University Hospitals of Morecambe Bay NHS Foundation Trust

Westmorland General Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Surgery	Good
Maternity and gynaecology	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Westmorland General Hospital is one of three locations providing care as part of University Hospitals of Morecambe Bay NHS Foundation Trust. The hospital provides elective surgical services, a midwifery led maternity service and outpatient and diagnostic services including pathology, radiology and endoscopy, and allied health services such as physiotherapy, occupational therapy, dietetics and pharmacy services. The hospital does not provide Accident & Emergency services, critical care or services for children and young people. However the hospital does hold paediatric clinics in the outpatients department.

University Hospitals of Morecambe Bay NHS Foundation Trust provides services for around 360,000 people across North Lancashire and South Cumbria with over 700 beds. In total, Westmorland General Hospital has 43 beds.

We inspected University Hospitals of Morecambe Bay NHS Foundation Trust as part of our comprehensive inspection programme in February 2014. Following our inspection in February 2014 we rated Westmorland General Hospital as 'good' overall. We judged the hospital as 'good' for safe, effective, caring, and responsive. Surgery and maternity were rated as 'good', however outpatients and diagnostic imaging was rated as 'requires improvement'. This was because of long waiting time appointments in some departments and difficulties in securing case notes and test results for patient appointments.

At this inspection, we rated Westmorland General Hospital as 'good'. We have judged the service as 'good' for safe, effective, caring, responsive and well-led care. Surgery, maternity and outpatient and diagnostic imaging were rated as 'good'.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- Between April 2014 and February 2015 there had been no cases of Clostridium Difficile in the surgical division at Westmorland General Hospital.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- The nursing staff vacancy rate was 18.8 whole time posts in May 2015. There had been no use of agency staff as staff had been made available from the elective orthopaedic unit which had been closed for two months.
- The nursing staff ratios were calculated separately in each area to determine safe staffing levels dependent on the activity for the day.
- Numbers of staff on duty met with the NICE guidelines "Safe staffing for nursing in adult inpatient wards in acute hospitals" in the ratio of one nurse to eight patients. This was maintained with clinical support workers providing additional assistance.

Summary of findings

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1 midwife to 25 births compared to the RCOG recommendation of 1 midwife to 28 births.

Medical staffing

- The number of medical staff employed to work solely at Westmorland General Hospital was 4.4 doctors. There was a vacancy of 1.4 doctors and recruitment was underway.
- Consultants completed operations for their speciality at this hospital at booked session times. If there were low numbers of permanent staff in that speciality, for example urology, then locum medical doctors would carry out the procedures.
- There was a resident medical officer who was on- call at all times, including nights and weekends. They visited the inpatient wards every morning, midday and evening seven days per week and were available to visit during the night if required.
- In maternity services, there were two consultant led antenatal clinics per week.
- There were vacancies for radiologists. The trust was actively recruiting for these posts and had introduced the use of extended roles for advanced practitioners to help manage caseloads.

Mortality rates

- The trust was highlighted as a 'risk' for the in-hospital mortality indicator - Cerebrovascular conditions in the CQC Intelligent monitoring report May 2015.
- Mortality and morbidity meetings were held weekly or monthly at the other trust sites and were attended by representatives from all teams within the relevant divisions from this hospital. As part of these meetings, attendees reviewed the notes for patients who had died in the hospital within the previous week. Any learning identified was shared and applied.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and by the speech and language therapy team.
- The patient records we reviewed included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- Where patients were identified as being at risk, there were fluid and food charts in place..

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided in outpatients.

In addition the trust should:

In surgical services:

- Ensure that there are systems and process in place to for staff to be made aware of any learning and change of practice from audit programmes.
- Review written consent being obtained on the day of surgery.
- Ensure that the 5 steps to safer surgery process is audited to monitor that it is being used appropriately, particularly in surgical care.

Summary of findings

In maternity and gynaecology services:

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust.
- Ensure that a practical test of the child and infant abduction policy is completed every 12 months in line with trust policy.
- Ensure safeguarding records always record outcomes of meetings with social workers.
- Ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.

In outpatients and diagnostic imaging:

- Ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.

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?
Surgery	Good	At the last inspection in February 2014, we rated surgical services as good. During this inspection, we found that surgical services at this hospital were good although responsive required improvement. The environment and equipment were clean and tidy with good infection control measures in place. Staff understood their responsibilities to protect adults in their care. Measures were in place to respond to patients whose condition deteriorated. The majority of mandatory training was up to date. In May 2015 nursing staff vacancy rate was 18.8 whole time posts at this hospital. There had been no use of agency staff in the same month as staff had been made available from the elective orthopaedic unit which had been closed for two months. There was some reliance on locum medical cover in specific specialities. However, measures were in place to manage this. Staff learned from incidents, but staff were unclear if they should report specific events, for example cancellations of operations, as an incident. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. Not all records were securely stored or adequately maintained. The 5 steps to safer surgery was used appropriately; however there was no documentation to support this as it had not been audited. There were good examples of effective multi-disciplinary working. The majority of staff were clear about how the mental capacity of a patient impacted on their role and responsibilities. There were good systems in place to manage patients' pain and maintain adequate nutrition and hydration. Consent forms were correctly completed, although written consent was routinely obtained on the day of surgery. Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. There were good additional specialist training opportunities and assistance for staff to keep their skills updated. Concerns with lack of access to information had been successfully addressed. Most staff were up to date with their appraisals.

Summary of findings

Staff attended to patients quickly when assistance was requested and staff treated them with respect. Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions.
The referral to treatment times for patients admitted to the hospital were worse than the England average; trust wide initiatives had been launched to reduce these and improvements had been made. The average length of stay was shorter than the England average.
There were services available to reduce the numbers of visits needed for patients who had to travel long distances to the hospital. There were measures in place to aid the access and flow of patients through the day surgery unit. All staff shared a vision of improving services for the patients through learning from feedback, being open to learning from shortcomings in their own service and sharing good practice from other trusts. Staff felt well supported by their immediate line managers and the divisional matrons.

Maternity and gynaecology

Good

At the last inspection in February 2014, we rated maternity and gynaecology services as good. During this inspection, we also found that maternity and gynaecology services at this hospital were good.
Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job. The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect while they received care and treatment.
The Helme Chase Maternity Unit had undergone a considerable restructure in December 2014 which altered the way in which the unit was staffed and operated. There was no provision for women to stay in the unit for additional nights and out of hours, the service operated on an on-call basis. There was clear leadership of the unit.
Women's care and treatment was planned and delivered in line with current evidence-based care. This was monitored to ensure consistency of practice. Care outcomes were within expectations or better than expected.
There were processes in place to ensure women received emotional support where required. The service was aware of risks to ensure services were planned and

delivered to meet the needs of the local population. Work was ongoing in partnership with other organisations to engage with the local community in order to raise awareness of the Helme Chase Maternity Unit and the changes in service provision.

Outpatients and diagnostic imaging

Good

Since our last inspection we found that improvements had been in some of the areas we inspected. However, we found that there were still improvements required in some areas such as the staffing levels in radiology and the provision of appropriate information available for patients who had a learning difficulty. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We found that overall access to appointments had improved but performance was variable.

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department along with temporary staff to the department.

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.

Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance.

During our last inspection we noted that there was no information available in the departments for patients who had a learning disability. Our last inspection report noted that we could not find information available in easy to read formats; or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that main outpatient had specific information and leaflets for patients with learning disabilities and easy read formats; or written in formats suitable for those patients who had a visual impairment.

Overall staff felt more engaged with the trust and felt that there had been some improvements in service

Summary of findings

delivery. There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.

Westmorland General Hospital

Detailed findings

Services we looked at

Surgery; Maternity and Gynaecology; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Westmorland General Hospital

Westmorland General Hospital is one of three acute hospitals forming 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 range of acute and support services for around 350,000 people across North Lancashire and South Cumbria.

In total, the trust has 708 beds across three acute hospitals and employs around 4409 staff. Westmorland General Hospital has 43 beds.

Westmorland General Hospital provides elective surgical services, a midwifery led maternity service and outpatient and diagnostic services including pathology, radiology and endoscopy, and allied health services such as physiotherapy, occupational therapy, dietetics and pharmacy services. The hospital also has a primary care assessment service (PCAS), GP led medical care and a renal dialysis unit which are operated by different NHS trusts.

During this inspection, the team inspected the following services:

- Surgery
- Maternity and gynaecology services
- Outpatients and Diagnostic Imaging services.

Westmorland General Hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). During 2014, 9,100 patients were admitted for surgery at this hospital. 83% of patients had day case procedures, 17% had elective surgery and there were no emergency surgical patients. There are two surgical wards, a day case ward and four theatres that carry out and elective general and orthopaedic surgery procedures and day case surgery.

Westmorland General Hospital provides midwifery led care in a standalone midwifery unit called the Helme Chase Maternity Unit. Between June 2014 and June 2015 there were 165 births at the Helme Chase maternity unit.

The hospital provides a range of outpatient clinics, including, allied health services and has departments such as occupational therapy, physiotherapy, nutrition and dietetics, and pharmacy services. The diagnostic and imaging service included: Diagnostic imaging and reporting across a variety of modalities including CT/MR imaging, Nuclear medicine, Fluoroscopy, Mammography, Ultrasound and General Radiography.

Our inspection team

Our inspection team was led by:

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

Detailed findings

Head of Hospital Inspections: Ann Ford and Amanda Stanford, Care Quality Commission

The team included a CQC inspection manager, ten CQC inspectors and a variety of specialists including: Head of Clinical Governance, Associate Director of Nursing, Consultant Radiologist, Consultant Obstetrician and Gynaecologist, Consultant Paediatrician and Neonatologist, Consultant Anaesthetist, Consultant General Surgeon, Head of Midwifery and Supervisor of Midwives, and a Matron in neonatal services. We also had experts by experience who had experience of using healthcare services.

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 about the hospital and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, NHS England local area team, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 17 July 2015. During the visit we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, outpatients and maternity departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held specific listening events for people using medical care and maternity services on 30 June 2015 in Lancaster and Barrow to hear people's views about care and treatment received at the hospitals.

Facts and data about Westmorland General Hospital

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 600 beds. The trust operated from three main hospital sites at the Furness General Hospital in Barrow, and the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal. The Queen Victoria Hospital in Morecambe provided outpatient services and Ulverston Community Health Centre provided nutrition, dietetics and breast screening.

For the period 2013/14 the trust had 512,694 outpatient attendances (148,535 of these were at the Westmorland General Hospital).

Cumbria and Lancashire are largely rural regions with a total population of around 1.5million. The 2010 Indices of Deprivation showed Cumbria and Lancashire were the 21st and 22nd most deprived counties (out of 149 counties, with the 1st being the most deprived). Life expectancy is between 8.7 and 10.6 years lower for men and 6.8 to 7.6 years lower for women in the most deprived areas of Cumbria and Lancashire than in the least deprived areas. Census data shows an increasing population and a lower than average proportion of Black, Asian and Minority Ethnic (BAME) residents.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

Surgery

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

Information about the service

Westmorland General Hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery).

Hospital episode statistics 2014 data showed that 9,100 patients were admitted for surgery at the hospital. The data showed that 83% of patients had day case procedures, 17% had elective surgery and there were no emergency surgical patients.

There are two surgical wards, a day case ward and four theatres that carry out and elective general and orthopaedic surgery procedures and day case surgery.

As part of the inspection, we inspected the main theatres, the day case unit, ward 6 (the trauma and orthopaedic unit), and ward 7 (the urology, and breast surgery ward). We spoke with six patients. We observed care and treatment and looked at seven care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, general managers, the theatres managers, the matron, the matron for theatres, the adult safeguarding lead nurse, and the divisional clinical lead. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of findings

At the last inspection in February 2014, we rated surgical services as good. During this inspection, we found that surgical services at this hospital were good, although responsive required improvement.

The environment and equipment were clean and tidy with good infection control measures in place. Staff understood their responsibilities to protect adults in their care. Measures were in place to respond to patients whose condition deteriorated. The majority of mandatory training was up to date. In May 2015 nursing staff vacancy rate was 18.8 whole time posts at this hospital. There had been no use of agency staff in the same month as staff had been made available from the elective orthopaedic unit which had been closed for two months. There was some reliance on locum medical cover in specific specialities. However, measures were in place to manage this. Staff learned from incidents, but staff were unclear if they should report specific events, for example cancellations of operations, as an incident. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. Not all records were securely stored or adequately maintained. The 5 steps to safer surgery was used appropriately; however there was no documentation to support this as it had not been audited.

The referral to treatment times for patients admitted to the hospital were worse than the England average;

Surgery

however trust wide initiatives had been launched to reduce these and improvements had been made. Consent forms were correctly completed, although written consent was routinely obtained on the day of surgery There were examples of effective multi-disciplinary working. The majority of staff were clear about how the mental capacity of a patient impacted on their role and responsibility. There were good systems in place to manage patients' pain and maintain adequate nutrition and hydration. Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. There were good additional specialist training opportunities and assistance for staff to keep their skills updated. Concerns with lack of access to information had been successfully addressed. Most staff were up to date with their appraisals.

