing clinical services into five clinical divisions and appointing substantive clinical leaders to each division. The clinical divisions are:

- Acute and Emergency Medicine
- Elective Medicine
- Surgery and Critical Care
- Women and Children
- Core Clinical Services.

Each Clinical Division is headed by a Clinical Director, supported by a Divisional General Manager and an Assistant Chief Nurse. Each Clinical Specialty has a Consultant with dedicated management time to act as Clinical Lead. Each Division also draws on dedicated support from Finance, Human Resources and Governance.

The board had a good understanding of performance in respect of operational standards and targets within the trust. However, we could not see how the trust's work streams and plans came together to address its particular and significant challenges. For example, the workforce 6-point plan identified an increase in staffing in a number of clinical areas and we were made aware of a number of business cases that were aimed at securing additional staffing resources, yet the cost improvement plan identified a reduction of some 246 posts to help the trust deliver its financial target. It was difficult to understand how both of these objectives could be achieved.

Leadership and culture and staff engagement

Although visits by the executive to the wards and departments had increased, many of the staff we spoke with felt that the executive team were not visible or accessible.

Although the board had provided a range of information, newsletters and engagement opportunities for staff, the staff reported that they felt disconnected from both the

executive team and the board. They felt that, with the exception of the executive chief nurse, the executive team and board members were not visible and communication with front line staff was poor. Staff also reported that the senior team did not listen to their concerns or respond in a timely way.

This sense of disconnect was evident in the NHS 2013 staff survey that reported the following four performance indicators as being in the lowest 20% nationally.

- The percentage of staff reporting good communication between senior management
- The ability of staff to contribute towards improvements at work
- Staff recommendation of the trust as a place to work or receive treatment, and
- Staff motivation at work.

However, the survey did indicate that there had been positive changes in the following two indicators since the 2012 survey:

- Effective team working
- Support from immediate managers (although the result for this indicator remained below the national average).

Such results indicate that despite the engagement sessions the trust had provided, staff still felt remote and disengaged from the strategic planning processes and from the board and executive team.

There were different cultures in all the three hospitals we inspected and although staff were loyal to their 'home hospital', they did not see themselves as part of the wider organisation. At the time of our inspection we saw little evidence of 'cross bay working', with the exception of the productive theatre initiative. Some comments from staff demonstrated that relationships across services were not always based on mutual professional respect. Members of board were not well known and staff felt they would appreciate the increased visibility of senior colleagues.

Leadership at service level was more apparent and there were examples of strong and positive role models for staff in some of the services we inspected.

Some consultants stated that they were not fully aware or engaged in wider trust issues, but continued to demonstrate leadership in developing their own services

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

regardless. Some consultants felt that the trust did not invest sufficiently in their services and were disappointed in the trust's response to some long standing recruitment and service development issues.

These are matters of continued concern, as it indicates that the trust has not yet embedded the required cultural change programme that promotes an identity of a fully merged trust and engages staff fully in the plans for future service provision. This was a recommendation made following CQC's investigation of the trust in 2012 and reinforced at the follow-up to the investigation in April 2013.

Staff reported to us in the focus groups that there were still elements of bullying in some services. We raised this with the trust, who had taken steps to support staff in raising concerns of this nature. 'Speak out safely' boxes had been provided where staff could raise concerns without being

identified. The trust was also committed to supporting staff that raised concerns via its whistleblowing policy. However, staff still told us that they did not always feel confident to raise concerns with senior leaders.

Learning, improvement, innovation and sustainability

The trust is aware that it has a number of significant challenges including the sustainability of services, staff recruitment and managing its financial position – all within a difficult geographical area. There is a heavy reliance on the 'Better Care Together' strategy to provide solutions for these challenges.

However, it is not clear if the trust can maintain and manage its position in the medium term if the 'Better Care Together' strategy cannot be agreed and implemented quickly.