Staff attended to patients quickly when assistance was requested and staff treated them with respect. Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions.

There were services available to reduce the numbers of visits needed for patients who had to travel long distances to the hospital. There were measures in place to aid the access and flow of patients through the day surgery unit. The referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made. The average length of stay was shorter than the England average.

All staff shared a vision of improving services for the patients through learning from feedback, being open to learning from shortcomings in their own service and sharing good practice from other trusts. Staff felt well supported by their immediate line managers and the divisional matrons.

Are surgery services safe?

Good

The environment and equipment were clean and tidy with good infection control measures in place. Staff understood their responsibilities to protect adults in their care. Measures were in place to respond to patients whose condition deteriorated. The majority of mandatory training was up to date.

In May 2015 nursing staff vacancy rate was 18.8 whole time posts at this hospital. There had been no use of agency staff in the same month as staff had been made available from the elective orthopaedic unit which had been closed for two months. There was some reliance on locum medical cover in specific specialities. However, measures were in place to manage this. Staff learned from incidents, but staff were unclear if they should report specific events, for example cancellations of operations, as an incident. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date.However, the electronic versions were in date. Not all records were securely stored or adequately maintained. The 5 steps to safer surgery was used appropriately; however there was no documentation to support this as it had not been audited.

Incidents

- In the surgical services at this trust there were 25 serious incidents reported including six delayed diagnosis and four grade three pressure ulcers from May 2014 to April 2015. These had been investigated and actions taken to reduce the risks. There had been no grade three pressure ulcers in the past three months.
- Incident reports for April and May 2015 showed the majority of incidents at Westmorland General Hospital were patient falls. The reconfiguration of the ward area had been carried out as a result of discussions about how to reduce the number of falls on the ward. There was now greater observation of patients with designated nursing administration space in each bay area with staff present at all times.
- There was no record of what constituted an incident which should be reported unless a staff member had begun the process, when a menu was present in the computerised system. Staff were unclear if they should

report specific events, for example cancellations of operations, as an incident. This meant staff were unclear what should be reported as an incident which could result in lack of investigation and actions to prevent recurrence.
- A nurse gave an example of an incident regarding a member of the medical team which they had reported. They told us they had good feedback about the concerns they raised and were satisfied that incidents were investigated thoroughly and actions taken to reduce recurrence.
- Staff said it was easy to use the incident reporting system and we saw this being done at the time of our visit.
- Learning from incidents was shared with staff at the monthly ward meetings and on an individual basis if appropriate.
- There had been a cluster of medicine management errors and these had been investigated. The outcome was that nurses were being distracted due to the lack of separation of patients; with those on multiple medications and with complex needs being accommodated with those returning from theatre. This was partly the reason for the separation of the two ward areas.
- There were no mortality review meetings at Westmorland General Hospital. Any deaths occurring at this site would be reviewed at one of the other hospital sites and discussed as part of their monthly mortality meeting. The trust's mortality review report in June 2015 identified that each division must hold mortality meetings at least monthly and have a robust system for sharing lessons learned. In order to do this more clinicians would need to be trained to review case notes.
- In the surgical division the anaesthetists were involved in the mortality meetings on a twice-monthly basis and formed part of the mortality review group which met quarterly.
- Senior staff we spoke with were aware of their obligations with regard to the duty of candour.

Safety thermometer

- Information about harm free care was displayed on boards at the entry to all wards and departments. Those we saw reported no falls or incidents of infection in the previous month. These boards had been changed recently to provide more information for patients which included recent positive and negative comments with resulting actions, and required and actual staff numbers.
- Between January 2015 and June 2015 there had been no falls, pressure ulcers or C.UTIs recorded on surgical wards within this hospital.
- Staff told us this information was used to inform them, during monthly ward meetings and shift handovers, of any identified shortfalls in harm free care and changes to practices as a result.

Cleanliness, infection control and hygiene

- The wards, theatres and clinical areas were visibly clean and tidy.
- Cleaning schedules were completed and specific areas and equipment were subjected to spot checks for cleanliness, such as commodes. These were recorded and a system was in place to ensure compliance with the required level of cleanliness. Between October 2014 and February 2015 commode cleanliness audits for this hospital demonstrated very high levels of compliance.
- We observed staff to wear personal protective equipment which was available as required.
- Pre-operative screening for MRSA was carried out.
- Between April 2014 and February 2015 there had been no cases of Clostridium Difficile in the surgical division at Westmorland General Hospital.
- Information from the 'Public Health England, surgical site infection surveillance report' showed that over a period of four years, there had been no surgical site infections for hip or knee replacements.
- There were measures in place to separate patients who had undergone elective or trauma surgery.
- In the day surgery unit the curtains between the beds were disposable and had a date recorded when they were fitted, however the date for changing them was blank. This meant it was not easily identifiable for staff to know when to change these curtains.
- There were hand wash sinks and hand gel dispensers throughout the wards. There were signs at the hand wash sinks to remind staff how to properly clean their hands and we saw staff doing so. The trust hand hygiene audit in February 2015 showed 84% of staff throughout the trust were adequately washing their hands. This did not meet the trust's target of 90% and we were told additional spot checks had been introduced.

Surgery

Environment and equipment

- There had been some changes to the environment the day prior to the inspection. This involved the designation of the rooms on one corridor of the L shaped ward to be for long stay and trauma patients with the other part being for elective patients. This meant that patients with needs for similar equipment, observation and support would be accommodated together.
- There was one area designated to the care and treatment of patients having breast surgery. This had relevant information posters and leaflets and a quiet room should confidential conversations be required.
- The resuscitation equipment in the day surgery area did not include a defibrillator. There was one available with the nearest alternative resuscitation equipment which was further along the same corridor and staff were aware of that.
- Records showed the resuscitation equipment was checked daily with a more in depth check on a weekly basis.
- Records showed that equipment was serviced and maintained within the necessary timescales.
- There was an electronic tracking system for disposable stores in place in the theatres at the other trust sites which was not in place at Westmorland General Hospital. The hospital used a manual system.
- There was a theatre supplies group which met to discuss the varied necessary equipment for each area and to ensure financial efficiency in equipment supplies.
- The emergency call bell in theatre 4 was not linked to the other theatres which meant staff would not be alerted if urgent assistance was required.
- The equipment required should a patient be transferred in an emergency from theatres to Royal Lancaster Infirmary was in a bag in a locked room on the ground floor of the theatres. The record of checks for this bag was in a separate theatre on another floor of the theatre suite**.**
- Theatre equipment was checked on a daily basis.

Medicines

- Medicines were safely stored including medical gases.
- Controlled drugs were safely stored and records were kept, including a daily check.
- There was lockable storage by each patients' bed for their medicines to be safely stored.
- Patients were encouraged to bring in their own medicines and continue to administer their own medicines if it was safe to do so, following a risk assessment.
- Temperatures of cold storage were checked and recorded.
- The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. This included the administration and safe storage of medicines policy dated September 2010 with a renew date of September 2012. These were trust wide policies and were readily available for staff stored in the clinical room with the medicines. However, the electronic versions were in date.

Records

- Not all records were adequately maintained to ensure patients' care could be clearly understood. We reviewed the records of seven patients. These included nursing and medical records. We found that two sets of notes contained loose papers and, in the medical notes, there was no clear division to separate the latest episode of care from previous ones.
- Some records were stored securely in locked cabinets and others were easily accessible on top of desks and cupboards in open administration areas. This resulted in a lack of confidential storage of patient records.
- For elective surgery the pre-operative assessment was recorded which included a detailed medical history, results of observations and examinations and a venous thrombo embolism assessment. These were fully completed in the files we reviewed.
- The nursing records we saw contained comprehensive information which included risk assessments for pressure ulcer prevention, mobility and nutrition with relevant plans of care. Details of the assistance needed for personal hygiene and any specific communication issues with evidence of family involvement. Those we reviewed were up to date.

Safeguarding

- Staff we spoke with had received training in the recognition of abuse, the types which may occur and

their responsibilities to report it. In the surgery division 100% of staff had completed safeguarding of adults and children to level one and 90% had completed the level two adults training.

- Additionally the lead for adult safeguarding at the trust had completed more in depth training for 1800 staff members across the trust since December 2014. This included all grades of nursing and medical staff and they received information about abuse, domestic violence, and prevention of terrorism. External speakers attended this course and those staff we asked said it enhanced their understanding.
- Staff were clear about the process to follow to report any concerns they had with regard to the protection of an adult. Those we spoke with, including ward managers, would report their concerns, via an incident form, to the safeguarding lead nurse for the trust. This nurse was available Monday to Friday 9am to 5pm with noone on-call outside of these hours. Staff were aware of how to make a direct referral to the local authority, should they need to do this outside of the lead nurses working hours.

Mandatory training

- 100% of staff had completed some of the mandatory training in May 2015 such as health, safety and welfare and infection prevention level 2. Training which was not up to date included fire safety where 66% of staff had completed it and resuscitation with 82% of staff up to date. Plans were in place to ensure that mandatory training would be completed.
- Staff could access additional training if it was beneficial to patient care. Four nurses had completed a course in breast care in order to become specialist nurses. There were plans for one nurse per year to complete the course at Manchester.
- Theatre staff had a half day on a monthly basis protected for training. This included specific training for example on new orthopaedic procedures.

Assessing and responding to patient risk

- Nursing staff told us they would assess the condition of a patient prior to assisting them to return to the ward from the theatre recovery area. If they were not satisfied that a patient was medically fit and stable they would not accept them back to the ward.
- Staff were aware of how to obtain medical assistance should a patient's condition deteriorate. This was provided by the resident medical officer who was on duty 24 hours per day. When the surgeons and other operating doctors were still on site they would be called to see their own patients if necessary.
- Medical staff said their assistance was requested in a timely way if a patient's condition was deteriorating and they were confident nursing staff monitored patients' conditions satisfactorily.
- Staff confirmed that pre-operative assessments were completed and that if a patient was assessed as having any high risk needs they would not have their operation at Westmorland General Hospital. This was because there was no high dependency or critical care unit available post-operatively should a patient's care require it.
- Should a patient's condition deteriorate and the decision was that critical care was required the patient would be transferred to Royal Lancaster Infirmary by an emergency ambulance. This had not occurred in the past 12 months.
- There was no standard operating procedure for the transfer of ill patients from Westmorland General Hospital. The development of this was within the remit of the Westmorland Hospital Acutely Ill Group who met for the first time on 11th June 2015.
- We were told there had been some issues of consultants not completing the venous thromboembolism risk assessments for all patients. This had been escalated to the medical director and measures were being taken to improve compliance.
- There was no pathology laboratory on site therefore provision was made for blood products to be available when required. Nurses were trained to safely manage blood transfusions.
- In theatres the 5 steps to safer surgery was used appropriately; however there was no documentation to support this as it had not been audited.
- The theatre manager stated the debrief had not been completed as effectively as it should have been and work was underway to improve this. There was no criteria for which staff member would lead the safety brief in theatre with the manager saying it could be the team leader, consultant or anaesthetist.

Nursing staffing

Surgery

- The nursing staff vacancy rate was 18.8 whole time posts being vacant in May 2015. There had been no use of agency staff in the same month as staff had been made available from the elective orthopaedic unit which had been closed for two months.
- Nursing managers told us the elective ward would not be re-opened until adequate staff numbers were available to safely accommodate patients in that area. This meant safe staffing was a major consideration and reconfiguration of the service occurred instead of managing with low staff numbers.
- The nursing staff ratios were calculated separately in each area to determine safe staffing levels dependent on the activity for the day. An example would be which procedures were taking place, if an operating list was being completed and the numbers of theatres running on the day.
- The "red rules" assessment tool to monitor the staffing requirement against the needs of the patient population had not been introduced at this trust site. We saw numbers of staff on duty met with the NICE guidelines "Safe staffing for nursing in adult inpatient wards in acute hospitals" in the ratio of one nurse to eight patients. This was maintained with clinical support workers providing additional assistance.
- Agency nursing staff had not been used on wards at this site in the past 12 months.
- Staff from this trust site had worked at Royal Lancaster Infirmary when they were short of nurses on a temporary basis. Managers said this should be required less when the current recruitment was completed.
- One nurse, either a ward manager or a band 6 nurse, was designated to cover all ward areas as a co-ordinator. This meant they had oversight of the staffing numbers for the day and any areas which may require additional support.
- There was a nurse co-ordinator on call during the night and at weekends to assist with any escalation of concerns such as low staff numbers.
- Staff on the day surgery unit worked in all areas in order that they had the knowledge and skills to be deployed throughout the unit.
- New staff had a period of induction which included them being supernumerary on the wards. This would be for two weeks if they were new to the hospital or newly qualified and one week if they were familiar with the trust.
- There was a "buddy" system for newly qualified staff in order for them to have a peer they could refer to for day to day support.
- There was a vacancy rate of four full time staff in the theatres at this hospital which had led to 9% of shifts being covered by agency staff in May 2015. There were measures in place to understand this shortage as the turnover was thought to be high and retention of staff was the focus of work by the new theatre matron.
- On the day surgery unit the nursing staff numbers varied each day dependent on the procedures which were taking place. They were increased if necessary due to specific areas being used, for example the cystoscopy suite. This meant there was flexibility of nursing staff to ensure the numbers were adequate at all times.
- The operating lists are produced two weeks in advance whilst the electronic rota is done eight weeks in advance which means there can be a mismatch of staff dependent on the operations booked on the list. This led to necessary late changes in staff rotas.
- 80% of the theatre staff who assisted in operations could work in any speciality theatre as they had received the necessary training.
- Nursing handover of information between each shift took place with written information available for staff. The medical and social needs were discussed with any plans for discharge or transfers between sites.

Surgical staffing

- The number of medical staff employed to work solely at Westmorland General Hospital was 4.4 doctors. There was a vacancy of 1.4 doctors and recruitment was underway.
- Consultants completed operations for their speciality at this hospital at booked session times. This meant if there were low numbers of permanent staff in that speciality, for example urology, then locum medical doctors would carry out the procedures.
- There was a resident medical officer who was on-call at all times, including nights and weekends. They visited the inpatient wards every morning, midday and evening seven days per week and were available to visit during the night if required. A monitoring report in July 2015 showed they had attended the wards at night twice per week or less during that month.
- Two resident medical officers usually worked opposite each other for 14 days then had 14 days off. At the time of the inspection one was covering one week holiday for

the second doctor which meant they were working three weeks without a day off. They stated because of the lack of work at night they found this acceptable and did not consider it too tiring.

- Should the resident medical officer require assistance at night or at weekends they had telephone support from a senior doctor at Royal Lancaster Infirmary. There was no provision for a doctor on-call to go into the hospital should they require assistance.
- Should they have concerns about the deteriorating health of a patient they would transfer them to Royal Lancaster Infirmary in an emergency ambulance.
- A doctor specialising in the care of older adults visited to consult patients on the wards at Westmorland General Hospital twice per week. There was some concern from other doctors that this was insufficient input for these patients who could have complex medical needs.
- The resident medical officers provided handovers to each other at the change of their two week shifts. This included comprehensive information about each patient's medical condition.

Major incident awareness and training

- Senior nursing staff knew what their expected response would be should a major incident occur. They had meetings to discuss their role and the policy which was in place. Other staff knew where the policy was held and how to access directions should it be required.

Are surgery services effective?

Good

Surgical services at Westmorland General Hospital were good. There were good examples of effective multi-disciplinary working. The majority of staff were clear about how the mental capacity of a patient impacted on their role and responsibilities. There were good systems in place to manage patients' pain and maintain adequate nutrition and hydration. Consent forms were correctly completed, although written consent was routinely obtained on the day of surgery. Care pathways including pre-operative assessments and enhanced recovery were based on the relevant national guidance. There were good additional specialist training opportunities and assistance for staff to keep their skills updated. Concerns with lack of access to information had been successfully addressed. Most staff were up to date with their appraisals.

The written policies and procedures held on the wards for guidance had not been reviewed within the timescales documented. There was a lack of a formal audit programme and systems for using the results to inform changes to practice.

Evidence-based care and treatment

- The ward manager had attended an audit meeting about orthopaedic and breast care, the outcomes of which had been discussed with the staff and changes made as a result. Although nursing staff stated they were not routinely involved in the audit activity within the hospital or the wider trust.
- Whilst the written policies we saw referenced national guidance most of these had not been reviewed within the timescale documented on them. This meant there was potential for the guidance referenced to be out of date.
- The care of patients prior to and following elective knee or hip replacement followed the enhanced recovery guidance. This included pre-operative multi-disciplinary education classes.
- In theatre there was a lack of understanding of what was audited. The interim manager was going to discuss with the managers at other sites what audits took place and the frequency in order to develop an audit programme.
- A senior member of staff in theatres had changed the moving and handling practices to improve patient care. This had not then been monitored or audited to assess the outcome.

Pain relief

- Pre-operative assessments of pain were carried out for all patients. Pain relief was prescribed to ensure there was no delay should a patient require this post operatively.
- The hourly assessment of patients included monitoring a person's pain by asking them for their own assessment. We observed pain relief was offered if patients stated they had pain.

- There was no dedicated pain team; however one band 6 nurse had completed additional training in pain management and anaesthetists were available post operatively should a patient require additional support for pain.
- There was one clinician with a lead for chronic pain in the trust. They provided support for other clinicians should this be required.

Nutrition and hydration

- There were “beverage stations” on the wards where staff could provide hot drinks and toast to patients who had returned from theatre. Patients said this had been provided at whatever time they had requested it.
- The food was cooked on the premises and patients said it was of good quality. Special diets, such as gluten free, were catered for. Ward staff served the food to the patients so the choices could be changed and they could provide a small or large portion dependent on the patients’ wishes.
- There was a discreet system of symbols used on magnetic boards above a patients' bed which indicated if they required assistance with food and drink.
- The Malnutrition Universal Screening Tool (MUST) was in use on the wards and access to a dietician was available should this assessment indicate this was required.
- As part of the enhanced recovery programme patients were nil by mouth for as short a time as possible pre-operatively and offered a drink in theatre recovery and food as soon as possible, dependant on their operative procedure.

Patient outcomes

- Staff we spoke with of all grades and in all wards and departments had the provision of positive outcomes for patients at the centre of their work. They discussed how they strived to make improvements through learning from shared practice with other centres of excellence and also understand how they could continually improve the outcomes for their patients.
- Overall the trust was matching the improvement seen nationally in 'Patient Recorded Outcome Measures' (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the England average.
- In the Lung Cancer audit 2014 the trust scored better than or similar to the England average in all 3 questions.
- The trust scored ‘good’ for two indicators and better than the England average for two indicators in the National Bowel Cancer audit 2014. The trust scored worse than the England average for “Seen by clinical nurse specialist”.
- Information provided by the trust showed the readmission rates for patients within 28 days following trauma or orthopaedic surgery was one patient at this site out of a total number of 100. This was the lowest of all three sites. An action plan was developed which included consideration of a rapid review for any patients readmitted with an infection and a further analysis of 800 patients across the trust.
- Nursing and medical staff in theatres were not aware of the audits which were ongoing in their department such as auditing the 5 steps to safer surgery checklist and the utilisation of the theatres. Some staff on the wards were aware of the audits ongoing in their immediate area such as hand hygiene and mattress audits; however they were unaware of other audits within their clinical field.
- Information provided by the trust showed the day case rate to be 80.49% which did not reach the trust’s target of 84% in May 2015. Staff in this unit at Westmorland General Hospital were unaware of this or any measures to achieve the target.

Competent staff

- The trust's target for appraisal rates was 95%. 93% of band 1 to 7 nursing staff were up to date with their appraisal. Neither of the band 8a and above staff with responsibility for other staff had completed their appraisal.
- 100% of medical staff were up to date with their appraisals.
- Staff told us they could request appraisals between the arranged dates if they required additional support.
- Staff told us they had the opportunity to expand their knowledge and skills in order to improve the care they could provide patients. One nurse had attended a specialist hospital to observe specific pre- and post-operative care for patients with shoulder surgery. They had then changed some practices at this hospital to improve the patient care.

- Nursing staff, including clinical support workers, had been supported to complete training to extend their role to include, for example, post-operative care of ophthalmic patients and assisting with diagnostic procedures.
- Due to Westmorland General Hospital not having an accident and emergency department or receiving major trauma patients staff could lose the skills they needed to recognise and manage the care of a deteriorating patient. In order to ensure staff remained competent they completed clinical skills training two days per month. This included assessment and care of a deteriorating patient and blood transfusion.
- There were some development days planned and taking place to encourage working across the three trust sites. This would help nursing staff to learn from colleagues in other trust sites and exchange ideas for working practices.
- Externally facilitated surgical development days had been held for band 6 nurses.
- Theatre staff said 80% of their work was orthopaedic procedures. In order to be competent to assist in other specialities they would like to rotate with the theatre staff in Royal Lancaster Infirmary. Current staffing numbers would not allow for this.
- The clinical director told us the revalidation process at the trust was well managed. Reminders for non-compliance were sent to the clinical director for follow up. They said all staff members were revalidated.

Multidisciplinary working

- Both medical and nursing staff reported good working relationships with open communication taking place, both formally through joint meetings and informally whilst working.
- There was a multi-disciplinary meeting daily with the relevant professionals attending depending on the patients accommodated. This could include the nurses, doctors, physiotherapists and occupational therapists.
- There were specific clinics, such as the joint school for education for patients who were to have a knee or hip replacement, which included nursing, physiotherapy and occupational therapy staff.
- Staff and patients told us support from therapists to enable mobilisation as soon as possible following surgery was readily available.
- There were trust wide multidisciplinary teams with established links with local speciality teams such as head and neck surgery and urology. Meetings took place as video conferences and were recorded with the outcome discussed at medical staff meetings and handovers.

Seven-day services

- Daily ward rounds took place on all surgical wards in the hospital. This included weekends when the resident medical officer would complete a ward round and contact the consultant if necessary for additional support or advice.
- The majority of services at this hospital were five days per week as the operating theatres were not open at weekends.
- The on-site pharmacy was open Monday to Friday only. This meant pharmacy support outside of these hours was obtained from Royal Lancaster Infirmary.
- The ongoing recruitment for theatre staff included staffing for two theatres to be open on Saturdays 8am to 6pm. This was in the planning stage only.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays, and electronic and paper records.
- Nursing staff said patients did sometimes return from theatre without the operating notes having been completed. They could either be written or kept on the computer and staff on the wards sometimes had to print them when the patient had returned to the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were accurately completed.
- Patients and staff told us the surgical procedure was discussed with them in advance of the surgery taking place. This could have been at an outpatient clinic or pre-admission assessment. Written consent was routinely obtained on the day of surgery. The Department of Health's "Reference guide to consent for examination or treatment" states: "If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt

as to its validity". This meant because patients' consent was routinely documented immediately prior to the procedure starting the procedures do not meet with best practice.

- Staff we spoke with had competed some training with regard to the Mental Capacity Act and Deprivation of Liberty Safeguards which was included in the safeguarding mandatory training. We found a varied level of understanding of the implications on their role and responsibilities that would result from a patient's lack of mental capacity.
- Nursing staff had some knowledge of the deprivation of liberty safeguards and how they might apply to patients in their care. They recognised what might constitute a deprivation of liberty and who to discuss this with.

Are surgery services caring?

Good

Staff were caring within the surgical services at this hospital. Patients spoke very highly of the attitude of staff describing them as attentive and helpful. They said their experience of the hospital was "very good". Staff attended to patients quickly when they requested assistance and treated them with respect.

Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions. There was a lack of formal emotional and psychological support for patients other than the chaplaincy service.

Compassionate care

- Patients told us the care was "very good" describing nursing staff as very attentive and helpful.
- Staff attended to patients' requests for assistance promptly and patients said staff were consistently helpful.
- We saw staff protect the privacy and dignity of patients on the wards and in all departments.
- Patients received additional support from staff when they were having an ophthalmic procedure. This included a staff member sitting with a patient whilst they had their procedure to offer comfort and help relieve anxiety.
- Staff had access to a hairdresser who would attend the hospital to assist patients to attend to their hair. They said this was particularly important for those patients who had a longer stay due to rehabilitation.
- Information from the May 2015 national friends and family inpatient survey showed an average of 99% of patients would recommend the surgical wards at Westmorland General Hospital. This was better than the national average of 95%. The average response rate for surgery within this hospital was 80%.

Understanding and involvement of patients and those close to them

- One patient said the physiotherapy they received was good and they felt included in their own recovery through education.
- A patient who was returning home said they had: felt involved in their care throughout their stay, been kept informed of progress and any changes to care and been able to ask questions and staff had listened to them.

Emotional support

- Staff told us emotional support for patients was provided by the chaplaincy service and any staff who felt able to offer this.
- There were no specialist support nurses for emotional or psychological support.
- There were no recorded assessments for anxiety and depression in the files we reviewed. Relatives and patients told us staff had recognised when someone was low in mood and had responded well to address their concerns.

Are surgery services responsive?

Requires improvement

Surgical services at this hospital required improvement to be responsive. The referral to treatment times for patients admitted to the hospital were worse than the England average; trust wide initiatives had been launched to reduce these and improvements had been made. There were services available to reduce the numbers of visits needed for patients who had to travel long distances to the hospital. There were measures in place to aid the access and flow of patients through the day surgery unit. The average length of stay was shorter than the England

average. Services and recent environmental changes were in place to assist patients with complex needs and communication problems. Additional support from carers for patients with complex care needs was welcomed onto the wards. Arrangements would be made, if possible prior to admission, for family members or carers to be present with the patient. Learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- One stop clinics had been developed in the urology speciality. This enabled people to attend the hospital once to have diagnostic procedures such as ultra sound scans, a biopsy, flow rates and flexible cystoscopy carried out with one visit. This helped people who may need to travel long distances due to the rural geographic location of the hospital.
- The hospital was a regional centre for the care of patients for breast surgery with referrals from Blackpool and Carlisle. This meant patients from these surrounding areas did not need to travel to Manchester for this care.
- The discharge matron considered the need for patients to be closer to their family members and would relocate patients, following their surgery, to Westmorland General Hospital from Royal Lancaster Infirmary or Furness General Hospital if necessary.

Access and flow

- Information provided by the trust showed that in March 2015 all seven of the surgical specialities monitored were not meeting the referral to treatment target of 90% in the admitted pathway. This was in line with the national amnesty on the admitted standard to fail the standard by prioritising the treatment of the longest waiting patients. Orthopaedics had suceeded in treating the greatest proportion of the longest waiting patients at 43.2% against the admitted standard and Oral Surgery the least at 82.8%. Measures had been put in place to further improve this position. These included changes to the waiting list management, use of local independent hospitals, assessing theatre utilisation, re-assigning sessions to increase availability for the longest waiting patients and providing additional operating lists at weekends. This had reduced the number of patients waiting in excess of 18 weeks, across the specialities, from 1091 in January 2015 to 712 in July. However, following this amnesty the trust continued to not meet the referral to treatment target of 90% in the admitted pathway. In April 2015 it was 70%, May 2015, 90% and June 2015, 77%.
- To increase the capacity for ophthalmic patients and reduce their time in hospital, part of the day surgery ward had been developed into an area for them to wait and recover from their surgical procedures. This could accommodate seven patients at any one time and was open Monday to Friday 7.30am to 8.30am. This meant these patients did not need to be accommodated in the ward area or take up an inpatient bed.
- The day surgery unit was described as being very busy with 445 patients having procedures there in June 2015. We were told this had increased due to initiatives to reduce the waiting lists.
- There were measures being put in place to develop a specific theatre list for patients having injections, for example, those into a joint for pain relief. This would mean waiting times could be staggered to reduce their waiting times and information changed to ensure they understood the procedure was categorised as day surgery. This would reduce the waiting times for patients as currently 16 patients could present at any one time for this procedure.
- There was one area of a ward designated to elective general surgical patients. This area was open from 7.30am to 7pm for day surgery patients. The operating lists were arranged so that those patients requiring a longer recovery time had their operation earlier in the day so that all were ready to leave the hospital by 7pm when the ward closed. Should anyone need a bed overnight this would be available in another part of the hospital, although we were told this rarely happened.
- The average length of stay for elective orthopaedic patients was 3 days which was better than the England average of 3.1 days.
- The average length of stay for all non-elective patients was 1.5 days which was much less than the England average of 5.2 days. The majority of patients at this site were elective patients.
- Patients were transferred to this hospital from Royal Lancaster Infirmary 72 hours post operatively if they were medically fit. This meant the flow of patients at Royal Lancaster Infirmary could continue as Westmorland had the capacity to accept these patients.

- A weekly meeting took place to discuss the discharge of patients. This included a social worker and ward staff. This meant plans for discharge of patients with complex health and social needs was begun at an early stage.
- In theatres there was no mechanism to plan for surgeons to operate at Westmorland General Hospital for a full day. This meant there were delays in starting the afternoon operating list if surgeons were late completing their morning list at Lancaster. The trust were unable to provide information of the frequency of late starts. We were told monitoring of this had recently begun.
- There was a weekly scheduling telephone conference between the theatres on all three trust sites on a weekly basis. This co-ordinated the work of all theatres ensuring the necessary personnel and equipment were in place for the booked surgical procedures for that week. This helped with the efficient running of the theatres.
- In June 2015 94 operations were cancelled and of these six were cancelled on the day of the operation for non-clinical reasons. The majority, at 52, were cancelled within 48 hours or more of the operation. Staff said all of these met the guidance of being offered an alternative date within 28 days.
- The process for admission varied dependent on the speciality and surgical procedure. Where possible admission was on the day of surgery with a pre-operative overnight stay only being used when additional preparation was required.

Meeting people's individual needs

- Nursing staff said there were link nurses who offered advice and support for them on how to offer appropriate care for patients with complex needs such as a learning disability or dementia.
- There was a resource room available where educational material for staff was kept and was separate to the patient areas.
- A small room had been designated as a sitting room to enable patients who were on the ward for a longer stay to have somewhere to sit, other than by their beds. This was to be decorated in a suitable way for patients with dementia or cognitive impairment. The dementia nurse specialist was to provide assistance with this.
- The matron with a lead in care of patients with dementia had trained two qualified nurses and three clinical support workers to be dementia champions on the surgical wards. This meant they could provide additional advice and support to other staff to aid their understanding of patients with a cognitive impairment.
- We saw some changes to the environment which had taken place due to an understanding of the needs of patients with impaired cognition. These included: the addition of nurse's administration areas in the bays with the patients for increased observation and the provision of appropriate sitting rooms to offer a change of environment.
- There were signs to assist visually impaired patients on the doors to toilets and bathrooms.
- Staff told us additional support from formal and informal carers for patients with complex care needs was welcomed onto the wards. Arrangements would be made, if possible prior to admission, for family members or carers to be present with the patient.
- The written information for patients was all in English. Staff said they could get leaflets in other languages if they needed to, but did not keep any and had never done so.
- Should a patient require a translation service to aid their understanding of their care and treatment this would be provided by a telephone translation service. Where necessary face to face translators could be arranged.
- We were told recruitment had taken place to appoint a trust wide nurse lead to advise on the care of patients with a learning disability. This nurse would assess the current provision for support and plan for improvements where necessary.

Learning from complaints and concerns

- Staff and ward managers said learning from complaints took place as part of the ward meetings and informally at handovers and safety huddles.
- If appropriate learning was also shared in the printed newsletter.
- Information on how to make a complaint was clearly visible on the wards and in the communal areas of the hospital.
- For the period 1 June 2014 to 31 May 2015 there were 10 complaints for surgical areas at this hospital.

Are surgery services well-led?

Surgery

Good

Overall surgical services were well-led. All staff shared a vision of improving services for the patients through learning from feedback, being open to learning from shortcomings in their own service and sharing good practice from other trusts. Staff felt well supported by their immediate line managers and the divisional matrons. Managers had some understanding of the trust's vision, whilst other staff did not.

The risks on the risk register were not dated therefore it was not possible to monitor progress towards reducing them. There was an open culture where staff could discuss concerns with appropriate people. Staff told us they felt included in the development of services and could make suggestions for change, especially in the operating theatres.

Vision and strategy for this service

- Senior managers talked about their vision for the service to include recruitment of staff to work across all three hospital sites within the trust. Staff we spoke with were unaware of this future planning.
- Staff in theatres told us they thought the theatres were underused and could run more efficiently. Senior managers told us plans were being considered to move more general surgery to Westmorland General Hospital, however theatre staff were unaware of any work ongoing to maximise their use. This showed the vision of the wider trust was not shared with other staff that it may affect.
- All staff we spoke with shared the vision of improving the patient experience within the surgical services. This included improving the patients' journey through the service, increasing activity and enhancing their own learning to improve patient care.
- There was an enthusiasm from all the staff to provide the best care and find new ways of doing this, especially in respect of emotional and psychological support.

Governance, risk management and quality measurement

- Monthly ward meetings took place and managers discussed local issues as well as those which affected the wider trust. Staff said they felt these meetings kept them informed; however they said they did not always feel part of the whole trust in terms of future planning.
- The risks on the risk register were not dated therefore it was not possible to establish how long they had been recognised. The majority of the risks were related to the quality of care. Action points with progress made were documented. Managers we spoke with were aware of the highest risks identified.
- Staff in specific wards and departments were aware of the risks in their area and measures in place to reduce them. This included increased observation in bays by the addition of administration desks to reduce falls.
- The quality assurance matron had been appointed to the trust wide corporate governance team. They discussed how they had tried to spend one day per week at the Westmorland General Hospital site to discuss the quality of care, with particular focus on the ward accreditation scheme. This had been based on similar schemes in other hospitals which had been visited and involved rated quality assessments which led to an overall accreditation for wards which maintained the highest standard for three assessments. The specific assessments were designed to encourage team work as they included varied care and support themes. This showed a focus on continued quality improvement.

Leadership of service

- Staff said their managers provided clear direction, and were approachable and supportive.
- All grades of staff spoke highly of the matrons. Comments included that they provided a good link to the operations managers and they were visible and approachable providing practical support when necessary.
- Additional leadership posts in the surgical services included a matron for theatres who would work across all the trust sites. This was seen as a very positive move by all the theatre staff we spoke with who said it would increase the visibility of the trust wide management team for them. This post had been created as a direct result of a review of the theatre working at the trust.
- Theatre staff stated the management team was very supportive and had given additional support when it was required.

- Drop in sessions were available with the management team and staff did utilise these to talk about any concerns, issues, ask questions or voice ideas.

Culture within the service

- Staff reported that they were encouraged to be open and honest with their immediate line managers and if necessary above. They said because the hospital was small it was friendly and staff of all grades were positive about the more relaxed atmosphere than they found at other trust sites.
- Staff who worked in theatre described a “family” atmosphere with professional working relationships and good support from peers and managers.
- Nursing and medical staff we spoke with discussed how they wanted to keep improving the service. Discussions shared a common theme of learning from other trusts.
- There was an open culture with a willingness to accept complaints and incidents as an opportunity to learn and improve practice. There was a willingness to accept the need for change as long as it was focussed on the care of the patients.

Public engagement

- Feedback forms were available on the wards and departments we visited with post boxes for patients and visitors to leave them. Patients told us they were actively encouraged to complete these.
- Informal feedback from patients was sought and we observed staff to be asking patients' opinions about various aspects of the service they provided.

Staff engagement

- Staff told us they felt as though their opinions about the specific ward or department they worked in were sought and they could make suggestions for change which were listened to.
- Some staff felt more open discussion about the services offered and the future plans were required in order for them to feel part of the changes. This included the closing of the elective surgery where there were no clear plans shared with staff about re-opening.
- There were no staff survey results for the surgical division.
- Staff spoke about the services offered with ownership for the provision of good care and being able to increase their productivity in the future.

Innovation, improvement and sustainability

- Staff we spoke with had ideas about how the services at this hospital site could improve. Some staff felt their ideas had been listened to and others, particularly theatre staff, felt they could be a bigger part of the changes they knew were necessary for sustainability of the service.
- Nursing staff on the wards had been able to present ideas for change, had been listened to and where possible their ideas acted upon.

Maternity and gynaecology

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

Information about the service

Westmorland General Hospital provided midwifery led care in a stand-alone midwifery unit called the Helme Chase Maternity Unit. Geographically there are 46 miles between Furness General Hospital and Royal Lancaster Infirmary and 32 miles between Furness General Hospital and Westmorland General Hospitals. Between June 2014 and June 2015 there were 165 births at the Helme Chase Maternity Unit.

The Helme Chase Maternity Unit had three delivery rooms, including one active birth room with a birthing pool, one home from home room and an antenatal clinic. It was a stand-alone unit staffed entirely by midwifery staff; however, consultants held clinics in the antenatal clinic and if on-site were available to review patients if required.

During our inspection, we visited the antenatal clinic area and the Helme Chase Maternity Unit. We spoke with two patients, as well as six staff which included midwives, the community midwife team lead, a matron, a consultant and support staff. We observed care and treatment and looked at five care records. We also reviewed the trust's performance data.

Summary of findings

At the last inspection in February 2014, we rated maternity and gynaecology services as good. During this inspection, we also found that maternity and gynaecology services at this hospital were good.

Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job. The individual needs of women were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect while they received care and treatment.

The Helme Chase Maternity Unit had undergone a considerable restructure in December 2014 which altered the way in which the unit was staffed and operated. There was no provision for women to stay in the unit for additional nights, and out of hours, the service operated on an on-call basis. There was clear leadership of the unit but staff satisfaction was mixed as some staff felt unsupported.

Women's care and treatment was planned and delivered in line with current evidence-based care. This was monitored to ensure consistency of practice. Care outcomes were within expectations or better than expected.

There were processes in place to ensure women received emotional support where required. The service was aware of risks to ensure services were planned and delivered to meet the needs of the local population.

Maternity and gynaecology

Work was ongoing in partnership with other organisations to engage with the local community in order to raise awareness of the Helme Chase Maternity Unit and the changes in service provision.

Are maternity and gynaecology services safe?

Good

There were clear guidelines in place for managing normal labour which had clearly defined criteria for transfer. Care and treatment was planned and delivered in a way to ensure women's safety and welfare.

Processes for checking expiry dates of stock items were not consistent in all areas which the trust addressed during the inspection. Medicines were stored safely. Emergency drug boxes and home birth kits were also appropriately labelled and stored.

Records for safeguarding referrals were not always adequately completed, signed and dated and outcomes from meetings with social workers were not consistently recorded.

There were sufficient staffing levels to meet the needs of women. There were improvements in the number of staff who had completed mandatory training from the previous CQC report; however the percentage of staff who had completed child safeguarding level three was low. Staff followed guidance for infection, prevention and control.

The unit although 'dated', was clean and staff complied with infection control guidelines. Staff used the maternity early warning scores to assess risk and women were transferred to the consultant led centres, if their scores became elevated or concerns were identified in labour.

Incidents

- Staff we spoke with said they felt confident to report incidents and were aware of the process to do so. Incidents were reported on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported, with details of the outcomes of investigations.
- There were five unresolved incidents reported for the Westmorland General Hospital (WGH) site between January 2014 and July 2015; the themes of these incidents were communication failure and unplanned place of birth. The grading of these incidents were four no injuries and one minor injury.

- There were three transfers from the Helme Chase Maternity Unit in June 2015 to the consultant led units which were for undiagnosed breech presentation, slow progress in labour and a 3rd degree tear which required surgical repair.
- A monthly 'Learning to Improve' bulletin was provided to staff electronically and in a hard copy format. A divisional bulletin was also available which reflected specific learning within divisions.
- Joint perinatal mortality and morbidity meetings were held quarterly across the three hospital sites. All serious cases, including stillbirths and neonatal deaths, were reviewed by a multi-disciplinary peer group. Minutes for December 2014 to June 2015 showed that recommendations to improve practice had included changes to documentation and clinical practice and review of guidelines.
- An audit of compliance with the Duty of Candour was put in place following the change in legislation from October 2014 and had been repeated for the period April to June 2015. The audit for women's and children's services showed all incidents reported as moderate or above had received a duty of candour where women received information about what went wrong with their care and an apology.

Safety thermometer

- Maternity had commenced using the national maternity safety thermometer. This allowed the maternity team to check on harm and record the proportion of mothers who had experienced harm free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition it identified those babies with an Apgar (a method to quickly summarize the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.
- A snapshot of the maternity safety thermometer March 2015 to June 2015, showed 83% of women did not experience any of the physical harms (infection, perineal trauma, PPH>1000mls, Apgar <7 (term only) or transfer (term only)).

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signs were on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.
- The CQC Survey of Women's Experience of Maternity Services (2013) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- We reviewed the results of environmental cleanliness audits; however, the Helme Chase Maternity Unit had not been audited since October 2014 where the results showed between 95% and 99% compliance. We reviewed meeting minutes from February and March 2015; an action was stated to chase up hotel services at WGH and request the information, however, there was still no data in the May report and there was no actions as a result of this.
- Data for April 2015 for aseptic non-touch techniques showed 100% of staff at the Helme Chase Maternity Unit were compliant.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure that relevant patients were managed on the correct care pathways. Trust data between January and March 2015 showed 100% of women had been screened for HIV and Hepatitis B.

Environment and equipment

- We found that processes for checking expiry dates of stock items were not consistent. For example, on Helme Chase Maternity Unit we found out of date equipment, including: catheters, catheter bags, clear film IV dressings and oxygen connecting tubes. During our inspection these items were removed from stock.
- Adult and neonate resuscitation equipment were adequately checked, stocked and maintained. Records showed that checks were carried out daily.
- The three delivery rooms had suction equipment with oxygen and ENTONOX® (nitrous oxide and oxygen) piped directly into the rooms.
- There were new Infant resuscitation cabinets in all delivery rooms, which were in use and connected to the walled oxygen.

- The Helme Chase Maternity Unit did not have a Cardiotocograph (CTG) to monitor fetal heart rate. Any concerns noted in intermittent auscultation would require transfer to either the Royal Lancaster Infirmary or Furness General Hospital.
- All portable appliance tests (PAT) were up to date and scales were calibrated appropriately.

Medicines

- We found that emergency medicines were being stored appropriately in tamper proof boxes.
- The unit did not use any controlled drugs, and we found drugs were stored and managed appropriately.
- Records showed medicine fridges were monitored in line with trust policy to ensure appropriate temperatures were maintained for the safe storage of medicines.

Records

- The service used the standardised maternity notes developed by the Perinatal Institute.
- Women carried their own records throughout their pregnancy and postnatal period of care. The personal child health record (also known as the PCHR or 'red' book) was given to parents before discharge.
- There was a standard operating procedure in place to transfer the medical records of women booked under consultant care who were transferred to the maternity unit of choice at 36 weeks gestation.
- The service completed documentation audits. We reviewed documentation audit results in May 2015, where it was identified that there were 13 areas of the 47 audited, which required improvement, for example, these included dates on entries, documented NMC number and documented appointment details. Recommendations and an action was in place, which required staff to continue with a monthly self-audit.A re-audit was planned in three to six months to identify the impact of improvement through the monthly staff self-audits.

Safeguarding

- Staff demonstrated a good understanding of the need to ensure vulnerable adults and children were safeguarded and understood their responsibilities for identifying and reporting any concerns. There was a dedicated safeguarding midwife.
- Training figures for June 2015 showed 90% of staff at the Helme Chase Maternity Unit had received training at level 1 for safeguarding vulnerable adults, 90% of staff had completed training for safeguarding children level 1 and 48% for level 3. We were not informed if plans were in place to increase compliance with level 3 children's safeguarding training.
- The trust had a child and infant abduction policy; however, staff were unable to recall when the last time a practical test of the procedures had been carried out. This was not in line with trust policy which stated that: 'there is a need to do a physical test on a 12 month basis to ensure that the procedures work correctly and that staff understand how they work'.
- Entry to the unit was through a buzzer system, however, during our inspection it was noted that there was no talk back system on the entry buzzer and staff were calling from the reception desk though the closed doors to identify who required entry.
- Children aged 13 to 16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team and were able to access consultant antenatal care at Helme Chase; however, their delivery was in Royal Lancaster Infirmary or Furness General Hospital.
- The service was developing processes for reporting cases of female genital mutilation in response to the Department of Health's multi-agency guidance.
- There was a part-time specialist midwife for domestic violence and substance misuse. The midwife attended the Multi Agency Risk Assessment Conference (MARAC), a local meeting to share information on the highest risk cases of domestic violence and abuse between statutory and voluntary sector agencies.
- Women were asked about any abuse at booking and when they were alone. Midwives tried to see women alone at least once in their pregnancy.
- We reviewed five records which contained safeguarding concerns and referrals; we found that the bespoke safeguarding paperwork was not adequately completed. For example, not all information on the referral paper work was completed dated and signed. Meetings with social workers were documented but outcomes were not recorded.

Mandatory training

- Staffing rosters were arranged to allow staff the time to attend mandatory training. The training covered a number of topics which included obstetric emergency skills training and adult and neonatal resuscitation.
- The service had introduced 'PROMPT' (Practical Obstetric Multi-Professional Training) an evidence based multi-professional training package for obstetric emergencies.
- There was a dedicated practice development midwife who monitored attendance and organised training sessions. Training records showed that staff had completed training in areas such as infection control (level 1 90% and 88% level 2), fire safety (87%) and resuscitation (100%).
- Data showed 90% of staff had completed information governance training.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the 'Maternity Early Obstetric Warning System' (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond if required.
- A clinical risk checklist was in place for suspected labour. Women with high risk factors presenting at home or in the midwifery led unit were transferred to the consultant led unit using the transfer guidelines. In line with policy all labouring women who required transfer were accompanied by a qualified midwife.
- Staff we spoke with informed us that there were an increasing number of high risk women requesting homebirth, for example, women who had previously had a caesarean section. Staff had developed a robust checklist for assessing and documenting high risk homebirths. This was shared with the Local Supervising Authority (LSA) and consultants.
- A venous thrombo-embolism risk assessment form was completed at booking and also when admitted in the antenatal period. If patients were identified as high risk a referral for consultant led care and prophylaxis was commenced in line with Royal College of Obstetrics and Gynaecology guidelines (RCOG) (2015).

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1 midwife to 25 births compared to the RCOG recommendation of 1 midwife to 28 births.
- A total of 21 midwives had been appointed across the trust, with two starting in June 2015. A further two were awaiting a start date to be confirmed and the remaining 17 were undergoing pre-employment checks. The residual midwifery vacancy rate was 6.1%.
- Staff we spoke with told us that agency staff were not used and we reviewed data which confirmed this.
- The unit was staffed by one resident midwife, one support worker and one community midwife Monday to Friday 8am to 8pm and from 8pm and 8am there were three midwives on-call. On the days we inspected there were no shortfalls in planned staffing levels.
- Community midwifery caseload numbers were 1:99, in addition to providing 2.7 WTE core cover. Community midwives were seconded to the unit on a rotational basis.

Medical staffing

- There were two consultant led antenatal clinics per week, however, staff informed us that if midwifery staff had any concerns during a delivery, then consultants would be happy to review women if they were on-site.

Major incident awareness and training

- A business continuity plan for safe staffing was in place. This included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were escalation processes to activate plans during a major incident or internal critical incident.

Are maternity and gynaecology services effective?

Good

Women's care and treatment was planned and delivered in line with current evidence-based. This was monitored to ensure consistency of practice. The service participated in relevant local and national audits, including external reviews.

Outcomes for women were monitored. Most outcomes were within expectations or better than expected. Where

labour was not progressing normally, it was identified and women were transferred to the maternity units at either Royal Lancaster Infirmary (LRI) or Furness General Hospital (FGH) depending on maternal preference and the receiving unit's capacity. If no rooms were available at LRI the transfer would go to FGH.

Multi-disciplinary team, professional training and development days had been introduced. Progress was being made for teams to work collaboratively across all hospital sites.

Consent to care and treatment was obtained in line with legislation and guidance. Staff had some awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- There was evidence to demonstrate that women using maternity services were receiving care in line with NICE quality standards 22 (which related to routine antenatal care) and guidance 37 (for postnatal care).
- Guidelines were reviewed by the maternity guidelines group and staff were consulted on amended guidelines and procedures to reflect changes in practice. Guidelines were audited regularly after being introduced and action plans were implemented and monitored where required.
- There was a clinical audit forward programme 2015/16 which detailed plans for national audits, divisional priorities and educational audits. The plan included the audit supervisor, completion date and frequency.
- The service had an audit midwife who worked closely with two clinical audit leads across hospital sites. Audits were discussed each month and included areas such as emergency and elective caesarean section rates, third and fourth degree tears, pre-eclampsia and postpartum haemorrhage.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them.
- Women who chose to deliver at the Helme Chase Maternity Unit did not have access to epidurals.If women required this form of pain relief they required transfer to Royal Lancaster Infirmary or Furness General Hospital. However, women had access to Entonox® (Nitrous Oxide and Oxygen) and Meptid.
- There was access to various types of pain relief for birthing women which included drug-free methods. There was also access to a birthing pool in the active birth room; we were informed 80% of women laboured in the pool and 50% of women who deliver at the Helme Chase Maternity Unit had a water birth.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital for February 2015 to June 2015 varied between 71% and 100% which was better than the trust target of 60%.
- At the time of inspection the trust had not registered an intent to undertake the United Nations Children's fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme; the aim of this scheme is to train staff in supporting women to make an evidence based choice in how to feed their baby.

Patient outcomes

- There were no risks identified in maternal readmissions for neonatal readmissions or puerperal sepsis and other puerperal infections (Hospital Episode Statistics January 2014 to December 2014).
- Between June 2014 and June 2015 there were 165 babies delivered at the Helme Chase Maternity Unit.
- The normal vaginal delivery rate was 100%.
- The trust maternity performance dashboard for the unit showed that between February and June 2015 there was one reported third / fourth degree tear which was better than the trust wide target of five. There was a rolling audit programme for tears which would be next presented in August 2015. All staff were trained in perineal suturing.
- There were no stillbirths reported at the Helme Chase Maternity Unit between February and June 2015.
- The service participated in the UK National Screening Committee: antenatal and new-born screening education audit. Trust data showed that the rates of avoidable repeat tests for new-born blood spot sampling showed improvements from 4% in April 2015 to 0.6% in May 2015 which was in line with national targets of no more than 0.5% and 2%.

Competent staff

- Newly qualified midwives completed a two year preceptorship programme which provided a framework

to develop staff from a band five to a band six in maternity care. This included rotation across all sites.Band five midwives rotated to the Helme Chase Maternity Unit, however, this was not a base unit.

- The North of England Local Supervising Authority's annual report to the Nursing and Midwifery Council October 2014 showed that the trust met the interface of statutory supervision of midwives and clinical governance, team working, leadership and development and supervision of midwives and interface with users' domains.However, improvement was required with the profile and effectiveness of statutory supervision of the midwives' domain.
- The range of caseloads held by supervisors of midwives (SoM) fluctuated from 12 to 15 midwives, which was in line with the recommended ratio of 15 midwives for each supervisor**.** All midwives had 24-hour access to supervisors. Some annual supervisory reviews were out of date because of workloads impacting on supervisory time however a full time dedicated SoM had been appointed and an action plan was in place to ensure compliance.
- Staff told us they received a yearly appraisal. Trust data showed that 81% of midwifery staff had received a yearly appraisal.
- Staff told us they had a training skills passport that had been produced to review skills and competencies.
- The service had made some progress to meet the requirements of the new nursing and midwifery revalidation process which was to be launched in October 2015. The head of midwifery told us a trust wide approach was planned. Staff told us they had some awareness of the process and were beginning to develop their portfolios.

Multidisciplinary working

- Communication between medical, nursing and maternity care support workers was described as good in the antenatal clinic.
- We found that specialist midwives worked closely with their colleagues across all hospital sites and had regular meetings to discuss practice issues.
- A multi-disciplinary team (MDT) and professional training and development day had been introduced which was currently a mandatory three day course.
- There was evidence of MDT meetings in place within the division which included knowledge, information, decision and sharing days, ward rounds, audit meetings and morbidity and mortality meetings. Staff were encouraged to attend.

Seven-day services

- The Helme Chase Maternity Unit was open for women to deliver 24 hours a day seven days a week. If women went into labour between 20.00pm – 08.00am there was an IT system in place which would forward the call to the first on- call midwife who could assess the women at home or in the maternity unit.
- The second on-call midwife would then be called in to ensure two midwives were present at the delivery.

Access to information

- During the transfer of women, there were processes in place to ensure all appropriate documentation and case notes travelled with the woman, together with the results of the appropriate investigations carried out.
- There were effective processes in place to ensure that the results of the antenatal screening tests were followed up and actioned in a timely way, in line with protocols. The screening co-ordinator worked closely with the laboratory to ensure investigations were actioned. Results were checked and all high-risk women were given an appointment to be seen in a consultant led clinic.
- Staff showed us how they accessed policies and guidelines on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had been given sufficient information to help them make decisions and choices about their care and delivery of their babies.
- A divisional wide audit of records showed 100% of notes had clear documentation of discussion regarding risks and benefits for any interventions.
- Staff were aware of Gillick competency for girls below the age of 16 to consent to their own medical treatment, without the need for parental permission or knowledge.
- Staff had some awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS) and said they had attended a study day.

Maternity and gynaecology

Are maternity and gynaecology services caring?

Good

Maternity services were caring. Women spoke positively about their treatment by clinical staff and the standard of care they had received. Staff interacted with women in a respectful way. Women were involved in their birth plans and had a named midwife. There were processes in place to ensure women received emotional support where required.

Compassionate care

- Feedback from the NHS Friends and Family Test (FFT) showed 100% of women would recommend antenatal care in May and June 2015. The response rate was 18%, for women rating their delivery in June 2015.This did not meet the criteria to be able to calculate the results for the Helme Chase Maternity Unit.
- Between April and May 2015, the scores for women who would recommend postnatal community provision from the community midwives was better than the England average with 98% and 100% against a target of 98%.
- Women spoke positively about the standard of care they had received. Women told us they had a named midwife and received good continuity of care by the community midwives. They felt well supported and cared for by staff and that their care was delivered in a professional way.
- We observed staff interacted with women and their relatives in a polite, friendly and respectful manner. There were arrangements in place to ensure privacy and dignity in clinical areas.
- The trust scored about the same as other similar size trusts in all 17 indicators in the CQC Survey of Women's Experience of Maternity Care 2013.
- The 'patient led assessments of the care environment' (known as PLACE) for 2014 showed that the trust was slightly better than the England average for privacy, dignity and well-being.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth at booking and throughout the antenatal period. All women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Women were encouraged to visit the maternity unit for a tour before deciding where they wanted to give birth and to familiarise themselves with the facilities.

Emotional support

- The service had a 'Listen to Mother' birth afterthoughts service which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.
- During our inspection we were informed of an incident that happened whilst we were on the unit. The midwife covering the dating scan clinic took the decision to delay the clinic to support a couple who had had a missed miscarriage (the fetal heart was not beating).

Are maternity and gynaecology services responsive?

Good

The service was aware of risks to ensure services were planned and delivered to meet the needs of the local population.

Women who had additional healthcare related needs were referred to the Royal Lancaster Infirmary or Furness General Hospital for specialist support and expertise. Women were kept informed of any disruption to their care or treatment.

Complaints were reviewed and appropriate actions taken. Learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- The 'Better Care Together' programme was developing a fully integrated maternity pathway which set out what women had a right to expect, so they were aware whether their care was as it should be**.**
- The reconfiguration of the Helme Chase Maternity Unit had been controversial locally, however, the trust consulted with staff and the local community to develop a sustainable service which met the needs of the local community in an aim to promote normality.

Maternity and gynaecology

- Maternity services were working to an action plan developed by partners in public health to reduce the levels of maternal smoking. Women were offered Carbon Monoxide (CO) monitoring at booking and referred to smoking cessation services within GP surgeries and pharmacies. The Helme Chase Maternity Unit performance between February 2015 and June 2015 showed that between 0% and 40% per month of women were offered CO monitoring and between 0% and 56% of women were offered a referral to smoking cessation services.This was below the trust target of 95% in both instances.

Access and flow

- There were no closures of the Helme Chase Maternity Unit however staff we spoke with informed us that there were processes in place should a woman labour at home and another woman was labouring in the unit.
- The percentage of pregnant women accessing antenatal care who were booked for delivery by 12 weeks and six days between March to May 2015 was 95% which was above the trust target of 90%.
- All routine antenatal care was provided by community midwives. They completed risk assessments with women and gave advice and support with choice of place of delivery and birth plans. Women also attended the unit for antenatal care. Those with high risk pregnancies attended consultant-led clinics.
- Midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- There was good access and flow in the antenatal clinic. We observed a morning clinic and saw that women did not have to wait long before being seen. Staff we spoke with did not collect data on waiting times at present as clinic bookings were paper based.

Meeting people's individual needs

- Women using the maternity services could access specialist midwives for the following aspects of care: diabetes, substance misuse, mental health and domestic violence during their antenatal care at Helme Chase Maternity Unit.
- Processes were in place to identify women with learning disabilities. Staff encouraged family and key workers to be involved in the care pathway.
- There was a substance misuse midwife who provided support and advice to women in their home or clinic. However, intrapartum care was provided in Royal Lancaster Infirmary or Furness General Hospital. Information was shared with the named midwife, health visitor and social services.
- Women with a booking body mass index (BMI) of over 30 were referred to for consultant led care and would not deliver at the Helme Chase Maternity Unit, however, would be able to access consultant antenatal care.
- Women were routinely asked about current and previous mental illness at their antenatal booking. A maternal mental health risk assessment form was completed and women were offered review with the specialist mental health midwife to develop a plan for the perinatal period. There was on-going assessment of the woman's mental health during the antenatal and postnatal period. Referral could also be made to the crisis team and adult mental health team. Depending on the medication women and their babies might need specialist care and would be delivered in Royal Lancaster Infirmary or Furness General Hospital.
- There were a range of information leaflets in clinical areas including tests and screening, breastfeeding and other sources of support. The leaflets were available in different languages if required.
- The 'new-born infant physical examination' (NIPE) was led by trained midwives. The NIPE checks were now undertaken using an electronic system. Staff we spoke with identified that this had streamlined the system and targets were being met.

Learning from complaints and concerns

- Complaints were handled in line with the trusts policy. Information was given to women about how to make a comment, compliment or complaint. Matrons gave women contact cards so they could call if they had any worries or concerns during their stay.
- There was one complaint for the Helme Chase Maternity Unit between July 2014 and May 2015. Learning from complaints and concerns was discussed at monthly and weekly governance and risk management meetings, which staff were encouraged to attend.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Good

Staff felt engaged with the staffing reconfiguration at the Helme Chase Maternity Unit. There was good local leadership of the service.

Trust wide maternity services were working towards implementing the recommendations of the Kirkup Report (2015) and governance processes were beginning to be embedded within the service. Clear guidelines were in place to ensure the risk of complications to care and treatment were reduced.

There was good team working and engagement amongst staff; this was particularly the case during the reconfiguration of the maternity care provision. Staff were confident to challenge poor practice and were supported by their local managers to do so.

Plans were being developed to support women in their choice of birth through the use of virtual tours and parent craft education, in the hope that this would attract more women to deliver at the unit.

Vision and strategy for this service

- The strategy for maternity services was aligned with the trust's operational development strategy 'Better Care Together'. The five year plan included a fully integrated maternity care pathway to meet the needs of women focussing on the provision of a midwife led service for birth.
- The reconfiguration of staffing for the Helme Chase Maternity Unit occurred in December 2014 and staff we spoke with informed us they felt involved with the process throughout.
- Staff were aware and engaged with this vision and strategy.

Governance, risk management and quality measurement

- Governance structures and processes were evolving. Divisional cross bay governance meetings were held each month. Minutes of 'we-see' governance forums showed areas discussed and actions taken included on workforce, efficiency, safety, effectiveness and experience.
- To support the governance process there was a full time risk midwife, governance lead and quality and safety midwife who were the interface between management and all other staff in maternity and gynaecology in sharing of risk management.
- The risk register was reviewed and updated through the governance processes. There was some alignment of what staff had on their worry list with what was on the risk register.
- The service had developed a maternity dashboard. The dashboard was a clinical performance and governance score card and helped to identify patient safety issues in advance. We observed that a number of areas were rag rated as requiring improvement, this included post-partum haemorrhage, third and fourth degree tears and caesarean section rates. We discussed assurance processes and monitoring against the dashboard with the senior team. The team acknowledged that further work was required relating to analysis and action planning and that the dashboard was being revised.
- The maternity risk management strategy set out guidance for reporting and managing risk. It detailed the roles and responsibilities of staff at all levels to prevent or minimise the possibility of re-occurring risks and their consequences.
- There was a divisional governance lead and risk manager who triaged all incidents. Low and no harm incidents were managed locally on the wards.
- Supervisors of midwives (SOM) were involved in practice issues. The risk team sent a letter to the SOM informing them of any issues and this linked into the practice development midwife, for example, if further mandatory training was required following an incident.
- We saw that the majority of maternity and gynaecology policies and procedures were accessible to staff on line and were in date and ratified.

Leadership of service

- The leadership structure in maternity and gynaecology consisted of a Clinical Director, Deputy Director and Head of Midwifery (HOM) and Divisional General Manager.
- The HOM was responsible for maternity and gynaecology across the three sites. The HOM was the

deputy director of Midwifery and reported to the Chief Nurse. There were three maternity matrons and a gynaecology matron who were accountable to the HOM. A deputy HOM had also been recently appointed.
- There was good matron support on the Westmorland site and staff said they had regular access to the matron or a manager who was on site every day. The matron also took part in the on-call rota for the Unit.

Culture within the service

- Staff we spoke with were positive about the reconfiguration of the Helme Chase Maternity Unitand reported they could raise concerns which would be listened to.
- We found good team working and engagement amongst teams.
- We observed willingness amongst midwives to integrate and work as one trust. They were aware of the challenges of the geographical area and acknowledged the need to rotate across sites. This was already happening for newly qualified staff.
- Staff turnover rates were 8% for midwifery staff, however, staff were being seconded from the community to gain experience of the Unit and to support vacancies
- The 12 month cumulative sickness absence by whole time equivalent for the Unit between July 2014 and June 2015 was 5.91% against a trust target of 4.3% (based on the NHS North West average as at 31st March 2014).
- We were told that a member of staff lived over 50 minutes commute from the Helme Chase Maternity Unit; this was identified as a concern as this commute would delay care. Therefore during this staff member's 'on-call' accommodation was made available on the Westmorland General Hospital site for her.

Public and staff engagement

- The service took account of the views of women through the Maternity Services Liaison Committee which was known as 'Maternity Matters'. The minutes from March and May 2015 showed areas such as user experience and feedback, compliments and complaints, and quality assessments and breastfeeding support were discussed.
- The NHS Staff Survey 2014 showed the trust was within expectations for staff agreeing that feedback from patients was used to make informed decisions in their department.
- Work was progressing to improve cross-bay working. The senior management team told us from August 2015 a new video conferencing facility would be available for the women's division to increase MDT working.
- We were told that plans were being developed to raise awareness of the Unit through social media and developing a virtual tour to support women and their families to make an informed choice of where they choose to deliver.
- Staff we spoke with reported that plans were being developed to improve the provision of parent education, through changing the times in which couples would be able to access the courses.
- The service participated in the 15 Steps Challenge, designed by the NHS Institute.This encourages patients and staff to work together to identify improvements which may enhance the patient experience. The challenge team consisted of a service user, staff members, a trust governor, the acting chair and director of governance and other members of the corporate governance team who walked the wards and took note of their first impressions. Action plans showed changes had been completed to the environment, with improved signage and updating of information displays.
- We were informed that there were good links with independent midwives who supported women in the local area and SoM support was provided for high risk cases. Staff also reported good links with Doula's (who are private birthing partners).
- A cross-bay midwifery and health visiting pathway was being developed and this included regular engagement meetings with health visiting managers.

Innovation, improvement and sustainability

- The Annual Local Supervisory Audit report October 2014 showed that the team of Supervisors of Midwives demonstrated great commitment to their statutory role and ensured that supervision was making a difference to the quality of service within the organisation.

Outpatients and diagnostic imaging

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

Information about the service

For the period 2013/14 the trust had 512,694 outpatient attendances (148,535 of these were at the Westmorland General Hospital). In the period 2104/15 this had increased to 520,602 attendances trust wide. Records we reviewed confirmed that there had been a steady increase in required diagnostic services appointments over the last three years.

Westmorland General Hospital provides a range of outpatient clinics, including allied health services departments, such as occupational therapy, physiotherapy, nutrition and dietetics, and pharmacy services. The trust runs a range of diagnostic and screening clinics across the three sites we visited as part of our inspection. The radiology service included: Diagnostic imaging and reporting across a variety of modalities including CT/MR imaging, Mammography, Ultrasound and General Radiography. The pathology service provided a full range of patient diagnostic and reporting services to support effective patient diagnosis and treatment plans.

The service had a Community Patient Contact Centre (CPCC) which acted as the patient focal point for correspondence, discussions and planning around bookings for their elective appointments.

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

We inspected a number of the outpatient clinics at this hospital including orthopaedics, ENT, physiotherapy and diagnostic services. We spoke with six patients and 10 staff including nursing, medical allied health professionals and support staff some of whom worked across the 3 hospital sites. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Outpatients and diagnostic imaging

Summary of findings

Since our last inspection we found that improvements had been in some of the areas we inspected. However we found that there were still improvements required in some areas such as the staffing levels in radiology and the provision of appropriate information available for patients who had a learning difficulty. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We found that overall access to appointments had improved but performance was variable.

During our last inspection we noted that there was no information available in the departments for patients who had a learning disability. Our last inspection report noted that we could not find information available in easy to read formats; or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that main outpatient have specific information /leaflets for patients with learning disabilities and easy read formats; or written in formats suitable for those patients who have a visual impairment.

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place for staff working in the radiology department along with temporary staff to the department.

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.

Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance.

Overall staff felt more engaged with the trust and felt that there had been some improvements in service delivery. There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

Since our last inspection, there had been some improvements such as in the provision of records but we found some further improvements were required. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the area where the Macular eye clinic was held. This was located on the first floor away from the main outpatient area. The manager told us that the location of the clinic presented operational difficulties such as managing the skill mix of staff between the two areas as well as not being fit for purpose in regards to Health and Safety standards. It was confirmed that health and safety risk assessments had been carried out. Following the inspection the trust informed us that a project team was looking at the location of the service across the three hospitals. The local manager appeared unaware of these plans during our inspection which did not assure us that staff were able to manage environmental risks effectively.

The trust managers told us that there was an "I've been cleaned" sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture. We did not see evidence of this being used universally across all the departments we visited. Mandatory training was variable, although managers were aware of the shortfall and were planning extra training sessions to ensure compliance.

At our last inspection we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services. At this inspection we found there was a shortage of radiologists and staffing shortages in pathology.

During our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had invested heavily in the medical records storage and provision on site. As a result we found there had been improvements in the availability of case notes. The trust had continued to roll out its "Paper Lite" project which ensured that electronic information was available for patients. This project was not yet fully implemented but staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.

Incidents

- There had been no serious incidents (STEIS) reported during the reporting period May 2014 and April 2015 in outpatients and diagnostic services at this hospital.
- At our previous inspection we told the provider that the trust must improve its incident reporting and all staff must be aware of their responsibilities to report both incidents and implement remedial action and learning as a result. During this inspection we found that staff were aware and understood their responsibilities with regard to reporting incidents. All accidents, incidents, allegations of abuse or complaints were logged on the trust-wide electronic reporting system.
- Previously we found that performance information and learning from incidents was not effectively used to drive changes and improvement. At this inspection we found incidents were investigated by trained managers. We saw examples of shared learning from incidents to secure improvement and prevent reoccurrence.
- We found that no IRMER incidents had been reported in the period prior to our inspection.
- During our last inspection of the Breast Screening Service at this hospital and across the three sites we were informed of concerns in relation to the breast screening of patients who had gone on to develop symptomatic breast cancer at the site of their original assessment. Following our last inspection there was an external review of the breast screening unit by an independent body. During this inspection we observed that the recommendations given to the trust were being followed.
- We found that no IRMER incidents had been reported in the period prior to our inspection.
- Staff were aware of their responsibilities to be open with patients under the duty of candour regulations. We did not see examples of where duty of candour had been required.

Cleanliness, infection control and hygiene

Outpatients and diagnostic imaging

- The outpatient and diagnostic imaging settings were visibly clean overall and regularly maintained.
- The cleaning records for the departments confirmed that the environment was cleaned regularly and this was displayed publicly for patients to see.
- Regular hand hygiene audits demonstrated good levels of compliance rates in line with trust targets throughout the departments.
- Staff in the outpatients and diagnostic imaging departments complied with the trusts policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidance.
- The trust managers told us that there was an "I've been cleaned" sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture. We did not see evidence of this being used universally across all the departments we visited.
- Staff working in the Radiology Department had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.

Environment and equipment

- We noted that space was limited in some areas and the service provision was physically constrained by the existing environment.
- We visited the area where the Macular eye clinic was held. This was located on the first floor away from the main outpatient area. The manager told us that the location of the clinic presented operational difficulties such as managing the skill mix of staff between the two areas as well as not being fit for purpose in regards to Health and Safety standards. It was confirmed that health and safety risk assessments had been carried out. Following the inspection the trust informed us that a project team was looking at the location of the service across the three hospitals. The local manager appeared unaware of these plans during our inspection which did not assure us that staff were able to manage environmental risks effectively.
- Equipment within the departments had been portable appliance tested for electrical safety. Our checks of equipment revealed that the equipment was well maintained and ready for use. All the staff we spoke with said that space was limited for the suitable storage of equipment. This was acknowledged by the trust and identified on the divisional risk register.
- We examined the resuscitation trolleys located throughout the departments. The trolleys were secure and sealed. We found evidence that regular checks had been completed. However, we noted that all the record logs were new and had commenced in June 2015 so we were not able to review practice prior to this date.
- The diagnostic department had a radiation protection 'local rules' policy in place to support the safe use of equipment.
- Radiological/hazard signage was displayed throughout the department.
- There were systems and processes in place to ensure maintenance and servicing of imaging equipment.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or IV fluids held in the outpatient areas. No medicines were kept in the Diagnostic imaging department.
- Medications that needed to be refrigerated were stored in locked fridges. Temperature records that we looked at were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range. This was in line with trust policy.
- Prescription pads were stored securely and there were monitoring systems in place to ensure their appropriate use.

Records

- At our last inspection we told the provider they must ensure the timely availability of case notes and test results in the outpatients department. We found that the outpatient departments were experiencing difficulties in obtaining patient records in time for clinic appointments. At this inspection we met with staff and managers who confirmed that the provider had invested heavily in the medical records storage and provision on the site. At the time of our inspection the latest data provided by the trust for Westmorland General Hospital was 97% availability for outpatient records and 98% for elective inpatients. The staff we met were very proud of the improvements they had achieved since our last inspection. They carried out a system of audits to monitor the improvements.
- The trust had continued to roll out its "Paper Lite" project which ensured that electronic information was available for patients. This project was not yet fully

implemented but staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.

Safeguarding

- Safeguarding policies and procedures were in place across the hospital. These were available electronically for staff to refer to.
- There was a safeguarding lead at the hospital and radiology/diagnostic staff told us they were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Audits provided by the trust showed that the staff had followed the correct safeguarding process.
- The trust target for safeguarding training was 80%. Records showed that the outpatient service had achieved 100% compliance with the relevant safeguarding training. 98% of staff working in the radiology/diagnostic department had completed mandatory safeguarding training to level 2, and child protection training to level 2.

Mandatory training

- The majority of staff received access to training in a range of subjects including health and safety, infection prevention control and manual handling. Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs. Some staff told us accessing e-learning had practical difficulties as it was located on the intranet. Staff needed to access it through computers in the department, which was not always possible.
- The trust target for mandatory training was 80%.Records showed a mixed result in the numbers of staff who had completed their mandatory training. At the time of our inspection records showed that the service had met the trust targets for equality & diversity, health, safety & welfare and infection prevention control. However we found that for fire and resuscitation training the figures in July for outpatient and diagnostic imaging at Westmorland General Hospital were 76% and 55% within month. Managers were aware of the shortfall and were planning extra training sessions to ensure compliance. The lack of appropriately trained staff may impact on the provider's ability to ensure the safe and appropriate provision of care to patients.

Assessing and responding to patient risk

- At our last inspection we found that that the trust previously had issues with the implementation of an electronic appointment booking system prior to 2011. At this inspection we found that patients' safety was being monitored on a regular basis in relation to delays in accessing appointments. An outpatient improvement group was in place to monitor and implement improvements in the management of patient appointments, in order to ensure care was provided in a safe and timely manner and to reduce risks such as delays in appointments (which in turn could cause delays in diagnosis and treatment).
- Policies and procedures were in place should a patient deteriorate or have an adverse reaction to drugs and preparations in the diagnostic and imaging department.
- If a patient became unwell in outpatients department the service had a clear protocol to follow. Staff were able to talk about and demonstrate a good knowledge of emergency procedures.
- There were policies and procedures in the imaging department to ensure risks to patients from exposure to harmful substances were managed and minimised.
- WHO checklists were completed for non-surgical interventional radiology and audits showed these were being completed in line with trust policies and procedures.

Nursing staffing

- At our last inspection we told the provider that they must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided.
- The trust did not have a formal tool for calculating the number of nurses required in outpatients; however staff told us that they tried to ensure enough staff to provide chaperones for all patients in clinic. Managers determined the number of nursing staff required by the number of clinics running at any particular time but also by the nature of the clinics.
- Staff told us they were able to plan rotas in advance to manage the workload. Staff felt that nursing numbers and skill mix overall met the needs of their patients.

Outpatients and diagnostic imaging

- We found that the outpatient staff had to access to agency staff to ensure adequate staffing levels were available to support the needs of patients.
- As of May 2015 the sickness rate at Westmorland General Hospital for outpatient services was 0.5% lower than the trust overall sickness rates. As of May 2015 the sickness rate reported in the radiology department was 5% which was higher than the trust target. Managers were aware of the staffing levels and absence rates which were monitored monthly.

Medical staffing

- At our last inspection we told the trust they should consider its investment into the diagnostic and imaging services to respond to increased demand. Staffing concerns were identified in radiology and dermatology, where there was a shortage of specialist staff. The trust was told they must continue to actively recruit medical and specialist staff in areas with identified shortfalls.
- At this inspection we found that the radiologist vacancies were identified on the divisional risk register as a high risk. There were vacancies within the radiology service. Managers told us that they were actively out to recruitment and had introduced the use of extended roles for advanced practitioners to help manage the case load. We did not see evidence of any sharing of staff with other trusts The service leads felt that there had been some improvements in staffing but the recruitment of experienced radiology staff remained a challenge. Records provided by the trust showed that the vacancy rates as of May 2015 for medical staff were 28%.
- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by specialist consultants and their medical teams.

Allied Health Professionals

- At our last inspection we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services.
- The need for additional occupational therapists had been identified on the trust wide risk register and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies. As of May 2015 Westmorland General Hospital data reported no staff sickness for occupational therapy compared with other trust wide locations. Trust data showed as of May 2015 the vacancy for therapy staff was below 1%. The lack of appropriate therapy staff may impact on the safe and timely care for patients and have a potential impact on their rehabilitation and length of stay.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment. There were clear instructions in place for staff to follow in the event of a major incident. We saw posters displayed giving advice to staff on how to use personal protective equipment in the event of a major incident. This showed that the incident planning was visible to all staff throughout the trust.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. Radiology staff were able to explain their safety protocols and the local rules were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy. The outpatient service operated six days a week and had extended normal working hours. However most activity happened between Monday and Friday 9am-5pm. There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.

Staff were competent and supported to provide a good quality service to patients. We found a varied level of understanding of the implications on their role and responsibilities that would result from a patient's lack of mental capacity.

Evidence-based care and treatment

- Care and treatment followed evidence based national guidance. For example NICE guideline 101: management of chronic obstructive pulmonary disease

(COPD). We also found that services were following royal college guidance such as the Royal College of pathologists' clinical guidelines for the management of abnormal blood results.
- NICE and best practice guidance was available to staff via the trusts intranet.
- Radiotherapy's guidance was condensed national guidance and was easily accessible on the departments own database.
- Radiology staff were able to explain their safety protocols and the local rules were displayed in all the rooms. Double reporting of scans was in place to ensure their accuracy.
- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective but safe scan for each body part and these showed appropriate exposure levels.
- Radiotherapy undertook both internal and external audits, which were mostly positive. These included system audits, such as equipment calibration, image review processes and British Standards Institute (BSI) assessment.
- The trust had developed integrated pathways in ophthalmology to ensure a consistent approach to care across the different locations managed by the trust.
- We found that the pathology service was the first in its regional network to develop a fully integrated haemorrhagic fever protocol across the primary and secondary care partners.
- The breast screening service had utilised new web based technology to allow the staff to share ideas with their sister sites to ensure consistent effective care and treatment in the services.

Pain relief

- Records confirmed that patients' pain needs were assessed before undertaking any tests in the majority of cases.
- Staff were able access appropriate pain relief for patients within clinics and diagnostic settings.
- Prescribed pain relief was monitored for efficacy and changed to meet patients' needs where appropriate.

Patient outcomes

- Radiotherapy and Diagnostics undertook both internal and external audits, which were mostly positive.
- We were told that Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) audits were conducted which showed that the service was compliant.
- The outpatient departments participated in audits such as hand hygiene, cleanliness and record keeping. We also saw evidence of staff using the electronic patient record system to carry out electronic clinical audits such as for waiting times in clinic.
- Records of local audit demonstrated a high rate of compliance with good practice across the service including IRMER audits in the imaging department. The day before our inspection we had observed at the sister sites a trust wide audit day was in action when staff from the three trust locations met together to take part in clinical audit presentations and learning. We were told by staff and records showed that this was a regular diary commitment to ensure that opportunities for audit were in place across all the trust locations.
- Records of local audit demonstrated a high rate of compliance with good practice across the service.
- The pathology service was compliant with the national clinical pathology accreditation scheme.

Competent staff

- Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages.
- The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial. Data provided by the trust showed that 71% of outpatient staff at band 7 and below and 98%of radiology staff had received an appraisal in the last twelve months.
- Staff were also trained in meeting the needs of patients living with dementia.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together.
- We found that the Radiology and Diagnostic services offered one-stop clinics in some specialties, such as those provided by the Breast Screening Unit (BSU). Patients attending the BSU could receive an ultrasound,

mammogram, and aspiration, dependant on clinical need. The clinic was staffed by specialist radiographers alongside a consultant. Specialist nurses offered a support service for patients.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any relevant treatment management plans.

Seven-day services

- Diagnostic clinics ran across six days at Westmorland General Hospital . However, most activity happened between Monday and Friday 9am-5pm.
- The service also provided access to services 'out of hours' this included 'out of hours' and weekend cover for radiography physiotherapy and certain pathology services.
- Weekend and late evening clinics were used to assist with capacity where waiting lists demands were greater than clinic capacity and to offer greater flexibility for patients to access the service.

Access to information

- Medical and nursing staff said they had access to the information they required. They said the notes were almost always available for clinics and always for surgical procedures.
- Staff had access to trust intranet to access policies, procedures and NICE guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although the staff told us they had received training in the Mental Capacity Act 2005, we found during our discussions with staff, their knowledge was variable. Some of the staff we spoke with could not demonstrate a sound knowledge of the principles inherent within the legislation.
- We found a varied level of understanding of the implications on their role and responsibilities that would result from a patient's lack of mental capacity. Most staff could not explain when an assessment might be indicated, how it would be requested or who would complete it. This meant a patient may not receive an appropriate assessment of their mental capacity or the support which may be indicated as a result.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.

The trust had a number of clinical nurse specialists and lead nurses available for patients to talk about their condition. There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and carers.

Compassionate care

- Patients said that staff had been polite and caring. Staff spoke with patients in a respectful manner and were open and friendly in their approach. We witnessed patients being treated with courtesy and dignity by reception staff, who showed patients to side waiting areas when required. We found copies of a "Dignity and Respect Policy" in each clinic room.
- We observed some instances where patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff could describe examples of how difficult messages were given to patients and those close to them both sensitively and privately. However, we observed and the trust data confirmed that some patients were told to expect results by telephone. Our specialist advisors felt that this was not good practice as patients should receive bad news face to face so that they could access emotional support in a timely manner.
- The service operated a continuous patient experience survey which patients were encouraged to complete, either during or following their visit to the department. We saw examples of completed surveys which were all positive.
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- The Friends and Family Test, which assesses whether patients would recommend a service to their friends or family, showed that 97% of patients would recommend the service to family and friends.

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Patients told us they were aware of their condition and that the doctors and nurses had explained this clearly to them. Patients told us they felt well informed about their care and treatment and could make informed choices.
- During our inspection we spoke with three patients who told us that the diagnostic tests they had undergone were explained and their consent sought as appropriate.
- Within the outpatient areas there was a range of information and literature available about a variety of conditions.
- Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- There was evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.

Emotional support

- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk about their condition. For example respiratory nurses to talk with patients who had been referred for oxygen therapy.
- We saw examples of access to volunteers to offer both practical advisory and emotional support to both patients and carers.
- Three records we looked at showed completed assessments for anxiety and depression appropriate to the clinical needs of the patients.

Are outpatient and diagnostic imaging services responsive?

Good

We found that overall access to appointments had improved but performance was variable. The percentage of people waiting less than 31 days and 62 days from diagnosis to first definitive treatment for all cancers varied. From quarter 1 to quarter 3 of 2013/2014 the trust performed in line with the England average. In quarter 4 of 2013/2014 the trust performed worse than the national average but from quarter 1 to quarter 3 2014/2015 the trust performance improved and they performed slightly better than the England average.

Vulnerable patients were managed sensitively and attended to as quickly as possible. The Outpatient and Diagnostic imaging departments were able to access telephone translation services for patients. During our last inspection we noted that there was no information available in the departments for patients who have a learning disability or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that this was not the case. Main outpatient had specific information and leaflets for patients with learning disabilities and easy read formats; or written in formats suitable for those patients who had a visual impairment

Service planning and delivery to meet the needs of local people

- The trust served a geographical area of 1000 square miles. The trust outpatient and diagnostic imaging services were located through the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Some services such as dietetics were piloting telephone clinics to reduce the need for patients to travel. We noted that this was not always suitable for each patient and this was being monitored for efficacy.
- Some staff felt that although they were encouraged to work as one trust there were still issues in inequalities of service delivery on each site. Staff reported that if they rotated to a different hospital site the policies and procedures were not always the same in a similar department. The lack of streamline provision may impact on the effectiveness and appropriateness of service delivery.

Access and flow

- The outpatient department undertook 520,602 outpatient appointments during 2014/15.
- The referral to treatment percentage score within 18 weeks for non-admitted and incomplete pathways were better than the standard from April 2013 to February 2014. From March 2014 the trust was similar to the England average and fell lower than the standard in January 2015.

Outpatients and diagnostic imaging

- Trust wide data showed diagnostic waiting times were generally lower than the England average with the exceptions of April, October 2014 and January 2015.
- All three trust wide cancer wait measures performed similar to the England average from 2013/14 and 2014/15.
- The percentage of people waiting less than 31 days and 62 days from diagnosis to first definitive treatment for all cancers varied. From quarter 1 to quarter 3 of 2013/2014 the trust performed in line with the England average. In quarter 4 of 2013/2014 the trust performed worse than the national average but from quarter 1 to quarter 3 2014/2015 the trust performance improved and they performed slightly better than the England average.
- Changes to the management of the waiting list meant those that had been waiting longest were now being offered the quickest appointments. This meant fewer patients were waiting extended periods. The average percentage of clinics cancelled from January to April 2015 was 0.6%.
- The trust had a number of patients who failed to attend for their appointments. The Did Not Attend rates were consistently lower than the England average with an average of 4% for the hospital compared to 7.2% nationally. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department. Staff were able to describe how they had responded to an identified delay in ENT clinics and how they had put systems in place to reduce the waiting times for patients. Data provided by the trust showed at Westmorland General Hospital, 1% of patients waited up to 30 minutes for their appointment in the last four months and only 1 % of patients waited over 60 minutes.
- We also noted at our last inspection that there were a number of incidents regarding the transport for patients. We spoke with patients and external staff who confirmed that this had improved over the last twelve months. No incidents related to transport had been recorded for Westmorland in the last six months.
- We found that the follow up to new appointment rates for the Westmorland site were consistently higher than the England average. This meant that patients may not always be followed up appropriately and in a timely manner.

Meeting people's individual needs

- The Outpatient and Diagnostic imaging departments were able to access telephone translation services for patients. We were told by staff that this could be arranged without notice when patients who required the service presented themselves in clinic. However, we did not see any information in any format explaining this to patients who may need translation services.
- During our last inspection we noted that there was no information available in the departments for patients who have a learning disability. Our last inspection report noted that we could not find information available in easy read formats; or written information in formats suitable for patients who had a visual impairment. During this inspection we noted that there was information available for people with learning disabilities. Main outpatient had specific information and leaflets for patients with learning disabilities and easy read formats; or written in formats suitable for those patients who had a visual impairment.
- We observed that patients with above average weight were weighed in the outpatient corridor which did not ensure their privacy or dignity. We also found that other patients were weighed and measured at the end of the corridor behind a curtain. We were not assured people's privacy was being maintained, although staff did tell us that they were discreet when telling patients their weight.
- There was a discreet trust wide system for the identification of a patient living with dementia who may require additional assistance.
- Vulnerable patients were managed sensitively and attended to as quickly as possible.

Learning from complaints and concerns

- We found concerns or complaints leaflets and Patient Advise Liaison Service leaflets were available throughout the departments. The response target for complaints is 35 working days from receipt of the complaint which data showed was currently being met. We saw copies of the latest "Learning to improve" bulletin. This bulletin highlighted the ways the organisation had considered complaints and changed or improved things. One area highlighted in the bulletin related to the outpatient department reminding all staff about the importance of informing patients of any delays during clinic.

Outpatients and diagnostic imaging

- Trust data for the time period 1 June 2014 – 31 May 2015 showed that 19 complaints had been received which were related to the outpatient service and two related to the imaging department. These included issues such as staff attitude and communication between the trust and individual patients.

Are outpatient and diagnostic imaging services well-led?

Good

Since our last inspection there had been an investigation into breast screening trust wide by an independent body. The investigation was initiated after concerns were raised regarding the quality of clinical practice in the breast screening service provided by Hospital of Morecambe Bay Trust (UHMBT). The investigation report was completed in 2014 and made a number of recommendations for action by the trust. The report outlined that the service was meeting national minimal standards, however there were quality issues in the service that needed addressing. During this inspection we observed that the recommendations given to the trust were being followed.

There were systems to report and manage risks. Senior staff were aware of the risk register and were actively engaged in monitoring the risks. The outpatient service reported risks through the core clinical services division.

Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.

The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited with post boxes for patients and visitors to leave completed forms. Patients told us they were actively encouraged to complete these. We looked at a sample of five completed cards which were all overwhelmingly positive about care people had received.

Vision and strategy for this service

- The trust's visions for the future "better care for the future" across the region were displayed through the trust. All of the staff we spoke with were aware of the trust's vision and values.

Governance, risk management and quality measurement

- At our last inspection we found that the trust's governance and management systems were not fully embedded in all parts of the service and not all services were following trust policies and procedures. At this inspection we found that improvements had been made.
- There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.
- The outpatient service reported risks through the core clinical services division. Senior staff were aware of the risk register and were actively engaged in monitoring the risks.
- Radiology consultants attended monthly directorate clinical governance and risk meetings to review the quality of service provision and ensure that the standard of clinical care was effective and in line with national standards.
- Since our last inspection there had been an investigation into breast screening trust wide by an independent body. The investigation was initiated after concerns were raised regarding the quality of clinical practice in the breast screening service provided by Hospital of Morecambe Bay Trust (UHMBT). The investigation report was completed in 2014 and made a number of recommendations for action by the trust. The report outlined that the service was meeting national minimal standards, however there were quality issues in the service that needed addressing. During this inspection we observed that the recommendations given to the trust were being followed.

Leadership of service

- Staff told us that there executive were more visible and showed examples of regular communication and feedback.

- However we had both positive and negative feedback about the visibility of middle managers.

Culture within the service

- Staff we spoke with were candid throughout our inspection about both the good parts of their service and the areas that required improvement. Senior managers told us the service had experienced issues with effective team working and had challenges in building team resilience and communication.
- Staff felt that the service was now more open and honest but other staff told us that they were still working as separate hospitals and not one trust.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited with post boxes for patients and visitors to leave completed forms. Patients told us they were actively encouraged to complete these. We looked at a sample of ten completed cards which were all overwhelmingly positive about the care people had received.
- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service and to seek feedback.

Staff engagement

- Overall staff felt more engaged with the trust and felt that there had been some improvements in service delivery.
- Staff told us a system had now been purchased to assist with communication between sites. The staff were positive and reported that they have been encouraged to communicate regularly.

Innovation, improvement and sustainability

- Strategies for service improvements were in place in both diagnostics and outpatients. However, staff we spoke with had variable knowledge regarding strategies for improvements across the department.
- We were shown minutes from the outpatient improvement group and the staff were able to describe initiatives they had implemented such as the outpatient contact cards to improve the communication with patients attending the outpatient department. Staff told us that the group was continuing to be proactive in looking at ways to improve service delivery.
- The service had also started to develop a patient passport and an advisory leaflet for patients when they wish to cancel appointments (Access Policy).

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided in outpatients.
- Ensure referral to treatment times in surgical specialities improve.

Action the hospital SHOULD take to improve

In surgical services:

- Ensure that there are systems and process in place to for staff to be made aware of any learning and change of practice from audit programmes.
- Review written consent being obtained on the day of surgery.
- Ensure that the 5 steps to safer surgery process is audited to monitor that it is being used appropriately.

In maternity and gynaecology services:

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust.
- Ensure that a practical test of the child and infant abduction policy is completed every 12 months in line with trust policy.
- Ensure safeguarding records always record outcomes of meetings with social workers.
- Ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.

In outpatients and diagnostic imaging:

- Ensure that staff act in accordance with the requirements of the Mental Capacity Act 2005 and associated codes of practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 15 (1) Premises and equipment The provider must ensure that all premises used by the service provider are clean, secure, suitable for the purpose for which they are being used, properly used, properly maintained and appropriately located for the purpose for which they are being used. This is particularly in relation to services provided in outpatients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 (2)(a)(b) Good governance Ensure referral to treatment times in surgical specialities improve.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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